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## Communicating Health: A Thematic Narrative Analysis Among Methadone Patients

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Communicating Health: A Thematic Narrative Analysis Among Methadone Patients

by

B. Liahna Stanley

A thesis submitted in partial fulfillment  
of the requirements for the degree of  
Master of Arts  
Department of Communication  
College of Arts and Sciences  
University of South Florida

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## **DEDICATION**

To those who share the pains of addiction. Let our tears, hurt, and struggles bring us together in our pursuit of recovery and survival for our friends, family, loved ones, others, and selves.

## ACKNOWLEDGMENTS

I view this project as a co-creation. It has taken form in the kindness, generosity, love, and guidance of my friends, mentors, and family. Thanks to you, what once was only a seed of an idea—a mere strand of thoughts—has become a garland of the most vibrant blooms.

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## **ABSTRACT**

This study seeks to understand and document how people recovering from opioid addiction communicate about health and identity in the context of a methadone clinic. This project emerges in response to the rising incidence of opioid addiction and overdose death in the U.S. and suggests there is an urgent theoretical and practical calling for bringing forth the stories of people experiencing addiction and recovery. Guided by the structure-centered approach (SCA) to health communication, this study employs a thematic narrative analysis through interviews with 4 methadone maintenance treatment (MMT) patients about the meanings of health, recovery, and identity. With respect to how methadone patients communicate about health and identity, study findings reveal three key themes, which I distinguish as: 1) health as normalcy; 2) health as lack of resources; and 3) recovering the self, (be)longing, and health citizenship. It is through an understanding of these themes that this project contributes, in several meaningful ways, to research and praxis on health communication in addiction treatment spaces. Limitations of research design and considerations for future research projects on health and addiction are provided.

## **CHAPTER ONE: INTRODUCTION**

This research project is about people recovering from opioid addiction and how they communicate about health, addiction, and identity in the context of a methadone clinic. In this study, I seek to understand the lived experiences of people living with opioid addiction against the backdrop of the organizing systems and practices of the methadone clinic. Often overlooked in dominant paradigms of addiction treatment are the communicative acts of people experiencing addiction and for this reason, this project moves away from behavioral-psychological approaches to understanding addiction and instead addresses health, recovery, and identity as interpretive and communicative phenomena to emphasize the role of social and structural influences in health, addiction treatment, and construction of selves.

Given the gravity of the current U.S. opioid epidemic, there is an urgent calling to understand and document stories and experiences of people experiencing addiction. This thesis project aims to answer this calling by drawing on analyses of rich, in-depth narratives with people using methadone treatment for opioid addiction to explore the meanings of participant narratives about health, addiction treatment, recovery, and identity. The central focus of this thesis project investigates how methadone patients communicate about and make meanings of health and the influence of methadone and the methadone clinic on their negotiation practices of addiction, recovery, and identity (re)construction. Using the structure-centered approach to health communication (Dutta & Basu, 2011), as well as a narrative methodology (Riessman, 2008), this project interrogates how the communicative practices in and surrounding the lives of

people living with addiction are situated within the organizing systems that influence and govern their ways of living.

In this introduction chapter of my thesis, I offer a brief examination of the foundational issues guiding this work. In the following chapter, I provide a synthesis of existing literature most relevant to the topic of opioid addiction, treatment, health, and identity as well as the theoretical framework around which this study is conducted. I end the second chapter with a statement of the research questions that guide me in my study:

**RQ1:** How do methadone patients communicate about and make meanings of health?

**RQ1a:** How does methadone treatment influence the negotiation practices of addiction and identity (re)construction?

Chapter three outlines the study methodology, followed by chapter four in which I present the study results. The final chapter provides a discussion and summary of the study's key findings.

### **Opioid Addiction: A Public Health Emergency**

The U.S. is experiencing an unprecedented level of mortality due to opioid overdose (Centers for Disease Control and Prevention [CDC] 2017b, Katz, 2017; Kolodny et al., 2015; Rudd, Aleshire, Zibbell, & Gladden, 2016; Rudd, Seth, David, & Scholl, 2016). At the time of this writing, it is estimated that 130 people in the U.S. die every day from opioid overdose death (CDC, 2018a).

As grim as these numbers are, even more disturbing is that the daily death toll is up from 115 in 2016 to 130 in 2017, meaning that someone dies from opioid overdose every 11 minutes. Indeed, the amount of people dying from opioid overdose has been steadily increasing for quite some time. In fact, in November 2011, the U.S. CDC issued a press release reporting that deaths from prescription opioids in particular had reached “epidemic levels,” killing more people than heroin and cocaine combined (CDC, 2011). These numbers parallel increases in the rates of opioid

prescribing. As I will discuss in more detail throughout this section, the “addiction crisis” is rapidly fueled by an increased use and acceptance of prescription opioids. The subsequent addiction rates in people prescribed opioid pain relievers (OPRs) led many users to discover illicit drugs, such as heroin and fentanyl, for its cost and accessibility (CDC, 2014; Cicero et al., 2014; Kerley, Webb, & Griffin, 2018). According to the federal government’s National Survey on Drug Abuse and Health (NSDUH), 4 out of 5 current heroin users report that their opioid use began with OPRs (Muhuri, Gfroerer, & Davies, 2013; National Institute of Drug Abuse [NIDA], 2018a).

Overdose mortality and addiction are not the only adverse public health outcomes associated with opioid use. Due to increasing trends of intravenous (IV) drug use, the rise in opioid misuse is also associated with a sharp increase in the outbreak and transmission of bloodborne infections and diseases such as hepatitis C, hepatitis B, HIV, and endocarditis (CDC, 2018d, 2018f). Further, the U.S. is experiencing soaring rates of infants being born opioid-dependent. In 2014, an estimated 32,000 babies were born with neonatal abstinence syndrome (NAS), which is a more than 5-fold increase since 2004 (CDC, 2016). In addition, emergency department visits for opioid overdose increased 30% from July 2016 to September 2017 (CDC, 2018c). Equally compelling are statistics about opioid-dependent individuals and addiction treatment: From 1997 to 2011, there was a 900% increase in individuals seeking treatment for opioid addiction (Kolodny et al., 2015). In 2016, it was estimated that nearly 2.4 million people in the U.S. suffer from opioid addiction, but only 20% of those people are receiving some sort of treatment (CDC, 2018b; Goodnough, 2018).

The upsurge in opioid-use related mortality and morbidity is reflective of a dramatic shift in the practice of treating non-cancer pain that began in the mid-1990s in response to an alleged undertreatment of pain (Buchman, Leece, & Orkin, 2017; Manchikanti et al., 2012; Meldrum,

2016; Quinones, 2015). Despite the lack of quality evidence in support of safe and low-risk OPR consumption for long-term pain management, the medical community has continued to prescribe OPRs at high rates (Kolodny et al., 2015). For instance, from 1999 to 2011, hydrocodone-use more than doubled and oxycodone use increased by nearly 500% (Kolodny et al., 2015). Critics have argued that the acceleration of opioid use was fueled in large part by the recent trends in the liberalization of laws governing prescribing opioids, as well as the introduction in 1996 of OxyContin, an extended release form of oxycodone manufactured by Purdue Pharma (Kolodny et al., 2015; Macy, 2018; Van Zee, 2009). Between 1996 and 2002, Purdue Pharma launched and pursued a multifaceted marketing campaign to promote the long-term use of OPRs, which included funding for over 20,000 pain-related educational programs to encourage a more aggressive identification and treatment of pain through the use of opioids in general and OxyContin in particular (Kolodny et al., 2015). As part of this campaign, Purdue provided financial support to doctors, hospitals, medical accreditation boards, and other pain organizations to mobilize the adoption of pain as the “fifth vital sign,” establishing new standards for clinical assessment and pain treatment that “gave pain equal status with blood pressure, heart rate, respiratory rate, and temperature” (Macy, 2018, p. 27). Needless to say, through these rules and regulations the pharmaceutical and medical industries accelerated (and legitimized) the rise in opioid prescribing.

It is difficult to ignore the relentless violence of the opioid epidemic. National concern about opioid prescribing, addiction, and overdose has roused conversations about public health that parallel responses to HIV in the 1980s (Williams & Bisaga, 2016). The driver behind several of these issues is the increased prevalence of opioid addiction in the U.S., which has generated a dialogue on treatment models and approaches. In what follows, I discuss medication-assisted

treatment (MAT), the overarching treatment model of which comprises methadone maintenance therapy (MMT), as well as an overview of harm reduction philosophy.

### **Harm Reduction and Medication-Assisted Treatment**

There are two dominant, yet competing, recovery paradigms that influence addiction treatment: harm reduction and abstinence. According to the Harm Reduction Coalition (HRC), harm reduction is a range of public health strategies and policies aimed at reducing or minimizing the negative consequences associated with substance use (HRC, n.d.). Rather than focusing on whether drugs are being consumed, the philosophy of harm reduction assumes substance use to be inevitable in society and, as a public health technique, advocates for social, economic, and political equity of people who use drugs. In contrast, abstinence is the complete cessation of all substances.

Medication-assisted treatment is considered a form of harm reduction. The principle of MAT is to combine behavioral therapy and medications to treat substance use disorders and dependencies. Most commonly, MAT is used for opioid addiction and dependence. There are three major approaches to pharmacological treatment for opioid addiction: opioid receptor agonists (methadone), partial agonists (buprenorphine, Suboxone), and antagonists (naltrexone) (Kleber, 2007). Despite pharmacotherapy heterogeneity, methadone remains the predominant medication for treating opioid addiction (Scimeca, Savage, Portenoy, & Lowinson, 2000). This treatment is often referred to as replacement, substitution, or maintenance therapy.

The pharmacological approach to long-term treatment of opioid addiction was first undertaken in the mid-1960s when researchers revealed methadone, a synthetic opioid pain reliever, to be effective in the treatment of opioid addiction (see Dole & Nyswander, 1965). In 1972, methadone was approved by the Food and Drug Administration (FDA) as a long-acting

maintenance agent for opioid addiction treatment. In general, the primary goals of methadone are to relieve opioid cravings, suppress withdrawal symptoms, and block the euphoric effects of illicit opioid use. Methadone works as a full opioid agonist which means it produces similar effects to other opioids such as morphine, oxycodone, and heroin. Unlike other opioids, however, methadone is long-acting in nature and has a slow onset of effects. The extended duration of methadone works well for its treatment potential since frequent dosing throughout the day is not necessary. For example, methadone patients only need to dose once every 24 hours to ward off opioid withdrawal symptoms.

Methadone is most commonly dispensed by certified opioid treatment programs, or methadone clinics. A methadone clinic is a place where a person who is addicted to opioids can receive maintenance treatment and therapy. Methadone is administered as a tablet, wafer, or in liquid form, but the most popular route of administration is in oral solution. By U.S. law, patients must receive methadone under the supervision of a physician. In addition, clinics require attendance at counseling sessions, medical evaluations, and drug screens, though requirements differ among clinics.

This study examines people recovering from opioid addiction and how they communicate about and make meanings of health, addiction, and identity. In particular, I investigate how methadone patients communicate about health and the influence of methadone and the methadone clinic as organizing systems on the negotiation practices of addiction, recovery, and identity (re)construction. In the next chapter, I provide a synthesis of literature related to methadone and patient experiences, addiction and identity, and narratives of health in the context of addiction.

## **CHAPTER TWO: LITERATURE REVIEW**

This chapter maps out existing literature relating to the individual and structural experiences of health, addiction treatment, and recovery. It outlines major themes, theoretical approaches, and challenges within the growing body of research of substance misuse and addiction. To end, I describe the structure-centered approach to health communication and how I apply this theoretical lens to my research. In particular, I theorize methadone treatment and the methadone clinic as organizing systems to bring into relationship health with surrounding structures that constitute it.

### **Methadone and Patient Experiences**

The literature about experiences with methadone maintenance therapy (MMT) reflects a treatment that is an imperfect compromise embedded within competing discourses of morality versus the medicalization model of addiction and treatment. Although several studies have found that methadone and other forms of MAT can reduce illicit opioid use (Ball & Ross, 1991; Dolan, Wodak, & Hall, 1998; Fareed, Casarella, Amar, Vayalapalli, & Drexler, 2009; Fareed et al., 2011; Murray, 1998; Nielsen, Hillhouse, Mooney, Ang, & Ling, 2015), HIV risk behaviors (Coffin, Rowe, & Santos, 2015; Corsi, Lehman, & Booth, 2009; Gowing, Farrell, & Bornemann, 2008; Hartel & Schoenbaum, 1998; Karki, Shrestha, Huedo-Medina, & Copenhaver, 2016; Nolan et al., 2014; Otiashvili et al., 2013), and drug-related crime (Marsch, 1998), studies also reveal that individual perceptions and experiences of methadone treatment are often negative and

fraught with challenges (Anstice, Strike, & Brands, 2009; Bourgois, 2000; Cooper & Nielsen, 2017; Earnshaw, Smith, & Copenhaver, 2013; Fischer, Chin, Kuo, Krist, & Vlahov, 2002; Gourlay, Ricciardelli, & Ridge, 2005; Harris & McElrath, 2012; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985; Koester, Anderson, & Hoffer, 1999; McElrath, 2018; Radcliffe & Stevens, 2008; Woo et al., 2017). Consequently, treatment comes with a cost: People using methadone report social stigma, concerns with “trading one addiction for another” (e.g., methadone replacing their addiction), apprehension about tapering off methadone, fear of withdrawal, fear of relapse, and restrictions to personal freedom (Gourlay et al., 2005; Kondoni & Kouimtsidis, 2017). With respect to the latter point, people using MMT typically visit the clinic every day to receive their medication (a process commonly referred to as “dosing”), which complicates treatment provision for clients who do not have access to transportation. Only after demonstrating high levels of compliance in treatment (e.g., testing negative for illicit drugs, adhering to attendance policies), clients may be considered for “take-home” privileges, or small supplies of medication that permit fewer clinic visits. In addition to convenience, clients can avoid the “agonizing” and “embarrassing” process involved in supervised methadone consumption (Anstice et al., 2009; Harris & McElrath, 2012).

While it may be true that methadone maintenance assists thousands of people quit heroin and other illicit opioids, methadone is still an addictive drug. Accordingly, methadone treatment raises hope and controversy. One reason is the limited availability of treatment and addiction treatment gaps (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017), low uptake and debated efficacy of treatment programs (Hunt et al., 1985; Kimberly & McLellan, 2006), and frequent rates of relapse and recidivism (Hartwell, 1998). Contributing to these dilemmas are competing recovery discourses in which methadone and other forms of MAT are often discussed and practiced in opposition to dominant recovery paradigms, such as the 12-

step philosophy that requires complete abstinence to be in recovery. Scholars have also investigated the social, embodied, and subjective experiences of substance misuse and methadone treatment, namely around stigma and social control (Room, 2003, 2005). Researchers using Foucauldian traditions demonstrate that MMT operates as a regulatory technology of surveillance and institutional control with the overarching aim of developing productive and obedient citizens in compliance with the Western social order (Bourgois, 2000; Fraser & Valentine, 2008; Friedman & Alicea, 2001; Harris & McElrath, 2012; McElrath, 2018; Parker & Aggleton, 2003). In this case, stigma is understood as not merely a consequence of socially deviant behavior and instead as a systemic marking of categorical differences between people that continually produce and reproduce social inequity.

The quagmire of power relations that govern drug treatment in the U.S. crystallize against the backdrop of the medicalizing model of addiction, that is, addiction as a “brain disease.” As a state-sponsored, medically supervised treatment, the definition of methadone maintenance as a “drug therapy” is exemplar of the politics of addiction and medicine. Moral categories of medicine versus drug and legal versus illegal reveal the ways in which state and medical authorities enact arbitrary distinctions to exercise in controlling bodies (Bourgois, 2000). In this context, methadone’s status as a standard medical care procedure becomes the voucher for methadone to discipline bodies in pursuit of a more autonomous and productive citizen under the guise of methadone as a healthier alternative to illicit opioids (Bourgois, 2000, Keane, 2002), despite their pharmacological similarities. For instance, conversations with methadone patients expose clinic practices conflate MMT with central problems of employment, income, and upward economic mobility with the goal of reinserting clients into mainstream society rather than rehabilitating them—making the methadone clinic a particular concrete example of disciplinary biopower at work (Bourgois, 2000). Indeed, the stereotypical image of the self-

destructing, crazed addict that will go to any length to feed their habit reveals an upset in the middle-class order, despite both lifestyles compelled by similar commodity-driven hedonism of indulging in pharmaceutical aids for pleasure, mood elevation, anxiety reduction, sleep aid, and amplified productivity (Crawford, 1994). In sum, MMT is argued to function less as treatment for health and recovery and more as 1) a pivot to improve the social and economic canvas of society and 2) a social control mechanism to protect the healthy selves from the morally infected others.

The reproduction of social exclusion and inequities in MMT research is not unlike the struggles over boundaries that have been a defining feature of postmodernity, such as the HIV/AIDS “disease of exclusion” (Bancroft, 2001). According to Bancroft (2001), “sex and intravenous drug use cross the boundary between body and society, body and self: the most intimate and yet the most social boundary” (p. 97). Not unlike HIV/AIDS, addiction violates the security of self that is necessary to renegotiate these boundaries. The “addict” or “afflicted self” is the abject that threatens to disrupt the distinctions between selfhood and otherness, namely the biomedically healthy self and the unhealthy other (Crawford, 1994; Green & Sobó, 2000). From this perspective, we can draw many connections to the reproduction of inequities and acts of patrolling the borders of identity in the context of disease to the experiences of MMT clients. While we could deduce inferences analogous to the current U.S. opioid epidemic, I caution against such correlation due to the emerging white user as the face of this crisis and subsequent public health reactions that have been critiqued for their medicalized and health-centered initiatives that exist in stark contrast to other “drug scares” that affected primarily black and Latinx communities (Dollar, 2018; Hansen & Netherland, 2016; Mendoza, Rivera, & Hansen, 2018; Netherland & Hansen, 2016). Instead, presenting arguments on the epidemic-as-boundaries by HIV/AIDS researchers is better suited for extending a discussion of the

methadone clinic as a tool for creating such boundaries and mechanisms of social control and exclusion.

Stigma is ubiquitous in the realm of addiction and the institutional supervision and regulation of MMT only reinforce this harsh reality, not unlike the marking of inequity and boundaries in the HIV/AIDS research. Living at the fringes of society in a tug-of-war between competing discourses of recovery, methadone patients are at odds in their identities as well. In what follows, I discuss the relationships among addiction, identity, and treatment and discuss how I use identity as a link between addiction and health in the context of maintenance treatment.

### **Addiction Treatment, Stigma, and Identity**

Over the years, recovery and treatment models have been based on social-psychological theories and models that focus primarily on individual behavior modification, such as twelve-step programs and cognitive behavioral therapies. As Cain (1991) and Denzin (1987) have shown, for example, these programs presume clients are “ready” and have willingly “converted” to the process of adopting a new construction of self (see also Paik, 2006). Because dominant recovery models often run the risk of minimizing the role of social identities or taking-for-granted identity development regarding health, a sizeable body of research suggests significant implications for recovery and health in the construction of selves and (non-) addict identities. Indeed, there is a wealth of research concerned with the interplay of addiction, recovery, and identity work by people in recovery (Biernacki, 1986; Copes, 2016; Doukas, 2011; Gibson, Acquah, & Robinson, 2004; Hughes, 2007; Keane, 2001; Kearney, Murphy, Irwin, & Rosebaum, 1995; Koski-Jannes, 2002; Larkin & Griffiths, 2002; Matto, 2004; McIntosh & McKeganey, 2000; Murphy & Irwin, 1992; Redden, Tracy, & Shafer, 2014; Reith & Dobbie, 2012). Studies in the symbolic

interactionist tradition emphasize that individuals develop self-concepts as a reflection of how individuals perceive others to see them, and so the self acts and becomes in relation to others (Mead, 1934). This becomes especially relevant in considering socially derived identities in relation to drug use (Becker, 1953; Goffman, 1959) and how addiction stories are told against a backdrop of normative and cultural “scripts” (Carr, 2010; Phoenix, 2008).

Addiction and addictive behaviors are embedded in wider medical, legal, and cultural discourses that revolve around shifting constructs of self. Constructing a “non-addict” identity is integral to the process of addiction treatment and recovery and involves self-reflection, transformation, cultural and behavior change (Biernacki, 1986; Copes, 2016; Hughes, 2007; Matto, 2004; McIntosh & McKeganey, 2000). Therefore, it is imperative to conceptualize processes of addiction and recovery as markers of identity. Addiction represents a suspension of wellness, a deviation from what is deemed as “normal” within shifting social, cultural, and political contexts. Recovery represents a journey in sought of wellness; thus, the two concepts are in constant interplay in the context of treatment. Equally important is understanding addiction identity work as a dynamic, embodied, and fragmented phenomenon that involves a continual making and remaking of selves (Keane, 2001, 2002). This constructivist approach to identity moves away from essentialist perspectives of identity as a fixed and determined set of characteristics and places emphasis on the linkages between social context, addiction, and identity. In Gibson and colleagues’ (2004) study of drug users’ experiences of oral health, the authors conceptualize “entangled identities,” where “entangled” emerged through sedimentation processes of habits and routines of drug use that replaced those of the everyday self. This theoretical move is particularly significant for engaging addiction and identity as multidimensional and complex, rather than singular and linear.

Recovery involves a process of identity (re)construction as opioid users move from being substance-dependent to being substance-free (Redden et al., 2013). Far from an effortless process, individuals in recovery often struggle in (re)discovering the world living substance-free. In the context of methadone treatment, “substance-free” essentially means being abstinent from illicit substances while using methadone to maintain opioid-dependence. Accordingly, methadone patients are viewed as addicts in recovery. Still, harm reduction and MAT philosophies are challenged with culturally dominant recovery narratives that herald complete abstinence as the most effective way to conquer addiction (e.g., 12-step programs). Frank (2011) suggests that as a result, treatment clients internalize abstinence/morality-based discourses and thus the dominant discourse contributes to the low uptake and poor reputation of MMT. Along with these challenges, feelings of exclusion and a desire to be viewed as and assimilated into “normal” society attributes to MAT/methadone patients’ marginalized status (Radcliffe & Stevens, 2008; Room, 2003, 2005). In the words of Koski-Jannes (2002), “achieving [an] acceptable social identity may pose a problem for marginalized individuals” (p. 187), and this heightens in the context of addiction and recovery. In the face of such complexity, then, MAT patients experience identity construction much differently than non-MAT patients. To better examine the relationships among addiction and identity, such findings suggest examining research at the level of the organization and discusses implications for individuals participating in addiction and treatment programs—an understudied area of addiction research (Kimberly & McLellan, 2006).

### **Medication-Assisted Treatment and the Methadone Clinic**

The methadone clinic is a messy place for identity (re)construction that is necessary for recovery. Acknowledging prevention in overdose and diversion as important practices, McElrath (2018)

argues the extent of social control mechanisms in MMT programs “can impede recovery by reinforcing ‘addict’ identities via the presumption of deviance” (p. 338; see also Harris & McElrath, 2012). The “addict” identity is morally cemented and “tends to take center stage to the obscuration of all other facets of identity and personality” (Lloyd, 2010, p. 13). On the whole, then, the “addict in recovery” remains, first and foremost, an addict. Earlier studies suggest that patients using MAT hide their treatment from others, which encourages a perception of maintenance treatment as a “dirty secret” and associates MAT with what Murphy and Irwin (1992) refer to as identity limbo—that is, not quite addict, not quite non-addict, not quite deviant, not quite conventional (p. 259). Contributing to these self-concepts are cultural narratives of addiction that pathologize the addicted “other” to the ideal of the healthy and autonomous individual (Keane, 2002; Room, 2003). Consequently, this poses fundamental issues for identity work within methadone patients.

The instrumental and relational practices of MAT clinics have implications for how people respond to treatment. Gourlay and colleagues (2005) argue that methadone patients who develop “non-addict” self-concepts respond better to treatment than patients with “conflicted” identities in relation to addiction and treatment. Nevertheless, recent studies complicate identity transitions in addiction and recovery. Findings suggest that methadone provision reinforces the “addict” identity, renders clients powerless and untrustworthy, and treats clients as suspects rather than patients (Anstice et al., 2009; Harris & McElrath, 2018). Moreover, Redden et al. (2013) observe clients continually blame themselves for their individual failing, noting an emerging theme that clients feel as if they “should suffer consequences in line with their actions” (p. 960). The authors identified other themes in the participants’ talk, including the absence of hope, motivation, and ambition, as well as the perception of methadone as a “crutch” for the

“weak” because patients are not strong enough to kick their “dirty habits.” Echoed in these metaphors is the ubiquity of stigma and social control in MAT programs.

Although the methadone clinic is part of a larger health culture, it is unlike other healthcare facilities in that the methadone clinic offers little to no opportunity for patients to hide their dis-eased identity (Lloyd, 2010). As a result, clients raise concerns about lack of privacy and often report feelings of humiliation, shame, and embarrassment, particularly about dosing in public (Anstice et al., 2009). In addition, the current practice model of medicalized treatment neglects the various social, political, cultural, and economic issues that inform, complicate, and govern experiences of addiction and recovery. Despite treatment literature recognizing the multidimensional and dynamic ramifications of addiction (e.g., housing, legal, economic, health, mental health, interpersonal relations), current treatment practice models do not comprehensively treat the sociocultural context of patients. According to Matto (2004), disregarding the specific sociocultural elements of lived client experiences hinder the construction of identity for clients. Such practices significantly influence the possibility for clients to make critical changes for recovery, including “cultural transformations” of the everyday rituals, symbols, and language associated with various aspects of living addiction and living recovery (Matto, 2004).

In conjunction with transforming a new social and cultural identity, addiction treatment involves the renegotiation of a client’s sense of self and everyday life. Disassociating with the drug-using world, reforming lifestyle routines, and learning how to replace dysfunctional, unhealthy interpersonal relationships with more supportive groups are common themes in fostering a recovering self-identity (Gibson et al., 2004; McIntosh & McKeganey, 2000). Consistent with these findings, Hughes (2007) states that a key feature of successful recovery narratives is an attempt to “re-orientate their living and identity practices as part of a transformative project toward becoming a non-user” (p. 687). For instance, finding and

maintaining employment can be a great achievement for methadone patients in their desire to lead routine, meaningful, and confident lives (Augutis, Rosenberg, & Hillborg, 2016; De Maeyer et al., 2011; Vigilant, 2005, 2008). In this case, routine activities are couched in terms of everyday practices characterized by those which are “normal” and communicated in terms of stability and control: having a job; healthy interpersonal relationships; housing; and “freeing” oneself from the never-ending hustle of buying drugs and getting high (Vigilant, 2005).

These findings suggest the process of MAT patients wish to, quite literally, be recovered. That is, recovery is implied as returning to their “normal” sense of selves, habits, and ways of living during recovery, though this process is one of social, political, and institutional turbulence (Nettleton, Neale, & Pickering, 2012). Hence, the methadone clinic breeds complexity in both the everyday workings of the clinic and the facility itself. While there is evidence that methadone programs have positively affected the lives of many people recovering from addiction, it does not dissuade from the barriers that methadone patients experience. Of course, social control, exclusion, and problematic identity construction practices are not limited to the methadone clinic, but clinic technologies contribute to the shrinking of space(s) and resources made (un)available for individuals and communities experiencing addiction and/or recovery.

What remains clear is the need for treatment programs to take into account the social, cultural, and economic influences of addiction (Singer, 2006; Weinberg, 2005) and use alternative theoretical perceptions to restore individual agency within treatment. As I have shown, attending to identity in recovery can highlight areas in which we can better treat the dynamic experiences of addicted and recovering selves.

## **Narratives of Health and Recovery**

A salient strand of health literature involves the work of narrative. Narrative approaches have value in therapeutic settings (Pienaar & Dilkes-Frayne, 2017), end-of-life care (Roscoe, 2012; Young & Rodriguez, 2006) and healthcare in general (Charon, 2006, 2009; Charon et al., 2017; Harter & Bochner, 2009). In addition, narrative research emerges in studies examining the ways in which individuals experience and recover from gambling (Reith & Dobbie, 2012), eating disorders (McNamara & Parsons, 2016), family cancer survivorship (Anderson & Geist-Martin, 2003), domestic violence shelters (Kunkel & Guthrie, 2016), and sex work and subalternity in India (Basu, 2010, 2017), as well as other forms of health communication research and practice (Bochner, 2002; Carmack, 2010; Harter, Japp, & Beck, 2008; Lee, Fawcett, & DeMarco, 2016). While this literature comes with differences in disciplinary and methodological approaches, the common thread among them all is that of story and narrative.

Indeed, personal narratives of addiction are widespread in popular culture. For instance, searching “addiction” in *The New York Times* generates results about mothers’ experiences of living through a child’s addiction (Warner, 2018), storied accounts of recovery (Szalavitz, 2018), graphic memoirs of family addiction (Krosoczka, 2018), narratives of addicted mothers (Egan, 2018), and short documentaries highlighting the tensions of opioid addiction among young adults (Syznol, 2018). While the increased attention to addiction biographies may be attributed of the recent media fascination about the U.S. opioid epidemic, the prevalence of addiction biographies in media and everyday life helps organize addiction discourse (Dollar, 2018) and form perceptions of what recovery should (and should not) look like for those experiencing addiction.

Increasingly, social scientists are acknowledging the role of narrative in the context of addiction and recovery (Hanninen & Koski-Jannes, 1999; Hiersteiner, 2004; McIntosh & McKeganey, 2000; Mosack, Abbott, Singer, Weeks, & Rohena, 2005; Rance, Gray, &

Hopwood, 2017; Rhodes et al., 2011; Vigilant, 2005, 2008). For example, Vigilant (2005) observes that most frequently, MMT clients communicate recovery in stark opposition to the chaos and disorder that typically characterizes addicted lives and ways of being. In the majority case, MMT clients talk about recovery as recapturing a state of ontological security. Individuals maintain that to be recovered is to be “ordinary,” “normal,” and “like everybody else” (Vigilant, 2005, p. 404) and bracket recovery with safety, structure, and risk-management. In another case, recovery is perceived as a perpetual process with no discernible end, and to some extent, is expressed as a nearly fatalistic impossibility in which individuals reject any and all conceptions of a strictly defined recovery paradigm (Vigilant, 2005). Other findings within this strand of research are the different types of recovery stories, including personal growth, co-dependence, love and self-care, and regaining self-control (Hanninen & Koski-Jannes, 1999), which showcases recovery as fragile, multiple, and simultaneous (Vigilant, 2008). As reviewed in the earlier sections, also important for recovery narratives is the construction of (non-) addict identities (McIntosh & McKeganey, 2000).

Addiction is a marker and (re)producer of meanings for human beings, meanings that extend far beyond the physical wellbeing of human bodies. In spite of notable findings relevant to how people experiencing addiction narrate their recovery (Hanninen & Koski-Jannes, 1999; Vigilant, 2005, 2008), little research beyond these studies are dedicated to understanding meanings of recovery. Even less common is the framing and discussion of recovery in and connected to larger domains of health. The World Health Organization (WHO) defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). Thus, I posit this project to examine communication about *health*, not just recovery. While it is evident that the two concepts intertwine and influence one another, the focus on health casts a wider net to other experiences of health and well-being apart

from the cessation of illicit drug use. Namely, and as highlighted throughout the literature review, these areas include, but are not limited to: social, economic, cultural, and political influences of addiction; addiction medicalization and institutionalization; interpersonal relationships; identity construction; and the role of MMT and the methadone clinic in the construction of health and (recovering) selves.

This project follows the recommendations of Rance et al. (2017) and presents a narrative approach to understanding how MMT clients communicate about health and the influence of methadone as an organizing structure on addressing health, addiction, and identity. As humans, we are storytellers by nature (Fisher, 1984). As such, narrative is a means of human sense-making and provides a foundation for understanding how we story “self” and “identity,” past experience, and our lived realities. By invoking narrative, we are always already participating in interpretive and profoundly social processes, which holds particular implications for those whose identities are entangled within webs of stigma, risk, and vulnerability (Frank, 1995; Rance et al., 2017). This project illustrates the role of narrative in the context of methadone treatment in addition to seeking to understand how these individuals communicate about health and the negotiation practices of addiction and identity (re)construction in the context of methadone treatment. In the next section, I discuss how I theorize methadone as an organizing structure with the structure-centered approach to health communication, the theoretical framework around which I position my study. I also emphasize how narrative is useful in shedding light on the research questions examined in this study.

### **Methadone as Structure: A Structure-Centered Approach (SCA)**

Methadone is an organizing principle in the everyday lives of people seeking treatment for opioid addiction and dependency. Treatment entails early morning visits to the clinic, but only

after individuals dose do their days begin. Methadone becomes the metric for recovery among patients: Methadone classifies their recovery and recovery progress based on the medication dose. While it may be effective in curbing overdose death and illicit drug use, undeniable are the barriers that come with methadone treatment and the ways in which methadone as a medication and an organization impedes on the overall health and well-being of individuals in treatment.

Guided by the structure-centered approach (SCA) to health communication, I posit methadone medication, methadone treatment, and the methadone clinic itself as examples of structural organizations and practices. Broadly defined, the SCA situates health in relationship to the social structures and organizing systems that constitute it (Dutta & Basu, 2011). As a theoretical tool, the SCA assumes that structures play a significant role in determining how people make sense of, or communicate about, health (Basu, 2014). Structure refers to the systems of organizing within which influence or limit the resources made (un)available to communities (Dutta & Basu, 2011).

In the context of health, Dutta and Basu (2011) define structures as “aspects of social organization that constrain and enable the capacity of cultural participants to seek out health choices and engage in health-related behaviors” (p. 330). In other words, the structural ramifications for health are twofold: on one hand, structures pose limitations for the opportunity for securing healthcare in vulnerable or at-risk populations; and on the other hand, structures have the potential for creating opportunities for transformation by challenging dominant frameworks within which health is constituted (Dutta & Basu, 2011; Zoller, 2005, 2017). At large, structures of power and history cannot be talked to; however, noting the impact of structures on individual health enable us to enter a realm of interpreting how structures influence and are influenced by communication. Though it is impossible to calculate with any accuracy exactly how health is constituted by and among social structures, the SCA moves us closer to

understanding the nuances in the relationships between social structural constraints and individual experiences of health.

Critical social science on substance misuse is exemplary of structure-centered approaches to offering fine-grained descriptions and experiences of addiction. Arguing addiction as inseparable from structural influences, these texts are generative in the sense that they foreground the experiences of people and communities living with addiction to advocate for social and structural transformation. Ethnographies of communities, treatment programs, and drug markets are relevant examples (Bourgois, 2000, 2003, 2011; Bourgois & Schonberg, 2009; Garcia, 2010). For example, in the introduction of Bourgois's (2003) ethnographic study of Puerto Rican crack dealers in East Harlem, he states:

This book is not about crack, or drugs, per se. Substance abuse in the inner city is merely a symptom—and a vivid symbol—of deeper dynamics of social marginalization and alienation.... Most importantly, however, these two dozen street dealers and their families that I befriended were not interested in talking primarily about drugs. On the contrary, they wanted me to learn all about their daily struggles for subsistence and dignity at the poverty line. (p. 2)

Here, Bourgois points to the ways addiction is inherently tangled in webs of social, economic, and political influences, thus underscoring the significance of these organizing practices. In this way, this project is guided by the work of critical medical anthropology and drug ethnography work. Still, within this body of research little consideration is given to the communicative functions and meaning-making processes of people living with addiction in relation to addiction structures.

As an organizing structure, the methadone clinic plays an important role in creating the discourse on health, addiction, and recovery. Examining the storied experiences of health, addiction, and recovery opens a space in which we can study identity, health realities, health outcomes, quality and accessibility of health services, technologies, and products against the

backdrop of the everyday workings of the methadone clinic within which addiction treatment is provided. I argue that framing narratives of health and addiction in terms of organizing systems of care and treatment advocates for a broader understanding of health and grounds addiction in wider social, economic, and political influences in which these phenomena are embedded. Further, I emphasize the role of narratives to argue that health issues are best understood locally and from the point-of-view of the people experiencing them (Farmer, 2003). Because the SCA comes out of the culture-centered approach (CCA) to health communication, which explores the ways in which cultural meanings are co-constructed by participants in their interactions with their surrounding structures (Dutta, 2014), communication and structures are considered to work in tandem with one another. I draw from these connections to emphasize the material and discursive experiences and interactions with structures in the context of health, addiction, and recovery.

The impetus for my work comes from theorizing methadone and the methadone clinic as organizing structures that constitute meanings of health; that is, I ask questions about how methadone patients communicate meanings of health and recovery in the context of an addiction treatment program. This study builds on previous research that looks at structural constraints of health and identity (re)construction in the context of methadone treatment, namely in the areas of institutional stigma and social control, as well as the ways in which people experiencing addiction communicatively construct ideas about health and recovery. A structure-centered approach to health, paired with narrative inquiry methodology, offers an opportunity to ask in-depth questions about individual experiences with methadone treatment and how people make meaning of health and addiction, as well as the role of methadone and the methadone clinic in their everyday lives. By making visible health in relationship to the social structures and organizing systems that constitute health, the SCA also opens a space in which we can explore a

discussion about the quality and content of addiction health services. With these issues in mind, I ask:

**RQ1:** How do methadone patients communicate about and make meaning of health?

**RQ1a:** How does methadone treatment influence the negotiation practices of addiction and identity (re)construction?

## **CHAPTER THREE:**

### **METHODS**

In this chapter, I discuss the methods used in this research project. I brief study data collection and IRB procedures, research site and sample, how I came to gain access to the research site, unstructured interviewing, and participant recruitment strategies and challenges. Then, I turn to Riessman's (2008) case-based thematic narrative approach and discuss how I analyzed the data and present the case studies of this project.

#### **Data Collection**

Data for this project were collected from two opioid addiction treatment centers, or methadone clinics, in Florida. The data collection process spanned from August 2018 to January 2019.

Research participants for this study include individuals who are living with opioid addiction and are using methadone to assist their recovery. To qualify for participation participants met the following criteria: 1) 18 years of age or older; 2) had experiences with opioid addiction and/or other substance misuse or problems; and 3) used medication-assisted treatment for opioid addiction. All participants in this study used methadone in comparison to other treatment medications (e.g., Suboxone).

To preserve anonymity and confidentiality, I have altered the names, locations, and other identifying details about the patients and clinics. Because the clinic name is often mentioned in participant narratives, I use Lighthouse Treatment Center (LTC) as a fictitious name for the clinic.

## **USF IRB Process**

The Institutional Review Board of University of South Florida approved this project in early July 2018. In late July 2018, I obtained a Certificate of Confidentiality (CoC) from the National Institutes of Health (NIH) to further protect the privacy of participants by prohibiting disclosure of identifying information to any federal, state, local, civil, criminal, administrative, legislative, or other proceedings. After I obtained the CoC, I submitted an amendment that was approved by the IRB in August 2018.

I communicated to research participants that study participation is voluntary, following an in-depth explanation of the purpose and benefits of study, contents of consent form, and confidentiality procedures. After these measures were described and clarified, I asked participants if they wanted to continue with participation and audio-recording. During this time, I invited any questions or concerns the participant had into conversation. I reminded participants that they are free to decline participation or withdraw from the study at any time. Any exceptions called for by participants (e.g., not willing to answer a question or talk about a particular topic, stating something as “off the record”) was noted and respected. I have altered names, locations, and a variety of other identifying details about the patients and clinics to preserve anonymity and confidentiality.

## **Research Site**

The two Lighthouse Treatment Center (LTC) locations are owned by the same corporation, so they are nearly identical in operation. LTC operates as voluntary outpatient treatment center and provides medication-assisted treatment for individuals seeking treatment for opioid addiction.

Hours of operation for the pharmacy are typically 5:00 AM to 12:00 PM with slight variations on weekends and holidays.

The clinic offers a variety of maintenance medications including methadone, buprenorphine, and Suboxone; however, methadone is the most commonly administered medication, mainly for its price in comparison to the alternatives. A single dose of methadone costs \$16 a day whereas buprenorphine and Suboxone range from \$22-30 a day. Although the medication is largely what makes up the fee, the clinic also requires monthly drug screens, annual physical evaluations, and regular meetings with an assigned substance use counselor. In addition to counseling staff, treatment teams consist of program directors, medical doctors, and nurses. The clinics are licensed, registered, and approved by Substance Abuse Mental Health Services Administration (SAMHSA), Drug Enforcement Administration (DEA), State Board of Pharmacy, Center for Substance Abuse Treatment (CSAT), State Methadone Authority (SMA), and the Commission on the Accreditation of Rehabilitation Facilities (CARF).

When a patient first visits the clinic, they are screened and evaluated by the clinic staff. Upon intake, the clinic monitors the patient's dosage and gradually increases the dose until the patient reaches an effective maintenance dose. Ideally, the medication should suppress withdrawal symptoms, relieve opioid cravings, and block the euphoric effects associated with opioid use. Once patients and clinic staff, including counselors and doctors, agree on an effective daily methadone dosage, the patient continues on that dosage with the goal of eventually tapering off of methadone completely. Patients who demonstrate high levels of treatment compliance, namely negative drug screens and regular attendance in treatment, may be eligible for take-home privileges, or small stocks of medication that permit fewer visits to the clinic. The clinics encourage patients to participate in the program for at least 2-3 years, though patients are free to withdraw from the program at any point in time.

## **Gaining Access**

In the beginning stages of organizing this research project, I predicted that working with people experiencing opioid addiction was going to be difficult. Considering the stigma and moral dilemmas that are characteristic of illicit drug use and addiction, people in the thick of addiction can be qualified as a hidden or hard-to-reach population (Lindlof & Taylor, 2019). In this way, examining addiction in the context of methadone treatment expanded my access to the population because patients visit the clinic every day. In addition, doing volunteer work in which I hosted naloxone distribution services at local addiction treatment centers helped enable my access to the site and to its members. Further, I believe my experiences growing up with addiction in the family not only marked my personal values and investment in this project, but also helped me gain rapport with participants, though I am hesitant to assume I had “membership” (Lindlof & Taylor, 2019) at any point in research. With that being said, I also am cognizant of the ways in which my deeply personal experiences with addiction guide my research design, including research questions, data collection, analysis, and writing.

## **Unstructured Interviews**

According to Lindlof and Taylor (2019), the “research interview unfolds as a social process, and what emerges from that process is a richly expressive inter-view that neither person could have produced alone” (p. 220). Far from a neutral tool, the interview recognizes the context of communication and locates the collaboration between the research participant and the researcher at the core of the meaning-making process rather than imposing an external researcher viewpoint (Lindlof & Taylor, 2019). In other words, this model of interviewing recognizes both the research participant and the researcher as co-creators of meaning, resulting in two active collaborators who jointly construct narrative and meaning (Mishler, 1986).

Inspired by ethnographic practice, my goal during interviews was to generate rich, detailed narratives rather than brief or general answers that are typical of standardized question-answer exchanges. Hence, I rejected a fixed interview format in favor for an unstructured, in-depth interview to encourage open-ended dialogue (Fontana & Frey, 2003). The heart of this technique is in allowing the unstructured interview to emerge as an opportunity to freely explore the multiple perspectives and experiences of research participants. In this way, I view the interview as a “narrative occasion” (Reissman, 2008, p. 23) in which we can examine communicative acts as knowledge construction. Keeping to an unstructured ethos, the duration and course of the interview were determined more by the responses of the participants than by any organized plans of my own. This method of interview kindled a style of talk in which participants became storytellers. As each story unfolded and flowed into the next, I followed participants “down *their* trails” (Reissman, 2008, p. 24, emphasis in original) and listened to what they wished to discuss.

I asked open-ended questions that invited extended accounts to encourage participants in articulating responses in ways they felt were meaningful. The overarching aim of questions were to engage participants in a broader commentary on issues such as how they make meanings of health and addiction, experiences with treatment, negotiation practices of recovery and identity, and the influence of methadone and the methadone clinic on addressing treatment and health for patients. For example, I asked, “What have your experiences been with addiction?” This question often evoked a chronological pattern in which participants began their story with the first time they used drugs, how they came to realize their addiction, and how understandings of their addiction and recovery has shifted over time during their involvement in the treatment clinic. Yet, because of the synchronicity of addiction, few participants stuck with a completely sequential approach and instead vacillated between different times and events. In turn, asking

questions like the example I provided expand relevant topics and create possibilities for closer investigation.

Turning briefly to another example, many interviewees told long stories in response to my brief and initial question, “Tell me a little bit about yourself.” Being present in the narrative moment and appreciating participant pauses between segments of stories as comfortable openings for narrative continuation rather than awkward silences seemed to encourage participants to continue talking and thus continue telling their story. Interestingly, a frequent comment by the research participants (particularly in the beginning moments of the interview) was along the lines of, “Oh, I got so off track. What was I talking about?” These comments were often blanketed with light chuckles and apologies for veering “off-topic” or “taking too much time.” In these situations, I encouraged participants that they need not follow a fixed “track” and reminded them that they were free to discuss whatever they please. Reflecting on these interactions, among others, prompted me to actively reflect on the implications for the interview process and context—that is, the presentation of the sterile informed consent forms followed by the introduction of the audio-recorder, as well as the ways in which even the word “interview” carries a stiff and unforgiving connotation. In short, even a simple question such as “Tell me a little bit about yourself” can be troubled by cultural expectations of interviews to which may be intensified by the seemingly “omniscient” researcher in search of particular responses. Nevertheless, in my attempts to mediate these concerns and create possibilities for extended narration, still I acknowledge relations of power are never equal and never diminish.

As a listener and co-collaborator, I was ready in negotiating the twists and turns of talk to explore, interactively with the participant, the associations that might thread together several stories. During the interviews, I also took notes to remind me of points they made to which I wanted later to return while being cautious of not disrupting the flow of participant stories. To

guide me in these communicative meanders, I kept in mind topics about addiction, treatment, and health related to the purpose of study, while still encouraging an open-ended dialogue. This practice was nourished by my belief in that through story, we make meaningful our experiences and in doing so construct our sense of self and worlds (Riessman, 2008). As discussed more explicitly in the sections on data analysis, narrative work influences both the method and methodology of this study.

### **Recruitment for Participants**

The purpose of this study is to offer in-depth analyses of lived experiences of addiction and to get a detailed sense of how people using methadone treatment communicate about health and the influence of methadone and the methadone clinic on the negotiation practices of addiction, recovery, and identity (re)construction. Accordingly, the goal of participant recruitment and data collection was to gather rich, robust information rather than merely recruiting as many participants as possible (Layder, 2013).

Participants were chosen through a snowball sampling technique. A snowball sampling strategy yields a study sample based on referrals from initial contacts that generate additional contacts in the community. Snowball sampling is often used by researchers to locate and recruit hard-to-reach populations (e.g., people experiencing addiction) or engage people about a sensitive topic (Lindlof & Taylor, 2019), such as illicit drug use or sex work. In this method, the researcher first identifies someone in the participant community who is willing to guide the researcher to new potential study participants.

Having established prior contact with clinic staff through my volunteer work, my regular contacts in the field agreed to initiate the referrals and research participation among clients of the treatment centers. I provided program directors, supervisors, and substance use counselors with

recruitment letters to give to patients who might be interested in taking part in the study. The recruitment letter briefly details the nature, purpose, and benefits of the voluntary study, what is expected of participation, as well as my personal contact information (phone and email).

A total of 31 MAT patients contacted me to participate in the research study. Interestingly, several people contacted me thinking it was a psychological assessment or clinical study. Upon further discussion of the research project, 14 people declined to take part because the study did not offer compensation. Seven of the 31 initially agreed to participate but did not show up to the research interview. In those occasions, I attempted to contact the participant(s) and continued to wait at least 30 minutes before considering the interview canceled. Three of the 7 no-shows ended up contacting me at a later date to reschedule, but even after multiple rescheduling attempts, they continued to not follow through with our interview. Two of the 31 were unable to find time to schedule a face-to-face interview. In all, I conducted 8 interviews with methadone patients and 1 interview with a clinical supervisor.

Interviews were arranged via phone contact. Interviews were scheduled and communicated to participants to likely last between 30 and 45 minutes, however all 9 interviews ranged in length from 1-4 hours in length. All interviews were conducted face-to-face. Interviews were scheduled at a time and place mutually agreed upon by myself and the participants, keeping in mind issues of privacy and confidentiality. Interview locations included empty office rooms at the clinic, coffee shops, and participants' homes. After obtaining consent, all interviews were audio-recorded.

### **Negotiating Recruitment Dilemmas: An Interlude**

Going into this study, I expected hesitance and reluctance on the part of the research participants. Nevertheless, I was surprised by how few people followed through with interviews. Recalling

my initial research design, one of my original goals of data collection was to interview at least 10-15 MAT patients. Despite my best efforts to recruit and reach out, I only accomplished 8 patient interviews in a time-frame that spanned much longer than my original schedule for data collection. For example, I wanted to have had completed all interviews by October 2018, but my first patient interview was not until November 2018 and the last one was mid-January 2019.

While I am grateful for every participant that contributed to this study, I did not anticipate the hurdles I experienced in participant recruitment. Looking back, I am not surprised. In my personal and volunteer experience with this population, I understand that many people experiencing addiction are living far from comfortable lives—meaning that they are often burdened with lack of transportation, lack of social support, food and home insecurity, work/life tensions and/or complicated job searches, and legal issues—regardless if they are navigating recovery or not. To put it simply, they have more important things to worry about than sitting down to talk to me so I can write my thesis and earn my degree. Another factor to consider is the controversy and risks associated with methadone clinics, which might engender fear in patients about participating based on the belief that the institution may cut them off from their treatment should participants criticize the clinic.

Drs. Ambar Basu and Jane Jorgenson, two of my advisors, encouraged me to conduct interviews with clinic staff in addition to MAT patients. I planned to conduct 5 interviews with clinic staff (e.g., counselors, nurses, program directors). The primary goal of the clinic staff interviews was to offer a more up-close examination into the organizational perspectives of opioid treatment, as well as a breadth of study into health, care, and addiction treatment in general. Several counselors seemed eager to participate. From August 2018 to December 2018, I received 11 phone calls from counseling staff requesting more information about the research

study. If it is not already apparent in my 1 interview with a clinic staff member, I had little success in solidifying interviews with clinic staff.

In all, the interviews came in very slow. Needless to say, I often felt in a quandary, thinking to myself: “How am I going to complete this project on time?” After reflecting on each interview, as well as the multiple stages of this research project, I checked myself on those initial feelings of being surprised at the relatively small sample size. Now, I would argue my feelings were more cemented in my taken-for-granted assumptions and the study itself. “I have experienced family addiction, I am involved with the community, it shouldn’t be *that* hard to get interviews,” I thought. Indeed, I did preface interviews with my experiences with addiction to communicate to participants that I approach addiction with sensitivity from a place of (imperfect) understanding—a place always already fraught with tensions and impossibilities. This might have helped me earn a slight gain in their trust, but I am still the researcher, the outsider-looking-in. In turn, trust is impossible, especially with a vulnerable population such as individuals in addiction treatment (Rance et al., 2017).

Thinking about these difficulties, I realize I am demanding time and resources from people who have little time and resources, especially with people in recovery from addiction. Throughout this process, I have learned about the significance of researching with humility, methodological sensitivity, and embracing the complex, messy inconsistencies involved with research in general. If this had been a funded study and I was able to offer a monetary incentive for participation (at best, I could offer coffee, donuts, and a ride home), perhaps I could have recruited a larger sample of participants. Likewise, perhaps I could have recruited a more diverse representation with respect to their progress in recovery—a majority of patients in this study had at least a year or more experience in recovery, which speaks to the particular sample.

While the amount of people interviewed nor how far patients were in their recovery is not of my particular concern, I believe it is meaningful to mention these research challenges as they invoke a larger methodological investigation. The difficulty in accomplishing interviews is just as telling as the interviews presented in this study and should be a point of interest for future research. I am overwhelmed with gratitude about the interviews we completed. There is a breadth and depth to these narratives that I do not believe could be captured in 30-45 minute interviews with 15-25 participants. And for that, I am beyond humbled by and grateful for being able to listen and communicate with the people of this study.

For these reasons, I examine my data through a narrative analytic strategy that preserves the “whole” story and the wealth of detail in each narrative occurrence (Riessman, 2008). The following section describes the data analysis and procedures I used in this project.

### **Thematic Narrative Analysis**

My approach to interpreting data is inspired by the narrative analysis tradition. Narrative analysis refers to a family of approaches for interpreting diverse texts, which have in common a storied form (Riessman, 2008). In practice, narrative inquiry seeks to understand human experience and social phenomena through the particularity and context of stories. Keeping in mind ways in which I can make visible my subjectivity as researcher at all stages within the research process and not “write myself out,” I include reflexive insights about interviews, transcriptions, and data analysis to encourage an ongoing reflexive dialogue throughout the writing and reading of this text.

This thesis employs Riessman’s (2008) case-based thematic narrative approach to examine the stories of methadone patients and their articulations of health and the influence of methadone and the methadone clinic on the negotiation practices of addiction, recovery, and

identity (re)construction. Thematic analysis places emphasis on the content a narrative communicates, or what Mishler (1986) refers to as “the told.” In practice, thematic analysts interpret “what” is said in a text by focusing on the meaning of a particular story. Continuing with Mishler’s distinction, of minimal concern for the thematic analyst is engaging with “the telling” of narrative. Put another way, thematic analysis is less interested in “how,” “to whom,” and “for what purposes” events and experiences are storied, structured, and interactively produced. These general characteristics, as Riessman (2008) posits, are what distinguishes thematic narrative analysis from other methods akin to the broader family of narrative analysis: structural, dialogic, and visual.

Although thematic narrative analysis is the most widely used analytic strategy in narrative work, it is often mistaken for an intuitive and straightforward analysis that evades the iterative-inductive processes that are hallmark of other forms of qualitative analysis, such as grounded theory and interpretive phenomenological analysis (Riessman, 2008). Yet, “good” thematic analysis is indeed methodical, meticulous, and painstaking and fosters data depth and richness just as do other forms of analysis. Of primary interest for analysts is in generating thematic categories even as individual stories are preserved and kept intact. With respect to the latter point, the narrative approach maintains that extended accounts need be preserved and treated analytically as whole units rather than fragmented or distilled into thematic components and codes (Riessman, 2008). Indeed, this is essential for narrative analysis work to be located in the broader realm of narrative research tradition. In comparison to other forms of thematic and qualitative analysis, distinguishing factors of the narrative approach are its methodological commitments to preserving narrative features.

The thematic approach is useful for theorizing across several cases, finding common thematic elements among research participants and their narratives. The cases that form the basis

for analysis in this study are the individual accounts by participants. Cases were constructed to illustrate the particular meanings in how people communicate about health, recovery, addiction, and identity in the context of methadone treatment. Following a case-centered analysis enabled me to preserve the “unity and coherence” (Mishler, 1996, p. 80) of research participants and reduced the risk of losing individual, nuanced meanings in eclipse. In other words, a case-based narrative thematic approach provided me with the strategy to protect the stories of each participant by analyzing them individually and thoughtfully, case by case. Along with engendering an intimate and rigorous relationship between the researcher and data, case-based methods ask for a meticulous consideration of the wealth of details and particularities within narratives. A case-centered approach offers more than just a snapshot of the data and instead tells the stories by the participants in living color (Mishler, 1996).

Not to be confused with grounded theory, thematic analysis is informed and guided by prior theory and thus, data is theory-saturated from the beginning. In this project, for example, I tack back and forth between prior and emergent research and theory, purposes of study, theoretical framework, and the data themselves to develop thematic categories. As Riessman (2008) notes, thematic analysts are still encouraged to search for novel theoretical insights within narratives. In sum, case-based thematic narrative analysis is viable for this research project in that it focuses on the *meanings* of communication, preserves the “whole stories” of research participants, and presents an approach for analyzing extended accounts, which reflects the data of this project. Using this method, I can develop a more robust and nuanced understanding of how the research participants in this study make meaning about health, recovery, and addiction in addition to the influence of methadone as an organizing structure on addiction and identity (re)construction of people in recovery.

## Data Analysis and Procedures

*By our interviewing and transcription practices, we play a major part in constituting the narrative data that we then analyze. Through our presence and by listening and questioning in particular ways, we critically shape the stories participants choose to tell. The process of infiltration continues with transcription, for language is not a perfectly transparent medium of representation.*

–Catherine Riessman (2008, p. 50)

In general, qualitative data analysis, including thematic analysis, involves a number of choices which are often not made explicit in discussion. This project strives for transparency in all stages of research, which, I believe, are interpretivist and value-laden in design. Informed by our ideologies, we select research strategies connected to how we view the purpose of our study, including research timeline, site and sample, data collection, analysis, and writing of the text (Janesick, 2000). Although research design is traditionally presented in linear stages planned by the researcher, there is a constant tagging back and forth between the literature and other stages of our research design as our projects develop (Tracy, 2012). For example, we may re-examine our research questions or adjust our interview approach throughout the data collection process to better render research participants' experiences, meanings, and behaviors with honesty and transparency (Tracy, 2012). In this way, I view the initial phases of data analysis to occur concurrently with data collection, which in turn informs both the questions being asked and the collaborative meaning-making of qualitative research (DiCicco-Bloom & Crabtree, 2006). Transcription then, too, must be recognized as an inherently interpretive practice. Beginning with transcription of interviews, I describe my data analysis procedures in the following section.

First, I transcribed the interviews verbatim, including notations of speech break-offs, pauses, sighs, silences, laughter, cries, and interviewer utterances common in interview

conversations. Most of these were minimal utterances such as “uh-huh,” “yeah,” and “mhhh” to encourage participants to continue narrating and cue that, as a listener, I was following along with their story. This method of transcription resulted in lengthy transcripts: 259 single-spaced pages of data. After transcription, I listened to the recordings once again while reading the transcripts to ensure my writing was accurate. In the second-review of transcriptions, I altered the names of characters and places revealed in the course of interview and removed other information that could potentially link interviews with participant identities. At the same time, I developed a revised transcript in which I extracted many of my affirmative utterances, as these did not add to the content of the narrative. I “cleaned-up” transcriptions by removing excessive participant vocal fillers and repeated phrases but notated emotional expressions such as laughter and crying. My comments, statements, and questions remained in the revised (and final) transcript to emphasize my role as a researcher in the co-construction of narratives. Because of the importance of understanding transcription as an interpretive, power- and value-laden process, I provide a brief discussion on how I approach transcription and data representation after explaining the rest of the data procedures employed in this project.

Second, I engaged in a close-reading (Charon, 2006) and re-reading with each text. Together with the reviewing of transcripts and re-reading the texts, I was already gaining a better sense of participant narratives. In the re-reading phase, I identified a set of stories that met specific criteria, keeping in mind study intent: communicative meanings of health in the context of methadone treatment and the influence of methadone and the methadone clinic on the negotiation practices of addiction, recovery, and identity (re)construction. To identify narratives of health, I paid particular attention to how participants communicated experiences with methadone treatment and clinic interactions. I also attended to social, economic, and structural influences that informed their meanings of health. Focusing on the interplay of addiction and

health, I looked to the ways in which participants spoke of and described experiences with addictions from which they are recovering in the context of methadone treatment. Stories of identity overlapped with both health and addiction and were saturated with complex descriptions about recovery and recovering selves. In selecting identity stories, I examined accounts by how participants constituted past experience, imagined future experience, and constructed selves and self-concepts. This stage of analysis resulted in blocks of text that coordinated with my analytical focus. Here, my goal was to examine the content of narratives and identify common thematic elements in each account.

Third, I reviewed the initial conceptual groupings within each narrative and organized them into themes, while still preserving narrative features. Subsequently, these themes became the categories for analysis. Keeping to coherence and sequence, I found that extended accounts defied easy categorization, which reinforced the need for a case-centered approach to presenting participant narratives. Guided by the thematic elements of the stories, I then used the highlighted excerpts to construct the cases for this study. These case studies provide a lens for understanding the multiple and simultaneous meanings of health, recovery, and identity.

I struggled with how to represent the narratives that emerged within the interviews with methadone patients. Remembering the co-construction process of narrative, all I could think about was how the stories were designed *for me*; participants developed their accounts and senses of selves for a particular listener, a young researcher who needed to be educated about methadone patients' experiences of addiction and health in order to write a thesis in fulfillment of her Master's degree. Although the structure and purposes are not explicitly examined in my analysis, I do attempt to include laughs, pauses, and an attention to local context of narratives to expand my understanding of participant stories. With that being said, there are several implications for how participants came to story their responses, such as recruitment site, how the

study sample generally reflects a certain stage of recovery, the clinic's focus on recovery that may influence how participants make meaning of health (e.g., as only in the form of recovery), and, of course, how my personal assumptions and values about substance use influences our interviews and my research design as a whole.

### **Thoughts on Transcribing: An Interlude**

I want to emphasize that though transcription appears to be a straightforward technical task, the process of producing transcriptions is far from neutral and benign. Data interpretation and representation are interpretive, value-laden processes imbued with power and judgment. Indeed, transcriptions are always the researcher/transcriber's re-presentation of the researched and are always filtered—as are other forms of qualitative research texts similar to the one you are reading right now.

It is well documented that many people struggling with substance misuse and/or addiction have experienced sexual abuse, rape, and other traumatic life events (Boyd, 1993; Harrison, 1989; Woodhouse, 1992). To no surprise, interviews elicited a myriad of sensitive topics. As a result, I thought carefully of how to represent the interviews, while still maintaining narrative coherence. Then, I decided some subjects simply do not belong in the writing of this project and conducted a third revision of transcriptions. In this edit, I demarcated bits and blocks of text that contained particularly graphic details. While I may write about the topics (e.g., suicide, sex trafficking, abuse, etc.) to contextualize participant backgrounds and experiences, I omit narrative excerpts containing explicit and/or highly detailed descriptions of distressing events. This is not a decision of censoring participant voices but rather an ethical move to resist the temptation of readers to turn participants into powerless objects of the voyeuristic gaze (Bourgois, 2003; Denzin, 1997). Although some may view the omission of detail as diluting the

coherence of narrative, for this study it is an ethical commitment—a commitment rooted far from any discussion about balancing risk with reward. Indeed, there is a fine line between voyeurism and sanitizing narratives, and I am cognizant of the ways in which I am still ultimately making these decisions and consequently altering the reading and interpretation of this research text.

For my readers and other researchers alike, I caution against fetishizing the human experiences represented in this project and remind you that as interpreters/observers, we can never perform the role of the neutral spectator—that is, we assume a position of power who looks to know (Denzin, 1997). As researchers, I encourage us to write with sensitivity and be mindful of how participants might interpret their dialogue in the finalized article and how might they feel afterwards, should participants wish and have access to read our writing. This is especially important in working with vulnerable, stigmatized, and marginalized people, as these bodies are most often subject to the inferior position of “the looked at.” If a particularly graphic incident adds insight into the participant’s experience—which, in many cases, they do—I urge us to consider how we can grasp the heart of their story without exposing graphic details that are risky and likely unnecessary in writing, and the implications for doing so. We need to be concerned about not only how ideas and people are represented but also the ethics and reflexivity of our own research and other forms of decision-making processes in our research design. For whom do we write, and for what purposes? How can we privilege transparency in our research? What are we risking when we do not include the voices of our participants? These questions, among others, need to come into the fore of our minds and echo in our research process-product.

This requires researchers to develop a deep reflexive stance in which we are constantly interrogating our positions, priorities, and taken-for-granted assumptions that pervades much of our inquiry. This stance is what Charmaz (2017) refers to as methodological self-consciousness, defined as a “means of examining ourselves *in* the research process” (p. 36, emphasis in

original), leading researchers to scrutinize our decisions about research design, data, interpretation, analysis, representation, and other research actions. In the initial designs of this project, for example, I set out to identify stories about addiction, but I felt it was better to frame stories about addiction in the context of health and/or recovery, since the two often intertwine—though, I make a conscious effort to cast a wider net about health and not frame health simply around ideas about recovery and/or the absence of addiction.

### **Casing the Stories**

Although I interviewed a total of 9 participants for this study (8 patients and 1 counselor), I only include 4 individual cases for this study. After careful examination of each interview transcription, I realized including 8 patient case studies was far beyond what this thesis could cover. In fact, patient interviews alone resulted in 18 hours of interview data. In the first few rough drafts of the 8 cases, I found myself shortening the case studies at the expense of detail, thus conflicting with the narrative methodology that informs my data interpretation, analysis, and representation. The goal of these case studies is to preserve each narrative and attempt to “capture” the heart of each story, not just present as much information as possible. As well, the goal of this study is not to generalize and instead present an involved, immersive examination into experiences of methadone patients. Importantly, too, my intentions in this project are not to tally the amount of thematic categories as an indication of higher theoretical value, but rather present a typology of narratives that develop a theoretical argument. Therefore, I felt that including anything more than 4 case studies would be doing a disservice to the particularities of each narrative as a whole.

The decision on what individual narratives to include and exclude was difficult. While I did keep study intent in mind, I want to clarify that evaluating the case studies was not process of

simply assessing which narratives “fit” with the research questions. The 4 patient case studies that I do not present in this study are equally powerful and moving as the ones that I do present, and for this reason, among others (e.g., wanting to include all participant interviews in some form), I intend to include them in a future project. The patient narratives that are excluded are ones that either 1) overlap with other narratives with respect to content and thematic elements; 2) do not include stories about health; and/or 3) are “messy” with respect to temporality and coherence and therefore would be better suited to a fragmented category-centered analytical approach (e.g., grounded theory). The latter two points, in particular, demonstrate the implications of using unstructured interviews and narrative analysis in my research design. While the single interview with a counselor supervisor helped me understand the everyday workings of the clinic, it made little contribution to the perspective of the counselors’ working lives as a whole. For this reason, I omitted the counselor’s interview from this study.

## **CHAPTER FOUR: CASE STUDY RESULTS**

This chapter is organized by case studies of each participant's narrative: Tilly, June, Leo, and Ozzy. In each case, I begin with an exploration of the local context of each interview, drawing on my interview notes and post-interview journal entries. My intention is to provide readers with an understanding the context of the interviews, such as interview place and the relationship between the participant and myself, to highlight the depth, detail, and co-constructive nature of each narrative. Then, I move into the participants' narratives and present them with a focus on how participants make meaning of their experiences.

### **Tilly – Navigating the Frays of Health and Recovery**

We are sitting at the breakfast bar of Tilly's recently settled apartment. Behind us is her living room, or as she says, "the un-living room, because it's too damn stuffed to move around." Her apartment is filled with cardboard boxes scrawled with black Sharpie, walls devoid of pictures or decorations. Hanging on the tail of the burning lavender and citrus incense is the lingering smell of cigarettes, producing a cocktail of floral and woody aromas. Tilly, the 33-year-old woman with whom I have been talking for almost an hour, lets out a deep sigh and rests her head in the palm of her right hand. "And that's another thing," she says. "I feel like this is such a huge accomplishment, you know, me having an apartment. But look at all this stuff. It's a mess and to be honest, I'm just not motivated to unpack it all yet."

“Can you tell me why that is?” I ask, sensing a complex relationship between Tilly feeling elevated and simultaneously sunken. She responds:

Well, you know, it’s just hard. About 3 years ago I was on the streets, homeless, nowhere to go. I’d beg and shit, panhandle, steal, whatever, ... ‘til I could get enough money to score. Even when I wasn’t sick, I was thinking about how to get the next high, or if it was in the evening, I’d think, damn, I’m gonna need a wake-up. And even then it’s like, I’m digging in trash cans on the side of the street to maybe find a receipt for a nearby store that somebody tossed. If I got lucky ... I could take that receipt into the store and find whatever the hell item they bought ... and pretend to return it to the cashier and get cash back for it. Even better was when I carried handcuffs and a police officer badge in my purse so I could fool johns into giving me their money and then pretending I was an undercover [cop], so I “make a deal” to take all their money in return of me not arresting them (laughs). That was always hilarious, they’d plead that they had a wife and kids and family, a job, all that, but it was great because I got the cash and didn’t have to screw ‘em. That was my hustle. But even so, obviously my life was shit and I knew it. There comes a certain point in an addict’s life where getting high isn’t fun anymore, and I was far beyond that. So when I eventually got to [Lighthouse], I was like, damn, this is it. My family’s gonna be happy, I can get a real job, I can live my life how I want to, in good health .... I want to be feel good again. I want to be healthy. And I knew it was gonna take a while with the methadone, especially because they started me at a 260mg dose .... But now, like 3 years later, I’m only at 240mg because they don’t push us to taper down. And now I feel like I’m in the same place I was before. It’s just a different kind of hustle, a different kind of dealer. I wake up, I get my [methadone] fix, and I go about my life. I don’t know, it’s tough. Honestly, I still feel just as trapped as I was before, if not more. And I’m not at the place I want to be in life, this is not what I had planned.

Tilly offers a poignant account that compares the lived reality of addiction with methadone treatment, two ways of life that are as similar as they are different. Recalling her experiences with addiction, Tilly directs our attention to the ambitious and involved hustle that characterizes the lives of so many people living with addiction, namely by scoring and using drugs to avoid withdrawals. For Tilly, Lighthouse represented a place in which she could recover aspects of her life that had fallen through the cracks during her addiction. In particular, Tilly specifies that she believed Lighthouse treatment could help mend her fractured family relationships, find a “real job,” restore self-agency, and recover a life lived “in good health.” Nevertheless, after 3 years in treatment, Tilly articulates that treatment is not what she thought it would be—in her words, methadone is just “a different kind of hustle” with “a different kind of dealer,” even referring to

methadone as her new daily “fix.” In this way, Tilly frames methadone treatment as analogous to that of living on the streets in the grips of addiction, which implies that the precarities of addiction do not simply evaporate during methadone treatment.

Tilly also describes feeling unmotivated and “trapped” when thinking about tapering off methadone. This is raised as a primary concern because Tilly measures her health progress by her methadone tapering. Although she acknowledges that tapering off methadone can be a long-term process, her account ends in saying that she is not where she wants to be in life in reference to her earlier statements about family, job, and health security. This suggests that the clinic has not only impeded her instrumental and relational well-being, but also fettered her possibilities in reaching her health goals.

“Did I ever tell you the nickname I came up for myself?” she asks with a smirk. I think for a few seconds. “No, I don’t think so.” She continues:

I call myself an oxymoron. I call myself that because, for the obvious reasons, that like, oxymoron is way of describing something that’s a paradox or is like, contrasting. The funny part is, the part that always makes me laugh and why I made it up in the beginning, is the ‘oxy’ part, because OxyContin was my drug of choice when I started using. I mean, it wasn’t long ‘til I didn’t give a shit if it was Oxies or Roxies or heroin or crack or you name it, but you know what I mean. And then I’m also a moron for getting myself on methadone, thinking I could get off heroin. I mean sure, I’m not shooting up anymore, if I could I wouldn’t feel anything, so that’s one advantage. But it’s damn expensive and I’m afraid I won’t ever get off this stuff, and that scares me to death. Like seriously. The withdrawals are horrible and that’s what kept me from not getting off [methadone] in the first place .... It’s just frustrating because like, in one way I’m doing the right thing, but I know the right thing isn’t going to get me anywhere. It’s got me stuck, I feel trapped. I’m not saying it hasn’t helped me get a job, get a place to live and stuff, obviously that’s helped. But like, even my job is shitty, I gotta figure a way to make my share of rent and also pay for my \$16 a day dose, and get a car, you know? .... And my brain functioning is better, but I still feel like I’m shackled to the methadone you know? I don’t really know if it’s, like, addiction, but if you’re just looking at the surface, and not all the shitty stuff addicts do ... then yeah, it’s addiction. Even though not all people on methadone are innocent. Which is why I don’t make friends at the clinic. And also, you know, I literally can’t name one person who’s gotten completely off all drugs by using methadone. So yeah, to me, methadone is like heaven and hell. And I guess that makes me like, what, in limbo? I hate it, but in some ways, it’s good too ... like, I don’t want to come across as ungrateful or your typical angsty addict that doesn’t get things her way. Because I’m not. The only silver spoon I grew up with was the one I was cookin’ dope with.

An oxymoron, hmm—Tilly is just full of witty sound bites. I nod my head, trying to grasp the myriad of tensions raised in her response. It is clear that methadone treatment is not as straightforward as it seems. Obviously, too, is that Tilly feels doing “the right thing” is a catch-22, but what is “the right thing”? In this excerpt, Tilly is quick to pay respect to methadone as it has helped her get a job and place to live, and it seems that she does this to ensure I do not interpret her frustrations as her being ungrateful for her treatment. Nevertheless, Tilly suggests “the right thing” is not using illicit opioids, working a job, and having a place to live; otherwise, mainstream societal values and expectations. On the contrary, she finds little distinctions between addiction and methadone because of how physically and mentally anchored she is to methadone and the clinic itself. She feels at odds with methadone, even mentioning that she refuses to make friends at the clinic as to distance herself from the organization. To this point, she also makes a reference to the “shitty things that addicts do” and connects that as to why she does not make friends at the clinic, while also differentiating herself from “other addicts.”

In her earlier account, Tilly mentioned that the clinic makes little effort to encourage methadone tapering; however, this too is complicated by the fears and vulnerabilities of methadone withdrawal. Again, Tilly marks the methadone clinic as a place fraught with turmoil and complications, describing methadone as “like heaven and hell.” Likewise, by Tilly’s account, methadone is not the most opportunistic way of treatment in that while methadone has helped her get a job, her working and living conditions are not favorable.

We share a brief silence, and then she continues, “I don’t know, I don’t want to be too dark or whatever. It’s not exactly easy to talk about. It’s really hard.”

“No, it’s not easy to talk about, and I can only imagine what you’re feeling. We can take a break if you want, or move to something you’re more comfortable discussing,” I say, trying my best to not suggest that I am turned off by her discussion and instead validate her experiences.

She shakes her head no and reassures me by saying “it’s nice to talk to someone about all this.” Then, Tilly asks if I would mind if she stepped outside to smoke a cigarette. Although I don’t mind, I still offer to stay inside if she’d prefer time alone. Tilly declines and instead encourages me out to her patio, mentioning “you can keep that recorder on, too.” Together we walk outside and Tilly takes a comfortable lean over the patio balcony.

“The things on, right?” Tilly asks, referencing to the tape-recorder. “Mhmm, it’s on.”

“Cool,” she responds. “I got something to ask you, it’s not weird though.” Cigarette-in-mouth, she brings the lighter to the tip of her cigarette, flicking the lighter while guarding the flame from the wind with her left hand. After a deep inhale, she says again, “I got something to ask you,” to which I reply, “Sure, go for it.”

“You know the song, ‘Hotel California’?” she asks, her words taking a deeper pitch as she exhales smoke out of the corner of her mouth.

“Yes, of course—The Eagles!” I respond. Tilly carries on: “Ah, cool. It’s weird, but there’s one specific line that feels so fitting when I think about methadone.”

“Which line is that?” I ask. Is it that, despite all our pleasures, we really are just stuck in our prisons because of our own “devices,” or vices? Or is it the song’s ambiguous ending?

“It goes: *You can check out any time you like, but you can never leave.* (pause) Now, enter guitar solo! (laughs)” she jokes. I laugh, admitting it is hard to think of the lyrics without turning my vocal cords into an electric guitar. I probe Tilly’s point and ask, “What about that particular lyric do you think represents how you feel about the clinic?” She rolls her eyes and replies:

Where do I start? (laughs) I mean, I guess ... it kind of goes back to what I was saying before, like, feeling shackled to the clinic. Methadone will always be a part of me, whether I’m on it or not. If I’m on it, then yeah, I’m like directly influenced by the clinic. But even after, if I ever taper completely off or whatever, I can’t really shake treatment the same way I can’t shake addiction. It’ll always be a part of me, literally injected into every person I ever was or ever [person] I want to be. What I mean is that ... even if I

tapered off, I know within a few days I would turn around and go right back in for intake, and start back at the drawing board ... or even worse, I would go back to shooting dope, which is probably, in all honesty, the more likely of possibilities. By some way or another, addiction is always gonna have its devilish little hands wrapped around my neck, even if the methadone is keeping me straight.

Tilly wrestles with the idea of methadone always being a part of her which is not unlike how she communicates her experiences with addiction. No matter if she is at the clinic or back to using heroin, addiction always has a grasp on her body and life in general. In this light, Tilly vacillates between addiction and methadone forever colonizing her identity and methadone as a preventative medication that keeps her from reverting to her IV heroin use. In the next excerpt, she continues to waver about the possibilities of her recovery, in which a number of meanings jostle with each other.

But even if I did get clean, like totally clean and off methadone, I don't think there's a return to normalcy for me. Like, people talk about being normal as like, holding a steady job, mending family relationships, finding a girlfriend or boyfriend and getting married and having kids. But no, normal isn't like that for me .... Normal is like, checking the box on every damn application that I've got a felony, that's my normal, and walking away ... knowing damn well they're gonna look into my record and say, "Hell no, this chick can't handle cash, we can't trust her." So what am I gonna do? I gotta find my own sense of normal I guess. Every addict does, and maybe that's part of recovery, but [clinic staff] don't talk about it like that. Rehabilitation is absent at the clinic, we don't talk about health at all. Not even job or medical referrals, or a "How are you feeling," It's just all about being off drugs. It's all about the dose. Honestly, the last conversation I had with my counselor was like three weeks ago and I told her I was getting a dog. That's it. Which is great because whoa, okay, that's an ordinary thing that I am doing .... But really, they don't really care about us. I get that they are really busy and hate their jobs and probably handle a million things, but ... they just want to pump us up with higher doses to make it harder to taper, or to leave entirely ... which, when you think about it, yeah, it sounds like a prison.

Tilly's relationship with the clinic is rife with conflict. On one hand, Tilly craves to be liberated from methadone dependence and covets a sense of "normalcy" in her life. On the other hand, Tilly wishes the clinic would focus on providing more health-centered conversations and health resources. For Tilly, the lack of health and support—the absence of rehabilitation—in favor of a concentration on the methadone dose implies that the clinic is organized more like a

prison than a treatment center, which reflects Tilly's overall concerns about being "shackled" to methadone and the clinic. On this note, equally important in Tilly's interview is recognizing the minimal discussion of treatment apart from just methadone dosing, which suggests "treatment" does little to quell patient anxieties and concerns. Instead, methadone is the axis of recovery, a decontextualized recovery that is remiss of health related to complete systems. Tilly continues to grapple with the complexities of using methadone to recover:

Uh, I kind of strayed off-topic, but I guess, going back to the original point [The Eagles' lyrics], I can leave the clinic and make something of myself, some kind of normal life that is oddly desirable after living such a fucked-up and abnormal life, and you might think, like, yeah, she's totally cool, she's good, she's not doing dangerous stuff to herself or anyone else anymore .... I mean, no matter what, methadone and addiction, which overlap in my opinion, they still got a hold on me. They always will. What I have done and what I am doing defines and controls me. I can't just return to living a normal life. I mean, like, you know, look at my arms. Looks like a damn train ran through 'em, right? I'm literally scarred on the inside and the outside. Yeah it's my fault, but does that mean I don't deserve to live like a normal person?

At this point, Tilly's narrative takes a slight turn. While Tilly wishes to assimilate into a "normal" life with normal jobs, relationships, and habits, she articulates that addiction marks her as undeserving of these seemingly typical aspirations. This directs our attention to the gaping hole of methadone treatment in that, for Tilly, treatment does not address the social and emotional incarcerations of addiction. I ask Tilly to expand on what kind of life she wants for herself with respect to her ideas about health.

It's hard to fathom. In the really fucked-up horrible parts of my addiction, when I was really in the horrors of it all, I honestly believed a normal life wasn't for me. I wanted out, to be cured, or something. I didn't think I deserved it, so whatever bad happened to me, I comforted myself with drugs. Because like I said, and I want to reiterate this, I truly believed a normal life wasn't in the cards for me. Then, when I got to the clinic, I was in this new environment, and I was like, "Hell yeah, these people [clinic staff] are here because they want to be here, they want to help people, they're gonna help me get clean." But like I said, they're not. It wasn't long 'til I realized that that's not the case. I can't get my version of clean here. So in the end, I'm still alone and miserable, my emotions are all out of whack. So even though [Lighthouse] preaches health and ... makes all of these promises to you, about health and recovery ... like, recovery just can't be done here. They can medicate you, but that's it. Where's the support systems or referral programs, you know? Not here. I can't get a visit with my counselor to save my life. And with the

dosing, I just feel that I'll always be tied to the clinic and my addiction overall. I'm telling you, even if you try to leave, you're still (pause) chained to the ... confines of methadone treatment and addiction. Hell, now I'm both a fuckin' patient and an addict. How am I supposed to release myself from that? If I don't, I don't see how I'm supposed to recover. It's just not in the cards. But then again, I don't know what else to do. I'll probably be at [Lighthouse] forever.

Tilly begins again discussing her wishes to living a “normal” life, despite her perceiving herself as undeserving. Similar to the first account presented in this case, Tilly again references Lighthouse as her way out of addiction. Although her belief was soon dispelled as she became more familiar with the clinic, Lighthouse, in many ways, still is her way out of addiction insofar as she is not using illicit opioids. In addition, methadone maintenance has helped her regain stability to find a job and settle into an apartment lease.

While Tilly acknowledges the benefits of methadone, the methadone clinic still falls short of anything more than a pharmacy. The clinic operationalizes recovery as the cessation of illicit drugs and thus treats patients accordingly. According to Tilly's interview, the clinic focuses exclusively on methadone dosing and neglects to address health and wellness in general. In the context of the methadone clinic, effective methadone dosing is the cardinal rule of recovery and prevails over other aspects of health such as helping clients construct healthy self-concepts, forge support systems, and heal the complete physical, mental, and social well-being within clients. Regardless of the clinic's empty promises of a holistic program of health and recovery, a frustration that surfaces in Tilly's recent account, Lighthouse embeds treatment in superficiality; that is, Lighthouse treats only the surface layers of addiction at the expense of the multiple layers bubbling beneath. Despite Tilly's success in continuing her sobriety from heroin and other illicit drugs, still she cannot actualize her “version of clean” at Lighthouse because she will always be, in some way or another, reliant on methadone and thus tethered to her addiction.

Through Tilly's case we can see how methadone can cause as much harm as good and can pose significant implications for identity construction. Tilly resorts to self-reliance and

presents this as a strategy to “find her own sense of normal” because the clinic does little beyond the provision of methadone. Tilly dreams of being off all drugs, methadone included, but is “scared to death” of what might happen should she risk her recovery. Methadone has provided her a way into a livable life, but it is one that is far from what she imagines as a state of complete well-being. For this reason, methadone offers a complex duality of health—a duality that Tilly wrestles with every day.

### **June – “A Love-Hate Relationship”: Methadone and Health**

I met June outside a coffee shop near her house. She rounded the corner as I stepped out of the car. On that particular day, the sun shined a brilliant warmth, reflecting a shimmer from the ends of her long eyelashes. I reached out to shake June’s hand, but then we quickly transitioned to a hug. Our conversation needed no jump-start: We talked for at least 30 to 45 minutes about various subjects before formally beginning the interview. Perhaps our two large coffees had something to do with our lively discussion.

My relationship with June felt organic and good-natured. Including the introductory talk and interview, we sat together for nearly 4 hours. We combed through a myriad of her lived experiences and discussed topics about her addiction, mental illnesses, personal and family traumas, and interactions with treatment and health care providers. We laughed, we cried, and we complimented people’s dogs as they walked by on the street.

Drug use and addiction consumed June’s life at an early age. In the beginning of our interview, she mentions that throughout her life, her mother and father suffered from a variety of illnesses. June accounts for these events as contributing factors to her addiction: “Growing up, there was always opiates in the house. And I mean opiates! Fentanyl, Dilaudid, Morphine, [and] hydrocodone.” Other prescription drugs, such as Xanax, Ambien, and Soma, filled the cabinets

of her home. Encouraged by an older peer, June took interest in these drugs. By the age of 13, June had already overdosed twice, which dramatically changed her relationship with her family and the course of her life. In this particular moment, she reflects on her experiences spending time at behavioral health hospitals after her overdoses.

Because of the amounts of drugs in my system, I would stay at the mental health hospital for a pretty good while. The doctors were like, is she trying to kill herself? What's she doing? And then when the doctor realized I wasn't trying to kill myself I'd go home. And it was just horrible, especially as a child. And of course my mom thought I was gonna die because she's got all of these drugs and I've overdosed already. Twice.

Although June's story of addiction began with peer pressure, it quickly evolved into a tumultuous cycle. Her parents locked their prescription pills away in safes and had June evaluated by several physicians and psychiatrists. June was diagnosed with bipolar, ADHD, generalized anxiety disorder, and a variety of other mental health issues, including agoraphobia.

So [the family] was also struggling with finding the right cocktails to deal with these things. Because of the agoraphobia, I didn't leave my home. So, um, this also meant psychiatric help had to come to our door. So doctors came to the house, therapists came to our house. Um, it just wasn't normal from the beginning, you know? Um, I couldn't attend school, the people, so many people ... I mean, I thought I was dying, you know. Like, the anxiety attacks and (pause), they were just so bad .... I never got sober because of my mental illnesses and I would self-medicate. That's what it always boiled down to, you know .... The moment I'd have mania or anxiety, and knowing that opiate releases lots of dopamine, well, that was what I did. I didn't want to feel bad.

June makes sense of her developing substance misuse problems through the idea that she was "self-medicating" in order to "feel nothing." or experience some sense of normalcy. Indeed, June's interview unveiled a pattern of close connection between the intensity of her drug use and the level of stress and traumatic events she experienced in relation to past and current life circumstances. June unraveled a history of horrific incidents in which she viewed as important causal explanations of her drug use. She looked to opioids as a method to "self-medicate" her mental disorders and, in turn, developed maladaptive coping strategies in lieu of professional healthcare that she needed. Despite her overt need for physical and mental health care, health

providers and treatment centers disregarded her “habits” as simply “indicators of being a normal preteen.” In these moments, June stresses the importance of treating mental health alongside substance misuse.

The best thing I can say is, and the reason that I’m talking about this is, you put a room full of addicts, I guarantee you 90% of them also have issues with mental health. And people wonder why somebody can go through 5 days of shitting on themselves and vomiting and wishing you were dead, and the moment you get out of rehab the first thing you do is take that drug again and get addicted to it. Most people, if something makes you feel like that, why would you pick it back up? And the thing is, for me, I was sober ‘til ... I was experiencing a mental crisis. And then I would pick up. So, people really need to see that. If somebody has mental health and substance abuse issues, just putting them in a rehab is not gonna get them better. It’s not gonna help them recover. It might be short-term, but it’s not gonna be a forever recovery.

I nod my head in agreement. “That’s a noticeable reoccurring theme in substance misuse work,” I comment, thinking of the several other interviews in which participants raised similar issues.

That’s what I’m saying. They [health providers] need to do dual diagnosis treatment, and that would be a facility that treats both addiction and mental health together, combined, as one disease, you know what I mean? Not, go see your psyche and get your meds, and we’ll try to work on your substance abuse problems. They are hand-in-hand, you know?

June’s traumatic lived experiences and lack of comprehensive healthcare made available to her only become more salient throughout her narrative. As she grew older, her substance misuse intensified. At the age of 19, June suffered a physical assault which caused two herniated discs. In this account, she describes her interaction with her doctor:

My doctor turned into my drug dealer. This doctor looks at my X-rays and sees herniated discs, so hell yeah, it hurt .... But this is what this doctor wrote me at 19 years old: OxyContin 80mg, Roxicodone 30mg, Morphine extended release 100mg, Xanax 2mg, Adderall 20mg, and Ambien 10mg. That’s what she sent me home with for my back and my mental issues. And she was a primary care doctor! And that’s what I mean, I stayed on pills for a long time. And then finally it was (long pause), you know, I was running out early, she caught up with it, she saw the track marks, and I was cut off. When you cut someone off from that, what do they do? They go to the streets. And, I’ll tell ya, I was, I was a drug addict for a long time just on pills .... But, uh, it didn’t become (pause) what I call my rock bottom devastation ... until I started using heroin and crack. So, um, ... once the needle and the crack became part of my life (pause), my life stopped. I existed. I was smoking crack and shooting heroin. And you know, when I look back, crack didn’t

even really get me high but what it was, was it was enough to wake me up so I could just do more heroin, you know what I mean? Just keep getting higher and higher. Okay, I'm too sleepy. Smoke, I'm too awake. You know? And it just enabled me to do more.

I was shell-shocked by the amount of pills that June was prescribed. How could a doctor give these many narcotics to a 19-year-old? What is the logic behind these prescriptions, if any? Unfortunately, though, June's "doctor-turn-drug-dealer" story is not so uncommon. In the decade following the launch of Purdue's marketing campaign for opioid pain management in 1996, for example, OPR sales quadrupled (CDC, 2018e) from the exponential growth in opioid prescribing in the U.S. (NIDA, 2018a). In 2015 alone, enough opioids prescribed to keep every person in the U.S. medicated 24 hours a day for three weeks straight (CDC, 2017a). And, recalling earlier statistics, 4 out of 5 heroin users report that their opioid use began with OPRs (Muhuri et al., 2013; NIDA, 2018a). While opioid prescriptions can be effective in, for example, easing acute pain from surgery or managing chronic pain for cancer patients, the amounts of opioids prescribed in the U.S. undeniably exceeds what is necessary for those uses.

I was interested in hearing more about this interaction with June's primary healthcare provider. "Wow, that is intense—all of it, but the prescribing... wow. What was that like for you? Can you remember conversations with your doctor about the risks of these medications?" I ask.

Conversations? No, they were non-existent. I mean, you gotta remember, I was using before, so I knew what I was getting into, but I was an addict, so what the hell was I gonna say? No? No way. But still, that doesn't take away from the fact that I was only 19. I mean, this doctor never even talked to me about how addictive these pills were. She NEVER warned me. I mean, again, I knew they were because I had a thing for them. But it wasn't like a normal doctor-patient relationship should be. It's not like she knew I was an addict when I first met her. I was just 19, and to her eyes, she didn't know I had a previous history. She didn't even bother to ask, and I didn't bother to volunteer. So, I think she should have said, "Hey, you know, these can be REALLY addictive." But still, everything she prescribed me was addictive, so it would make her look bad. These were the strongest of and the most addictive of opiates at the time. And no warning. Absolutely no warning. Even though I knew they were, she should have warned me .... Maybe my previous history saved me, because in my first month on the prescriptions, I could've killed myself so quickly if I did not have a history and knew what I was doing.

June acknowledges her accountability in these interactions, but also holds her doctor responsible for her reluctance to sit down and communicate with June the addictive risks of these drugs. Again, June frames her experiences against the “normal”: her experiences were far from what a “normal doctor-relationship should be.” She spends some time imagining what would have happened had she not used opioids before and, in part, credits her own survival to her history and knowledge with substance misuse. June continues to ruminate on the medical community’s paradoxical commitments to patient safety:

As a medical professional, you take an oath to protect and educate patients and try to make sure no harm is done to your patient. Like, you know, “do no harm.” You are there to help. You take an oath to ... do things that are going to help them, not make them worse. Your profit doesn’t excuse you from these oaths. And, you know, the thing about narcotics also means I need to see her every month. Because they have to write a ‘script every month. So, that means more office visits, more insurance billing ... I think that’s one reason why they prescribe it, because then you have to see them every month. Or, sometimes, doctors will be like, I’m going to give you a 2-week supply since it’s a narcotic. Then they get you twice a month, and from there on, it’s all money. It’s all money .... And cutting me off on that amount of Xanax, that was bad. I had seizures to where I was choking on my vomit and all that. That was [the doctor]. Mixing benzos and opiates are bad enough, but yeah. It was horrible.

It is clear that June is well-versed in the ethics of clinical practice as well as the profit-driven motives of doctors and prescribers. Equally apparent in June’s elucidations is how the healthcare community has played a significant role in the development of substance misuse problems. In particular, June explains how she compensated for the lack of professional and compassionate communication in her healthcare interactions by taking responsibility for her health into her own hands, whether it be learning the dangerous risks of opioids and other prescription pills by experience or self-medicating when healthcare institutions fail to meet her physical, mental, and emotional needs.

At this point, our discussion shifts to other instances of June’s life in which health issues were particularly salient. June described how, after being cut-off from her provider, she sought

heroin and crack to stave off withdrawals from her full-fledged addiction. Moving from prescription pills to street drugs, I asked June, “What changed for you in these moments?” A significant portion of June’s recollection involved the loss of her living situation with her parents. Her parents moved to Florida and left her in North Carolina, a move for which June does not blame them. Although she was left alone, she understands the decision her parents had to make because they could not be around her when she was using drugs. In her response, she continues, “This is when things got really bad. And violent. Homelessness was a big issue ... and then I got involved in sex trafficking against my own will.”

June was lured and ensnared into a lifestyle through false promises and deception. A man promised her to provide her protection and comfort, namely by drugs and a warm place to sleep. For years, June was held captive in a motel with no form of communication or interaction with the outside world. June was exploited for commercial sex and experienced severe physical, psychological, and sexual abuse and coercion. Although the traffickers employed a variety of manipulation and control tactics, the thought of escaping crossed June’s mind thousands of times. If not for her own safety, she wanted to escape to save the lives of the several underage women that were also subject to physical and sexual violence. Still, June was scared for her life: She knew that the lead trafficker was infamous on the streets and had a reputation of murdering those who went against him. In her account, she states:

I thought, if I leave, where the fuck am I gonna go? He’s gonna find me. And the other thing is, he was ... keeping me from being sick .... I mean, pill withdrawals suck, but heroin is horrible. It is HORRIBLE. Just imagine the worst flu ever and times it by a million. But yeah, this guy had ranking. So the other drug dealers knew him, you know. Like, even if I did get out, those are his homeboys. So they’re not gonna [help] me, you know? So, I just, I totally felt trapped. Totally, totally. And yes, drugs had a lot to do with it, when it comes down to [feeling trapped] .... And then this guy walks in. He was white and clean-cut. I thought to myself, this is not what they normally look like. Please be a cop. PLEASE be a cop. Prostitutes don’t say please be a cop, you know, like, but yes, please be a cop. And thank God, um, it was.

I couldn't help but interject here. "I don't think it's even fair to say it's prostitution, that is sex slavery," to which she agreed and reiterated her point about being there against her will as well as the use of drugs as control mechanisms. I could still sense shame in June's story when she compares her position to the other women being trafficked: "Well, yeah, it's not right no matter what, but I was already addicted before he got me. The underage girls there had never touched a drug before, they were just run-aways .... Truthfully, my heart goes out to them." This elaboration introduces a dilemma when one is a survivor of sex trafficking, *but still* a "drug addict," which demonstrates the ways in which "addict" identities are always morally cemented and take center stage for identity construction (Lloyd, 2010). Despite her gut-wrenching stories, the silver-lining was that through her survival, she did not contract HIV or any incurable STDs. She did contract hepatitis C from sharing needles, but through the help of a local non-profit organization and her insurance plan, she was cured within 3 years of contraction.

From here, June's discussion shifts to when she entered the methadone clinic. Remembering her emphasis on the urgency to treat mental health alongside substance misuse, I asked if such resources were ever made available to her, to which she responded a resounding no. She then moves toward the complexities of methadone treatment.

Methadone is \$16 a day. I pay almost \$500 a month to be sober. And they don't take insurance. That's ridiculous. It's a lot of money. That's one of the biggest things, really. I make enough technically to have a place of my own. But because of the methadone, I can't. I am stuck living with my parents at 26 years old, because all my money goes to my recovery .... It's so hard. I know I need it to stay sober, but on the other hand, it's like I'm stuck .... I might be clean on heroin, but I still have a ball and chain. Because (pause) I can't just go to Europe on vacation, because I need to dose. So I still feel like I have a ball and chain, you know, like before I felt like on heroin I had a ball and chain, I can't leave my city because I don't know a drug dealer here. It's the same thing with methadone, you know? I mean yeah, they have guest dosing, but .... When you're on vacation, do you want to wake up at 5:00 AM, and drive to the clinic? And, you know, \$16 a day is a lot of money .... How are you gonna pay your rent and \$16 dollars a day? I mean, your medicine is a rent payment. And the fact is ... I told [Lighthouse] ... I pay \$500 a month here to be sober. You go on your website and it says you offer methadone maintenance, but it also says you offer one-on-one counseling, group counseling, family counseling, and relapse prevention. Aside from my counselor calling me in once every

three months to literally sign a piece of paper, my treatment plan that I don't even get a copy of, they don't do anything. I don't even know what the hell it says .... Other than that, what do you give me besides medicine? I said, if I were to quit this program right now, I have learned absolutely nothing about being sober. The only thing I've done is replace my drug .... I came to you because you supposedly offer all of this stuff, but where is all this stuff? Because the fact is, I'm no better than I was when I was using.

Indeed, the price of methadone is an impeding factor to health with respect to the various social and economic determinants of health: finding and maintaining employment, managing finances, transportation, and housing. Further, June describes Lighthouse's treatment operations ineffective beyond providing methadone doses and restricts her freedom more than they expand her health. June couches her frustration in articulating her responsibility and compliance in the treatment program, arguing that she is a "model patient" for Lighthouse. During her 3 years at Lighthouse, she has never failed a drug test and has phased up 4 levels, which means she gets 4 take-homes a week. She enjoys the take-homes because she doesn't have to come to the clinic as often, avoiding the long lines and hassle. According to June, out of the 7 total dosing windows, there are usually only 2 operating windows and only 1 that distributes methadone in tablet form, which is June's prescription. This is because oral solution, or liquid methadone, is the most common form of methadone.

June uses 40mg methadone wafers in contrast to the typical liquid methadone dose. In addition, she is on a particularly high dosage of 320mg, which raises concerns for June. When patients go to the clinic and visit the dosing window, the nurse asks for the patient's name, dose, and if they are eligible for take-homes. By verbalizing the dosage, however, the clinic jeopardizes the patients' safety and confidentiality. She illustrates a particular instance in which the methadone clinic put her in a vulnerable position, recalling back a few weeks when she was on a 300mg tablet dose and had 3 take-homes a week.

So before I was on wafers, I was taking 30 10mg pills a day for over a year. Anyways, you walk up to the window—"Uh, yeah, [my name is June], 300mg. And yeah, I get three take-homes today." That means I'm walking out of the clinic with 90 pills .... And

the windows are like, bank windows. Thick, glass windows, with the little metal talk thing, so you've got to say it loud for them to hear you. Which means everyone in that line .... heard that I'm leaving with 90 pills .... That's like hitting gold! It just makes me really uncomfortable. So, when I walk out, I put my safe in the trunk .... I know that I should not have to scream my dose. Why are you putting me in that situation? Because, people can follow us, like if we stop at [a gas station] to get a drink, or [a restaurant] to get breakfast on the way home ... I don't want some addict robbing our car! I already make a point to AVOID people and NOT make friends at the clinic. And frankly, it's nobody's fucking business what my dose is, besides mine. I know it's breaking HIPAA. I flat out KNOW it is ... and their violations are putting me in danger.

June and I collaborate on ways in which the clinic can address this issue. She brings up the idea of using a pen and paper to disclose health information, though it has been consistently vetoed by nurses and clinic staff. She recites several instances in which she approached counselors requesting their help in addressing this issue, but at the time of our interview, no progress had been made. I continue probing her about her interactions with clinic healthcare providers.

They really aren't interactions at all. Like with the doctor even, it's just one annual examination they require. And an annual consists of you going in the room and the doctor says, "How's your dose holding you?" "Good, I don't have withdrawals," "Okay then, your dose seems to be good. You're fine." And that's it .... There are so many more questions that should be dealt with. Like, how are you coping? Uh, are you having cravings? Um ... your friends ... are they clean, are they using? .... These are things that are so detrimental to someone's recovery. I'm lucky to have a good counselor, but even she doesn't have time to get into all this stuff with me. She's too busy and overworked. And really, all they care about is the dose. And that's what I mean when I say I pay [Lighthouse] for drugs, that's it. Because I'm not getting any treatment, you know. And I mean it. I'm not. The clinic is just my drug dealer. It is all just really messed up.

Yes, very messed up indeed. If I were simply interested in identifying the criticisms of the methadone clinic, no more discussion need be provided because the rest of this narrative moment was essentially a reiteration of the controversy surrounding methadone. However, in order to understand how June communicates about health, it is necessary to examine how her views of the methadone clinic calls forth the essential relationship between treatment, or lack thereof, and health.

An important point about interviews is that they are always co-constructed and co-authored. Narratives, then, are bounded by and constructed in relationship with various people,

organizations, and discourses. With regard to health and addiction, any narrative emerging from this context needs to take into account the often conflating definitions of health and recovery.

The methadone clinic promotes recovery as health, and while recovery is a facet of health and vice versa, this has implications for interview responses. When I ask June about health in particular, she frames her story along meanings of recovery.

For me, recovery is—and I'm not one of those people that say you have to be absolutely abstinent from things, because in my experience, when I'm abstinent, I end up using regardless. I mean, if you don't have a maintenance drug, you're gonna relapse 99% of the time. So, methadone to me is recovery. But it's still a drug, just replacing heroin with methadone. If you ever want to get off methadone and make it, you know, not relapse, you need the other parts. Help with jobs, housing, coping skills, support systems. And like I told you, dual diagnosis care. These are the things that somebody in recovery is supposed to be taught .... The thing is, methadone stops your cravings. Without it, how are you gonna cope with life? Or function? You're just gonna pick back up the drug! It's all you know! So that is how I think of recovery. We need to be taught how to survive and how to be a normal person without always leaning on a drug. But it's really hard.

June articulates that methadone *is* recovery. Yet, still she is unsatisfied with her health in general. With respect to her addiction, she is certain that she will relapse without methadone—a thought she will soon return to in a later excerpt. At the same time, June's recovery is complicated because she cannot justify complete health while still on methadone based on her belief that it is just a replacement drug. Likewise, she lacks instrumental and relational skills that she feels should be taught at the clinic to help stem relapse without a blocking medication. After a brief pause, I ask June to expand upon the difficulties of recovery.

Well, one example is that they don't encourage tapering. In fact, they encourage the opposite, to increase [the dose]. Ideally, it would be nice if we had a schedule ... or help by the counselors .... My ideal goal is to not get off methadone entirely because I know what happens when I don't have maintenance—I end up high. Methadone withdrawals are HELL and last forever—it's months of agony. Ten-fold heroin and fentanyl, everything in between. And you gotta remember, I came in on using 7 grams of heroin a day. But I would like to be at like, 150mg ... I've been sober three years, I think it's about time I can start going down. But it would have to be on my own .... That's why I guess methadone clinics are a love-hate relationship. They're beautiful, they gave me my life back as in I can hold a job, I'm not running the grimy streets always looking for my next high but ... if they cut me off today, I would be [downtown] tomorrow looking for dope. Sure, [methadone] doesn't make you a piece of shit, on the side of [the street], you

know, trying to hustle money and using people. You're not an outstanding citizen when you're on heroin .... But the fact is, I'm addicted to a substance still, and I haven't learned anything about recovery in my time at [Lighthouse] .... I pay so much for so little. And they expect us to accept that. It's like, well, if you don't like it, then leave. But they know we're not going to leave. They know that they put a ball-and-chain on us, so nobody is going to leave. Because we're addicted.

From this perspective, recovery is tapering. June explicitly states that she would like to be at a 150mg dose, which suggests she would identify more positively with her recovery if she were at a lower dose. However, tapering down from her current 320mg dose is bound to be a painful and strenuous process. Compounded with the lack of guidance by her counselors and other clinic staff members, I anticipate problems looming ahead in her treatment since she feels like the clinic works against her and not with her with respect to her recovery goals. She again references methadone treatment as a kind of insurance against being jobless or "running the streets," but this does not alleviate her fears about methadone tapering. In conversation with her earlier excerpt, being without methadone does not only increase her chances of relapse due to June not feeling equipped with adept coping or life functioning strategies, but it also threatens "months of [agonizing]" withdrawals.

Despite her criticisms of the methadone clinic as a profit-driven drug dealer operating under the guise of treatment and her articulations of methadone as an inescapable "ball-and-chain," June admits that she does not ever want to be completely off methadone. A primary motivation is avoiding methadone withdrawals and risking illicit opioid relapse, but I believe it could also be a fear of not knowing how to lead a healthy life outside of the routine safety that methadone provides. Methadone has helped her feel as if she regained her life, which suggests that it has influenced her constitutions of health in relation to having a job and helped her construct a more positive identity that distances her from the "grimy streets" in which addiction thrives.

## **Leo – Health as Work**

*Be calm, Liahnna. You've got this. You know your stuff, you have your interview guide, everything will be fine. You are going to do great.* These thoughts became my mantra for the next 45 minutes as I drove to Lighthouse for my first patient participant interview. I was nervous, but also very excited. After several failed interview attempts, Leo seemed enthusiastically ready to talk with me. I can remember literally jumping with joy after I hung up from our first phone contact, not only because I had an interested participant, but because his excitement matched mine.

It was not but a few minutes into meeting with Leo that I felt my nerves melt away. Truthfully, Leo is a bundle of joy. His personality overflows with vibrant charisma and a contagious energy. I talked with Leo for nearly 3 hours, and while we got off-subject plenty of times, we always made a point to come back to our original subjects. We could have talked for much longer, and sooner or later, we did. Leo is one of few participants with whom I developed a deeper relationship and we still keep in regular contact. While I do not include our personal conversations, I am thankful to have met Leo so early-on in my research because he has been a supportive friend for many discussions about the research process-product.

During the beginning of our interview, Leo disclosed a lot of information about his family. In fact, his strong and caring relationship with his family reverberated throughout the interview. He grew up what he describes as a “well-off, middle-class family,” but his family situation took a turn when his father died of cancer. Leo was only 14 when his father died and he recalls a vivid narrative of him dying in the living room, which significantly altered the lives of him and his family. Illness was common throughout other family members as well: Both Leo and his mother have lupus, while his mother and sister battle a combination of other diseases,

including type I diabetes and cancer. Although Leo was already using drugs recreationally when his father died, his drug use accelerated when he started selling drugs for money for his family.

After my dad died, I figured I needed to start selling more drugs. In a way, it was so I could do more drugs. I started selling cocaine when I was 14—and not just a little bit of cocaine, it was in large quantities .... I moved out when I was 16, down to the south side of town. My mom was pretty much okay, because my father paid off the house, but she was living off her disability so she wasn't living the best she could. She had a little bit of money, but nowhere near where we were before when my dad was alive. So, I would send her money and things like that. So, it kind of seems like, in a way, I started using to use and then in a way I started selling to make money for me and my family—to make a living in some aspects .... And then it got to where I wasn't selling just cocaine, it was whatever drug made profit, like eventually pills were the best way to make money. In like 2008, 2009, those years were probably the most amount of money I made. I mean, you're looking at making \$40,000 a month just on pills just from two doctors alone, so at 18 or 19 years old, it's hard to walk away from money like that .... It's easy to apply how you sell drugs to how you run a business, or marketing in general. But yeah, it was bad I guess because I started using when I was really young. I'm 29 now, so it's been like, 14 or 15 years of on and off drug use.

Leo goes on to describe a few run-ins with the law that, along with the stress of selling copious amounts of drugs, encouraged him to quit the “business of narcotics.” Leo articulates himself as a born-to-be-entrepreneur and tells me about various companies he founded and managed, such as a particularly lucrative smoke shop with the latest wrinkle in marketing. In addition, he ran a complex segment of the narcotic economy which extended well-beyond the “underground” and into hospitals and pharmacies, making deals with medical professionals in exchange for morphine drip bags and thousands of pills. Working several legal and illegal jobs, he would help his mother, brother, cousin, and nephew with their financial needs, while also funding his drug use. When Leo was 22, however, his addiction caught up with him and has, irritatingly so, never left his side:

That's when I started getting into really bad drug use. I started using, you know, needles, and things like that. I know it's probably kind of graphic, but I would use like 3 or 4 different drugs in a single shot, like cocaine, meth, heroin, and Dilaudids. I eventually got arrested for [burglary], which pulled me out of school. It totally wrecked my life and has screwed my attempt at getting pretty much every job I've ever attempted to apply for. I've just been trying to get farther and farther away from it. I haven't had a single arrest since then. So, everything after the arrest just shows I've been attempting to better my

life, but it's never enough when it comes to jobs. I even graduated college with honors, but that doesn't matter. It will always be an uphill battle because ... you always have to show 20 times harder than the next person. I've had my slip-ups every now and then, but I was trying to get clean. I stayed clean for 2 years at one point, but everything was just useless.

At the time I interviewed Leo, he was celebrating his first month in recovery at Lighthouse. It does not serve a purpose to focus on the difficulties of his addiction and recovery in particular, but what is important is how he associates health (and recovery) with having a job. During the interview, there were several moments in which he paused to answer phone calls from hiring managers and by the end of our time together he had 4 job interviews lined up for the week. Although he discussed numerous stories about his experiences and struggles with addiction, looking for employment was the most prominent and commonly occurring theme, often threaded between illustrations of tragic life events that contributed to his drug use. Before we got into an in-depth discussion about work, however, I asked what brought him into treatment.

Well, physically, um ... I've just started to beat up my body. Like, most of my veins—I can't use any more of my veins. And I don't want to sound like a victim, but the reason behind a lot of my extensive drug use was living through tragedy after tragedy, seeing my family get worse and worse. But another thing is the people. I wanted to get away. You cannot trust a single person [who uses drugs]. I mean, I hate to say it that way, but you can't. It's actually a joke, you know what I mean? A meth head will actually steal from you and then help you look for what they stole from you .... But when my addiction got bad, I started realizing differences in myself, too .... I have a neurologist, and he's told me about the physical damage I've done to my brain using drugs. Like dopamine deficiency, things like that. So even right now I'm on a high depression medication. But through all of this I've learned that the person I used to be back when I was like 18 or 19 didn't care about anybody but myself. I don't want to be that person anymore, a person who has no loyalty and can't stick up for other people .... It sucks to say, but addicts are just out for themselves. I don't want to be that.

Leo quickly transitions from the physical harms of his drug use to the social realms of addiction. He spends little time explaining why he is in recovery in terms of addiction itself, though this might be because he does not want to sound like a "victim." In a brief moment after this excerpt, he even argues that he is hesitant to tell his "story" (physical air quotes for emphasis) because

“addiction stories tend to make you sound like a victim.” I am more interested in how Leo communicates about what he has learned in recovery—of little concern for Leo is the obvious, physical benefits of recovery. Instead, he attends to the relational and identity aspects of addiction and the ways in which he can change himself from the way he lived his life before, particularly about morality.

While Leo grappled with his moral dilemmas about distancing himself from addiction, I found myself thinking about all of the efforts he made to help his family while he was using and selling drugs, even noting this on my notepad. As I reflect on this interview now, I wonder how the stigma of addiction and my positionality as a researcher, and perhaps even his “young” status in recovery, influenced Leo’s emphasis on his achievements and his continuous efforts to remind me that he did not want to make it seem as if he was looking for sympathy or perceiving himself as a “victim.” Though these questions would be of more interest to structural or dialogic narrative analysis that, respectively, examines how a story is told or how communication is interactively performed, I am encouraged to consider them as I write this paper.

As I stated earlier, this was my first interview for this project, so it is fair to say that I was less adept at listening for narrative areas in which I could steer the interview in a particular direction; thus, we got off-subject quite often. Still, I was intrigued by his stories and his descriptive lived experience, and he eventually summarized his points quite succinctly:

I guess the point of all of this, like what I’m trying to say, is that my life experiences are so different than just about anybody else’s. It’s so difficult to fit in this society where people consider [addiction] to be such a nasty stigmatization .... In my personal opinion, society wants to ostracize drug addicts and keep them out of society. It’s all about productivity and being that perfect citizen, and we’re not that. I don’t buy things, I’m not paying taxes. I don’t have a job, it’s hard to even get a job. How can I model that citizen? It’s hard to be a functioning member of society, you know what I mean? And if you consider relapse rates, and like, prison recidivism rates, it’s just a revolving door. And I’m lucky to have my mom to support me in recovery. But right now, it’s all about getting a paycheck .... It might sound weird, but if you point drug addicts in the right direction, with all the life experiences, we could excel tremendously, but we don’t get the chance. I have to pay nearly \$500 a month for my methadone, so yeah, money is

important. And like, last month, my mom and I skated by. Usually the last week of every month we don't eat because we only have \$200-300 to live on. And I have a 13-page resume. I've done nearly every job you can think of, from social security work to tree work, yet nobody will hire me. I know I can do it, but the rejection is very discouraging. Especially when I could go back to making good money easily by selling drugs.

Leo brings into conversation how the stigma of addiction impedes his ability to become a “functioning member of society,” despite his unique lived experiences that he argues could be potential strategic tools for working organizations. For example, Leo describes how his experiences in the drug world have helped him embrace his “manipulative side” and how these characteristics are typical to workers in sales and marketing industries. He further elaborates on a long list of job interviews in which he describes himself as in “a constant performance of what I think that person wants me to be, something I've also learned from being on and off drugs for 15 years.” Even outside job interviews, this is his way of Leo trying to “fit in” with non-drug using people and communities. Giving an example of everyday talk, he states: “When people ask what I did in high school, what am I gonna say? I can't be honest. I make up stuff or pretend I was there. If not, we can't have a regular conversation. I'm on the outside.”

In this moment, I am also interested in how Leo articulates the interplay of work and recovery as a way of assimilating into mainstream society. This is coupled with his financial insecurity and the high-cost of methadone treatment, but also being perceived as a “normal” member of society—a “citizen.” I ask about Leo's experiences with methadone treatment:

It's been a great experience. The biggest issue was making sure I had enough drugs not to be sick because when I came in I was doing like 3.5 grams of heroin and a cocktail of other stuff .... When I drink a cup of methadone, it's not like I get high, so it makes you move past other hurdles in order to be okay, when before I could use drugs to be okay. Drug use is really a daily regimen, making sure you have the right amount of drugs for you to live day-to-day. So the clinic gives you the chance and the opportunity ... to give me some sort of normalcy in my life to tackle everyday problems .... I have a lot of time to fill, but I try to do things like work out and read. You have to find those areas ... that you have to fill in instead of doing a shot here or a line here. Even what you might consider a little thing, like cleaning the garage, is huge for somebody like me. But not so much for everyone else, it's all about productivity and work. We live in such a fast-paced world ... that people don't learn to deal with the normal stressors of life, like, you know,

anxiety and depression .... We keep people medicated around the clock, always. It makes money. But at least methadone forces me to not look to drugs to deal with those stressors.

Methadone gives Leo the opportunity to navigate around the everyday stress of the world and realize small achievements as big ones. Once again, Leo's case is particularly illustrative of the dynamics of living through a sense of normalcy. Then, he returns his focus to the importance of having a job:

In all, though, it's about getting a job. It gives me the time to look for a job and that stability needed to hold it down. So that's like, what you were saying about health, that's what it looks like to me—just a decent paying job. Because what do you need to live? You need a job. What is the basis that hinders you from getting a job? Your arrest records, unfortunately. Methadone can't get rid of that but it can help me look like I'm trying to do better. Also, I want to be able to have a place of my own and ... possibly a girlfriend, hopefully in the next couple years .... I want to go back to school—that's a real big thing for me. So yeah, the important thing is just really like, what a normal life would look like. A normal life that other people have. But getting clean and everything that it involves, like getting a job and mending relationships ... in a way, all that is harder than being an addict. It's just a long, slow process.

Of particular focus for Leo is discussing health in terms of establishing work and a steady income. In short, health is work. Health is work in that it is demanding and disciplinary and health is work in that it is literally defined by his (search of) employment. In struggling through his day-to-day experiences with trying to make ends meet for him and his mother, Leo continues to point out that until he finds a well-paying job, he cannot experience health. Leo ties his desires in establishing viable, legal work with the social realms of addiction and the ways in which his past crimes continue to haunt him and impede his ability to get a job. By the same token, his past experiences become a barrier for developing a normal way of living. In these ways, "normal" again is saturated in the context of work and productivity in pursuit of living as a "functioning member of society" to attain "model citizen" status.

### **Ozzy – Addiction and Recovery: A Balancing Act**

"A black coffee, with a little cream and sugar is good. Nothing fancy, just regular coffee."

I met Ozzy at a coffee shop. I remember scrambling to get there on time, because I had originally got the address wrong and went to a similar coffee shop about 15 minutes away.

“Come on, red light, turn GREEN! This guy is gonna be so upset with me!”

When I finally parked, I was 7 minutes late, but I did achieve one thing: I beat my phone GPS by 4 minutes! I ran inside and ordered our coffee and met Ozzy outside. Per Ozzy’s request, I brought a plain black coffee—nothing fancy—with a little cream and sugar.

I was probably more apologetic than necessary. Ozzy let me know that it was no big deal at all and proceeded to make me feel better by making conversation about how many coffee shops there are in the area. He really does exude warmth and kindness, and this became obvious in the two hours we talked with one another.

Ozzy brings a particularly unique perspective to the topic of addiction treatment and recovery based on his 20-year off-and-on-relationship with medication-assisted treatment. He articulates that he began “experimenting with drugs” at age 15 and eventually got arrested for a felony ecstasy and marijuana possession at age 20. After he was released from jail on bond, his heroin use escalated from being a “come-down drug” after a night of partying to a regular habit. Ozzy describes, “[Heroin] calmed me down. I was so anxious at the time and so young. I didn’t know if I would go to prison for life or something. It was the only thing that made me feel normal.” For Ozzy, heroin emptied his mind and body of his extreme worry about the imminent court case. In this account, he also describes heroin as “soothing” and as a way to “escape from everything else and really just feel nothing.”

At 20 years old, I was scared. I know it was my fault, but I didn’t really have anyone to help me through it. Heroin was pretty common in the clubs, so I started doing more of it, snorting it. Then I kept on and eventually noticed physical uh, problems when I didn’t do it. Just really lethargic, not full on horrible withdrawals . . . I don’t even think I quite realized that I was in the process of becoming addicted. Because I was doing everything else normal, like I got my AA degree on my 21<sup>st</sup> birthday while awaiting my court case, so this was back in 2000. It was weird to balance it all, but like I said, my drug use kinda helped me with it all, in a twisted way.

Ozzy associates his substance misuse with simultaneously feeling “normal” and “nothing,” particularly in the way that he describes heroin as a mechanism for escaping his worries about his pending court case. Until this point, he communicates his substance misuse as “experimental learning” against the backdrop of difficulties within his family. Growing up, Ozzy lived with a chemically dependent and abusive family and moved around with several different family members throughout his childhood and early adolescence. His heroin use became more intense over time.

And of course, eventually I get addicted, like full on. When you’re snorting, there comes a point where it’s not enough .... Then I go to a friend’s house, noticed he had a Q-tip behind his ear, so I knew he was shooting, you know, because of the cotton .... That’s when I finally decided to use the needle, and it went on from there. I started doing that every day and never went back to snorting it. And then of course, by the time my court date ... arrives, it ended up being just a felony marijuana possession. The ecstasy charge got dropped due to some funky stuff on the police side—it got thrown out .... So I managed to get myself addicted from the time I got arrested to the time I went to court to get sentenced, which ultimately I think was 2 years of probation, that could’ve been shorter depending on my behavior. So, it sounds like it would’ve been easy, especially since it was just a damn marijuana charge! But I was a drug addict at that point, I was shooting up .... I stopped smoking pot ... that was easy, but I couldn’t stop doing heroin. Physically, I couldn’t stop, or else I wouldn’t feel normal. And then, things went bad with my probation. I had a couple of dirty urines and then I knew I was fucked. So I said screw it, and just kept on using, and my probation was revoked after 3 months .... Then, I knew I had to go to jail. At first, I planned on just turning myself in, but I didn’t want to go in strung out. So that’s when I went to detox.

These comparisons and interpretations of Ozzy’s injection and non-injection routes of administration for heroin use are an integral part of his developing addiction. Ozzy realized his addiction when he transitioned from insufflating, or snorting, heroin to injecting heroin. Likewise, he articulates his “addict” status along the lines of beginning to suffer from physical withdrawals, though fully aware of his emotional attachment to heroin for its comforting and relaxing effects. A crucial importance for Ozzy’s self-understanding, too, is how he learns to see himself as needing heroin to “feel normal.” Recalling his earlier accounts, we can also read the

ways in which Ozzy seeks to function normally by using opioids to address his anxiety and stress. Ozzy continues his story:

I was only there for 4 or 5 days. I could have stayed for up to 28 days, but my insurance wouldn't cover it, and it was really expensive. If I stayed for that long, the actual detox part would've been done, even though I would still have to take classes and stuff. It was a good program, though. It was before Suboxone was FDA approved, so it was an experimental thing. Back then, they used [Suboxone] more like a detox drug than a maintenance medication. And it's shitty because it's such a good drug, but now it's so expensive .... But anyways, I turned myself in ... which means I got a felony conviction right there at 21, which made things difficult. And it was for marijuana! (laughs) So I was sentenced for 120 days. But even when I was in jail I had still had every intention of getting high as soon as I got out. There's not much else to do in there but think of what you'll do when you get out. As twisted as it is, I had a bag of heroin within 3 hours of getting out [of jail].

Eventually, Ozzy's addiction was not about getting high anymore: It was about avoiding withdrawals and sickness. In his words, "The stress and fear of getting sick is sometimes worse than the actual withdrawal, although that's bad, too. It's just a constant chase and I needed some sort of relief." At this point, Ozzy shifts his story to how he came to use methadone treatment.

I was 22 when I started [methadone]. And truthfully, my life immediately got SO MUCH better and so much easier. On methadone, you know, I thought I was "cured" (physical air quotes for emphasis). Um, (laughs) obviously I wasn't quite right. I was on it for (pause) maybe 9 months .... It was kinda messy when I first started. For the first two weeks, I was still using heroin while on methadone, until I'd gone up to a comfortable dose, like a blocking dose .... I did that for a while, then I started going down. I did the tapering relatively fast—over 6 weeks I went from 90 to 50mg. And then I went down 5mg a week until I was at 10mg. And I said eh! What's 10mg? It's a pretty low dose, I thought I could walk off it and get off pretty easily. (laughs) I was so wrong. Nine days later, I was like, I can't do this anymore, then went back and stayed on [methadone] for another year and a half. This time, I also did 12-step meetings with treatment. They don't really like methadone or harm reduction, because they say you're still using ... so I never found anyone that would sponsor me. So, then I tried to get off methadone, because I wanted to be totally clean. I got myself back to a 40mg dose and then went to another detox center to detox off the methadone using Suboxone ... It was a great plan, but I pretty much just wanted to keep going to NA [Narcotics Anonymous] and actually really be clean and have a sponsor .... But now I know the 12-step thing doesn't really work for me. It does for other people though, which maybe could be because of how NA is considered morally better than methadone.

To press his point, Ozzy camouflages his first experiences with methadone by proceeding casually with an account of how he rapidly tapered his dosage. Ozzy explained his recurrent

relationship with addiction and treatment early on in our interview, so this is the first of many returning visits to the methadone clinic and other treatment programs. Fully aware of the competing discourses of recovery—that is, abstinence versus harm reduction—Ozzy decided to commit to a 12-step program in attempt to follow the steps alongside his methadone treatment. Reflecting on this stage in his life, he positions 12-step programs such as Narcotics Anonymous as morally superior to MAT programs because of the underlying belief that it is the higher moral path to achieve true sobriety from all substances. This is an example of Frank’s (2011) suggestion that methadone patients internalize dominant abstinence-based discourses that conflict with methadone recovery discourses and thus complicate recovery and recovery ideals.

After finishing the detox program at the end of 2003, he felt confident in his recovery and believed he could use heroin “just one more time.” However, after this “one time,” he relapsed into using heroin every day and again went back to the methadone clinic in the spring of 2004. This time, Ozzy stayed at the clinic for 6 years; however, he continued to fluctuate between maintaining a high dose to block opioid euphoria and lowering his dose so he could “cheat” by using both methadone and heroin at the same time. “I was frustrated that I wasn’t feeling [the heroin high], so I kept lowering my dose. This way, I felt like I had some handle on my recovery, but I could also get high every once in a while,” he states. There exists in Ozzy’s testimony an interpretation that almost epitomizes archetypal “drug addict” behavior (Vigilant, 2005) that is calculating and unscrupulous in nature, and these tensions manifest often throughout his narrative. I read his negotiations, however, as subverting the clinic regulations in order to define and make sense of his own method of recovery—that is, a method derived from Ozzy’s individual pursuit of responsibility and control. In theory, treatment programs uphold these values and in doing so also promote self-discipline, rationality, and righteousness, all of which are typically seen in opposition to the chaotic, self-destructing dope fiend.

Perhaps one could make the argument that Ozzy's statements are tangled in a warped logic fueled by incessant substance misuse. Or, more specifically, that he is simply confessing his faults or showcasing his wit, but there is neither a sense of shame nor pride in Ozzy's account. Instead, he asserts that his goal is to be completely abstinent, which suggests he is well-aware of how he conceptualizes his recovery as well as the moral dimensions of substance misuse treatment and recovery within mainstream society. To be free from all substances is also to be free from treatment institutions and organizations, and from this perspective, it appears that Ozzy seeks to restore his agency by liberating himself from the fetters of addiction by reclaiming control of his addiction in the cloak of recovery. In a similar fashion, living both as a responsible recovering addict and a responsible using addict inverts the power relations of the clinic and enables Ozzy to navigate his health in his own capacity. Despite how nullifying these endeavors may be on the surface, they are undoubtedly constitutive of how Ozzy makes meaning of his health and addiction.

Ozzy carries on and describes his complicated back and forth relationship with addiction and treatment. Eventually, he left the clinic once again to check himself into a detox program. With a sprinkle of sarcasm and a slight chuckle, he remarks that he "got the brilliant idea that Suboxone would be the answer" for his recovery. Instead of a detox program, though, Ozzy was prescribed Suboxone in tablet form. Ozzy never fully climbed out of the pits of his addiction and continued to use both Suboxone and heroin, reporting that he felt "there was no end in sight." He began selling his Suboxone to support his heroin habit while always keeping a few spare Suboxone in case he could not get heroin. In these moments, he describes his experiences in the context of the upsurge of prescription opioids, or what Ozzy refers to as "the era of the blues" ("blues" are slang for Roxycodone 30mg tablets). At the time, prescription opioids were the trending drug and their popularity made pills an easy alternative to heroin. As a result, Ozzy

combined his heroin habit with prescription opioids, namely Roxicodone. He describes these years—2010 to 2012—the worst years of his addiction: “It was far worse on the blues. It was absolutely horrible.”

In this jarring moment, I am again reminded again why I am motivated by my research. “Blues” is a particularly triggering term and indeed brings me back to the years of which Ozzy is describing. At my high school, I recall frequent locker sweeps and drug dogs sniffing around campus. These searches came in response to a rise in opioid use in the general area, as well as several overdose deaths among teenagers and young adults, including middle and high school students. Even writing this text, I cannot help but think of my art classmate, the 14-year-old boy who lived across the street from me, the popular boy on the football team, my co-workers, and my history teacher’s daughter, who all died from prescription opioid overdose within the years of 2008-2012. As well, I remember this term being a household name in my experiences living with family addiction. Indeed, *it was absolutely horrible*. I ask Ozzy, “Can you tell me a little bit about how you felt about your health in those years?”

Ugh, my health. It was just awful. My health was awful. I was 100 pounds lighter than I am now, and I was doing ... really shady things. It was really bad. I was miserable and trapped. I did honestly feel trapped in it. The blues were a whole new culture of evil. Like, awful deceitful stuff that I’m not gonna name. I didn’t have a home, I was basically homeless and staying on people’s couches. I wasn’t working, I got laid off. I was living off unemployment checks and whatever I could hustle. I had absolutely no structure in my life, no routine, which is all I really wanted. It was crazy.

Ozzy couches his health in relation to his drug-related behavior and other social structures such as housing and employment. In addition, he remarks that his life lacked the few overarching principles he truly desired: structure and routine. As the preceding excerpts on responsibility and control demonstrate, Ozzy’s deprivation magnifies as his health and quality of life degenerates. He continues:

Then I finally went to detox, a new place. It sounds bad, but it was kind of good because there was nothing comfortable about this place. The beds were stiff, uncomfortable, they

didn't let you sleep, and you felt like crap .... I stayed there for just 6 days but man, I looked so good after those 6 days. It was crazy. I remember feeling so much better. Then after I left I did this after-care program, where it was like school, I had classes and lunch and stuff. And again, after I left I decided to do the 12-step thing, which eventually went sour .... In 2012, I was a little over a month clean and had a NA meeting at 7:45 in the morning. I hadn't had any caffeine when I was in detox, so I was really sensitive, and you know, people are hardcore coffee drinkers at NA meetings. I went to the meeting and had like, three cups of coffee. And when I go to leave there, I'm just unbelievably jittery (laughs) .... I thought, well, a beer will take the edge off ... but of course that isn't allowed in NA. So there I was, January of 2012, drinking a beer at the bar ... and I just start thinking of like, man, you screwed up. That's my problem with 12-step—you're keeping such close tabs on your time and your white chips and a little mess up like that just drives you mad. I viewed it as the end of the world like I threw out my 30 days clean that I had. And so, I had a couple more beers and used it as an excuse. I felt like a complete loser, and then ended up going and getting heroin .... The philosophy that NA preaches, you know, I was just so down on myself, and I figured I was already technically using by having that beer, so I said screw it. Sure, I could've just ended it there and gone back and got a white chip, but I kinda hated myself for it .... And then I was back on the train for another 3 months, until I finally went back to the clinic—this time for the last time.

The contrast between Ozzy's nonchalant attitude about his frequent relapse with treatment medication versus the demoralization by his perceived failure with NA highlights the delicate balance between health and recovery, a balance of which is complicated by treatment paradigms and self-identity. In the first few sentences of this account, Ozzy celebrates the *goodness* how he looked and felt after just 6 days of the detox program and communicates a positivity that, so far in the interview, is unprecedented. On the contrary, he articulates time as the capital criterion for health and recovery within 12-step programs, and when he pollutes his "time" it becomes literal waste and thus contaminates his identity with shame and hopelessness. Ozzy continues to elucidate on his experiences with NA:

To me, I don't think recovery necessarily changes me, like NA says. It's not really black and white, like I was that and now I am this. Polarizing is easy but it doesn't work for me ... I'm a lot happier with the way my life is going now that I've accepted my individual recovery, and that took a while, like, you know, feeling like shit in 12-step and stuff. You know, I wasn't fucking happy then, it is obvious because I've never stuck around long enough in a 12-step program. Those meetings make me more on edge than the times when I've been on methadone and out of other stuff.

Perhaps it is the pressure of complete abstinence, the intensity of the 12-steps and traditions, the benchmark of a full month sober, or the acknowledgment of recovery with a symbolic token or chip—or, perhaps it is none of these things. Though I do not focus on Ozzy’s relationship with substance misuse in a causal form, I am absolutely interested in how these systems influence his health and identity. In Ozzy’s case, the possibilities of health are opened by the paradox of freedom and dependence in methadone treatment:

It’s been like, over six years now that I’ve been really invested, but after all this time I’m thinking, maybe I’m a lifer. Like, I’ll never get off methadone! I see it really as the lesser of two evils ... since I’ve been at [Lighthouse] I’ve gotten to do little stuff, like I finally went to the doctor. Got some blood-pressure medicine ... got a job, I’m going back to school now, too .... My anxiety is still pretty bad, but being on methadone has given me the opportunity to at least deal with it .... And I am bipolar, but they don’t treat it .... When you’re out running and doing drugs, that’s the number one thing ... you don’t have time to care about your health. Or (pause) a family event, school? No way .... Methadone gives me the ability to go to a family event and not be on the phone trying to hustle, um, I can go to school .... It gives me something to do every day, every morning, at least when you start .... So, the routine is nice, and I can find other things to fill my time. Like, I’ve started building back a great collection of punk rock records that I lost in my addiction, I’ve restocked to like, maybe 100 CDs and 30 records or something now, which is awesome, because that’s my passion, music .... But uh, like I said, I don’t want to be a lifer, but at the same time, I’m not rushing it. I mean, health to me is definitely abstinence from all opioids—that part is for sure. For now, methadone is included. I know most people want to get off it, but to me it feels safe. And so maybe I’m scared to, you know, get off it, but I’m also trying.

Ozzy expresses his current experiences with methadone in relation to his long history with medication-assisted treatment. He refers to methadone as an apparatus, opportunity, a “safety,” and, not coincidentally, again articulates methadone as equipment for routine and structure. Ozzy interrupted this particular illustration of the clinic to give me an alternate perspective:

I have my criticisms of course though, I mean, obviously it’s insanely expensive and insurance doesn’t cover it. \$16 a day, \$496 a month, that’s like a car payment, plus insurance, plus groceries. That’s transportation, that’s a way to live, financially .... And I hate how they only gauge your progress through drug screens because that’s not everything. If I have a dirty drug screen—it’s like, okay, sure. But before I started, I was on the streets. Uh, I wasn’t working, wasn’t going to school, my health sucked. But that doesn’t matter to them. Um, there’s no social groups either, like the groups you’d get in a

rehab center. So it would be nice to have some way to cope with others, you know? Maybe even just a relapse prevention group. Anything is better than nothing .... And of course they don't treat mental health which, I'm not gonna go off the deep end or anything, but mine is pretty bad. It's just not handled here. The counselors, it's not really like they're even there, so they can't do anything. I mean, I'm not gonna lie, I've had lots of ups and downs (laughs), that's my life, with my drug screens. You know, like weed, cocaine, off and on. But they feel more like probation officers than counselors, at least some of the ones I've had. I've gone really long periods without touching any drug while on methadone, like up to 2 years .... But to some people, even admitting that would be like, welp, you're still a dirty addict. I don't like to think a slip-up defines my person, you know? And that is usually cocaine, like, I don't know, maybe once a month. And I beat myself up over that, but, I don't know, I pick myself up and dust myself off. I just have to remind myself that I'm not a fuck-up and that I don't set this goal of perfection for myself.

For Ozzy, methadone treatment is to walk a tightrope. While it enables Ozzy to change aspects of his life for the better, there is little to no room to compromise. The limitations for health are driven by the clinic as well as his own beliefs in what he can and cannot do in recovery:

It's complicated because I always thought I was gonna reach this point to where everything was going to be all good ... like I was gonna have my own place, I was gonna be growing as a person. But I've learned that it's more about the journey than just the end goal .... Having more close friends would be great for my health, too .... And um, I'm not close with most of my family, so I don't have a lot of people. Being able to have like, my interests and the things I love, like reading and watching movies .... Just some normalcy, like balance and stability .... Even doing things like this is progress. If I was using you maybe could've had my attention for 15 minutes and I would've split. So even just trying new things and doing as much as I can, things that I missed out on a lot when I was doing drugs and making that the main focus. I guess, wherever I am in my recovery, I just want it to be about the journey, not really whether or not I still use drugs off and on or not. I'm not super concerned about that, as long as that's not the main focus in my life ... I have friends who recreationally use drugs, and on occasion, I will, too. But (laughs) like I said, drug addiction is part of me ... I've realized it's one of the biggest parts of my life, and I've come to accept it now .... Now it's just about doing things that make me happy, making friends, doing stuff with music, that to me is my recovery. Like re-finding myself, you know, like growing up all over again. Kind of like, literally recovering what I had.

Ozzy emphasizes his health in relation to *recovering* in the most literal sense of the word:

Ozzy seeks to return to his normal ways of living, regain a sense of control and structure in his life, re-find his hobbies and passions, and make up for lost time during his addiction. Discussing the ways in which he defines his own recovery as juxtaposed with the clinic's expectations is

essential to Ozzy's articulations of methadone as providing him with feelings of safety. Just as he is a consumer of health care, he is also an expert for his own health. Interestingly, too, he rewords his occasional substance use as "recreational" as opposed to much earlier in the interview when he noted his "slip-ups" as "cheating" the methadone clinic. Worth noting throughout Ozzy's narrative, too, is the tensions between craving routine and structure as an individual endeavor but also seeking structure through methadone and the clinic itself.

## **CHAPTER FIVE:**

### **DISCUSSION**

In this final chapter, I bring into conversation all four cases into conversation and make general theorizations within and across participant narratives. Accordingly, this chapter is organized around overarching themes that emerged in study. In doing so, I draw together existing literature and the central findings of this project and demonstrate how this study fits into and expands previous research on experiences of health and addiction treatment. I then read the major findings through a structure-centered approach (SCA) to health communication to identify the study's particular findings to provide a discussion for the original research questions guiding this project. As well, I make a case for how this project contributes to health communication. Finally, I address the limitations of research and offer suggestions for future research on health and addiction. This chapter ends with a conclusion regarding the study.

This project takes a narrative methodological approach to analyzing how people recovering from opioid addiction communicate and experience health, addiction, and identity in the context of methadone treatment. The central focus of this project investigates how methadone patients make meanings of or communicate about health and the influence of methadone and the methadone clinic on their negotiation practices of addiction, recovery, and identity (re)construction. Using the SCA theoretical lens, this study interrogates these phenomena against the backdrop of the organizing systems and practices of methadone treatment. In particular, this study explored the following research questions:

**RQ1:** How do methadone patients communicate about and make meanings of health?

**RQ1a:** How does methadone treatment influence the negotiation practices of addiction and identity (re)construction?

I designed the research questions to be fit for an exploratory examination into the experiences of and issues with health, addiction, and identity in people using methadone treatment for opioid addiction. Using in-depth interviews and thematic narrative analysis, my objectives were to examine the content and meanings of their narratives to discuss findings and draw conclusions to the questions in study. As I stated earlier, this section intends to make general theorizations within and across participant narratives. Remembering the commitments to narrative particularity (Riessman, 2008), I am careful of the ways in which I might be eroding the individual experiences that each patient shared in relation to their health, treatment, and recovery, so I make several references to individual cases when illustrating examples. This project revealed three themes, which I distinguish as: 1) health as normalcy; 2) health as a lack of resources; and 3) recovering the self, (be)longing, and health citizenship.

### **Health as Normalcy**

When asked to discuss their health, participants often located the discussion in the context of “normal.” In many cases, as with other themes discussed in this chapter, participants overlapped ideas about health and recovery. I did not interrupt their talk, rather, reflected on the ways in which their particular situations may drive them to focus on being recovered—that is, the lived experiences of addiction and their usage of methadone treatment. I make this note because interestingly enough, the definition of “recover/y” indeed does entail a return or a recapturing of something once lost. In this way, it makes sense that participants often couched health in terms of normalcy.

Although I never asked participants to give in-depth descriptions of how they make meaning of what is “normal” or how they came to imagine these depictions, there were general categorizations of illustrating “normal.” The most common discussions of normalcy were about finding and maintaining employment, owning/renting a home, mending interpersonal relationships, being self-sufficient, enjoying regular hobbies, and distancing oneself from drug culture. For most of the participants, the search for normalcy is bred from a long life of being perceived as *not* normal. Finally, participants are at a place in which they can reassemble their lives, however, they are still at odds with methadone treatment (Anstice et al., 2009; Cooper & Nielsen, 2017; Earnshaw et al., 2013; McElrath, 2018; Radcliffe & Stevens, 2008). This is reflected, for instance, in Leo’s accounts discussing his belief that mainstream society intentionally oppresses people experiencing addiction to keep them on the “outside.” Methadone treatment does little to alleviate these concerns. To be normal is to regain a sense of control over opioid addiction with assistance of methadone, ironically a synthetic opioid (Biernacki, 1986; Hanninen & Koski-Jannes, 1999; Vigilant, 2005). Health is constructed in the context of typical, everyday privileges that can easily be taken-for-granted, such as Leo’s explanation about cleaning the garage. Despite the common criticisms of the methadone clinic, every participant credited methadone with allowing them the opportunities to accomplish their life tasks, whether it be going to the doctor to get blood-pressure medicine (Ozzy) or having a pet dog (Tilly).

Participants do not spend a great deal of time describing what is impeding their ability to achieve a sense of normalcy; however, it takes but a quick read of the case studies to notice thematic elements about participants feeling “shackled” to and “trapped” in the clinic or that methadone is their “ball-and-chain.” These metaphors nearly identical to what Redden et al. (2013) found in their study about how methadone patients communicate their recovery. Likewise, they echo the inherent stigma and negative self-concepts that perpetuate addiction

treatment and individual identity (Koski-Jannes, 2002; Lloyd, 2010; McElrath, 2018; Murphy & Irwin, 1992). I believe it is a fair assessment to claim that these are not methods to live a normal life and indeed stem from several years of not being able to escape the grip of substance misuse and addiction. Thus, defining health as a return to a normal state, one that “frees” individuals from the constant, cyclic hustle of addiction, becomes complicated when the methadone clinic is the organizing structure that constraints patients’ ability to seek and achieve their health goals. For instance, methadone becomes a structural barrier for June when she elucidates her inability to travel because there might not be a clinic at which she can dose. In this way, methadone limits and restricts her personal freedom (Gourlay et al., 2005; Kondoni & Kouimtsidis, 2017).

Though methadone treatment can create opportunities for securing health, it is the very structure that prevents opportunities for health transformation as well. In line with Vigilant’s (2003, 2005) findings of addiction narratives in search of ontological security, descriptions of routine and structure were recurrent subjects in the frames of normalcy. This is where methadone treatment becomes slippery. In one way, the methadone clinic provides patients the routine and structure they often crave after a living through the culture of addiction. Patients typically have to visit the clinic every day to dose in order to ward off physical sickness from opioid withdrawal. In most cases, this is communicated as one of the positive effects of methadone treatment, however, the routine falls short at just simply a “dose-and-go.” The lack of resources provided by the clinic, which I discuss in more detail in the next section, in combination with patients methadone dependency reinforces the confines of methadone as an organizing structure of health.

Meanings of health demonstrated in leading and living “normal” lives were also couched in dialogue about productivity and ways in which one can assimilate into mainstream society as a functioning citizen. Here, normalcy is conceptualized as a dynamic process that leads to a social,

economic, and political system of values that influences how participants can become accepted by others. Unsurprisingly, health is very much individualized, which could reflect the individualistic culture of the U.S. or perhaps treatment discourses that communicate self-reliance, discipline, and rationality as recovery. Participants articulate a strong desire in finding a job and becoming a legal contributor of society not only to help with the financial burden of methadone treatment, but also to earn a sort of social and economic voucher to establish their societal “membership.” From this perspective, the search for normalcy through employment is similar to what Bourgois (2003) examined among Puerto Rican crack dealers in East Harlem in their quest for dignity and respect, often through failed attempts at legal business ventures.

Past research examining how people experience methadone treatment demonstrates discourses of normality to be common in the process of recovery (Augutis et al., 2016; De Maeyer et al., 2011; Nettleton et al., 2012; Vigilant, 2005, 2008). As this study shows, it is clear that personal, cultural, and political complexities operate simultaneously to make meaning of our health experiences and practices. Cultural conceptions of mental illness and addiction perpetuate stigma and shame and contribute to the marginalization of individuals experiencing addiction (Radcliffe & Stevens, 2008; Room, 2003), and normalcy is in opposition to these negative concepts. Likewise, health as normalcy is communicated around systems of organizing that fit the scripts of mainstream society, such as finding a job and maintaining healthy interpersonal relationships. Underlying these narratives are cultural notions of addiction that pathologize the addicted “other” in contrast to the ideal healthy and autonomous individual (Keane, 2002; Room, 2003).

The desire for normalcy is profound, however it is also complicated by the consequences of methadone treatment that hinder the possibilities for normalcy. Worth noting throughout these narratives is the meanings of what it means to be healthy and the ways in which health is

defined. Narratives show methadone to be the ways in which they can access normalcy through ideas of employment and productivity, while also being the very structure that prevents this process. Moreover, participant narratives reveal methadone to be a way into normalcy in the context of health as well as the implications for identity (re)construction. Narratives show these concepts to not be mutually exclusive, that is, to be healthy is to be normal and achieving a normal identity parallels this process. Finding and maintaining employment, enjoying healthy relationships, and becoming a functioning member of society all reflect on the ways in which participants speak of themselves and their identities. This demonstrates that health is inextricably tied to identity and shows that methadone treatment has critical implications for identity (re)construction and therefore, health. As well, future research should investigate how these participants come to make meaning of what is normal (e.g., in day-to-day life, doctor-patient relationships, “normal” addiction treatment experiences).

### **Health as Lack of Resources**

In general, there was minimal discussion about health resources outside the context of what the methadone clinics are and are not providing. Most often, participants were quick to point out that in spite of methadone giving them the ability to lead livable lives, they ultimately are unable to do so because of the structural barriers. Located in the larger realm of structural inaccess, many of these barriers overlap with articulations about employment, housing, and relationships discussed in the previous section.

Most notable are the articulations of the methadone clinic as nothing more than the provision of medicine. In Tilly’s case, for example, she mentions that, “Rehabilitation is absent at the clinic, we don’t talk about health at all.” She continues to reference the lack of health and support services that the clinic could potentially help with, such as job, housing, and medical

referrals, and notes the clinic staff's overall practice as that of a prison. June and Ozzy also raise poignant points about the urgent need for an integral health framework that addresses mental health and substance misuse as interdependent illnesses. For another example, health is once again constructed in relationship with access to resources in the recurrent theme of methadone cost. Although \$16 a day is, in many cases, cheaper than daily habits of illicit opioid use, it certainly is not cheap.

Participant dialogue takes on an autonomous tone with regard to the sheer invisibility of clinic workers in the provision of healthcare. For example, June mentions that doctor visits treated with a checklist mentality and result in shallow, ineffective health interactions. In another excerpt, June asserts that she only sees her counselor once every three months to sign her treatment plan, which suggests that in addition to a lack of instrumental health resources, there is also a lack of relational health resources. Excerpts from Tilly and Ozzy echo the point that counselors are overworked and spread too thin, which might contribute to their dim presence—still, participants make comments about the clinic simply not caring about them. Relational health, as demonstrated in these instances, align with participants' need for empathic communication with health care workers and providers and aspirations for social support groups. Moreover, there were several moments in which participants addressed the need for programs oriented around mentorship and learning recovery and relapse prevention coping skills.

When compared to other recovery centers that prioritize social support, group meetings, counselor sessions, regular check-ups, sponsors, and creative writing exercises, there is little offered at the methadone clinic. Health, therefore, is absent within the clinic. Several narratives compare methadone to a replacement drug, the clinic to drug dealers, and a corporation filled with empty promises of recovery services. The lack of compassion and efforts for outreach by the clinic fuels a belief within patients that the clinic is nothing more than a greedy, corrupt, and

profit-driven pharmacy that seeks to keep patients addicted to methadone for life. June and Tilly particularly excavate these issues, arguing that tapering is near impossible because the counselors do not encourage it. While most participants want to eventually stop methadone treatment altogether, it is a long process that is riddled with fear of withdrawal and losing what participants often describe as “safety” and “security” in methadone.

Patients acknowledge the positive effects of methadone in preventing them from relapsing and using illicit opioids, but ultimately, patients are provided with little to no guidance in how to approach methadone tapering. In consideration of their rational fears of potentially risking their health and recovery, as well as the lack of outreach by clinic staff, I am left to wonder: How does the clinic expect patients to taper, if at all? It appears that the clinic places an exclusive focus on the medication (methadone dosing) and neglects to address health and wellness as a complete system, leaving patients unequipped to work on their health outside the context of the clinic. As a result, methadone becomes socially, economically, and geographically restraining with respect to patients’ overall health. The clinic’s concentration on the dose could also have implications for how patients even come to make meaning of health apart from recovery, since recovery from addiction is the only context in which health is practiced or discussed at the clinic. In this way, examining narratives of the clinic at the level of the organization and how they materialize into the lives of patients should be of interest for future research.

Taken together, communicating health as a lack of resources brings forth the tensions between the clinic just existing as a clinic versus an actual treatment program. To reiterate, health is absent in the clinic insofar as the clinic does not address health, rather it addresses methadone treatment in substitution of illicit opioid use. While the effectiveness of methadone treatment for reducing opioid use, HIV risk behaviors, and drug-related crime is well-established

in the literature review, critical research of methadone treatment generally focuses on methadone stigma, social control, and the discipline of bodies in pursuit of productive citizens (Anstice et al., 2009; Bourgois, 2000; Cooper & Nielsen, 2017; Earnshaw et al., 2013; Fischer et al., 2002; Gourlay et al., 2005; Harris & McElrath, 2012; Hunt et al., 1985; Koester et al., 1999; McElrath, 2018; Radcliffe & Stevens, 2008; Woo et al., 2017). These results are practical in the sense that they demonstrate how methadone reinforces stigmatization, “addict” identities, and hinders the possibilities for recovery, however, they generally do not focus on the particular practices of the methadone clinic as already lacking in the basic capacities that constitute health. In this way, methadone is an impossibility for health as much as it is lacking in resources and shows that health is about more than just not being sick.

### **Recovering the Self, (Be)longing, and Health Citizenship**

The participants often discussed their health as a way of being socially, economically, and politically recognized and accepted. For example, Tilly, Leo, and Ozzy all, to some extent, reflect on the ways in which they are limited by their past criminal convictions. When Tilly speaks about finding her own sense of normalcy, she says, “Normal is like, checking the box on every damn application that I’ve got a felony ... knowing damn well [they won’t hire me].” Similarly, Leo offers several elucidations on the obstacles he has faced in trying to find employment and suggests it has more to do that he is in recovery from addiction and far less with his actual criminal record. While there are institutional restrictions regarding employment and crime, important in these accounts are the participants’ construction of selves in the face of rejection and (not) belonging.

Participants have a desire to prove their individual worth. At the clinic, the only evaluation for treatment progress (which is limited to only “recovery,” not health) is through

drug screens. Ozzy gives a particularly illustrative account of the implications for this sort of evaluation:

I hate how they only gauge your progress through drug screens because that's not everything. If I have a dirty drug screen—it's like, okay, sure. But before I started, I was on the streets. Uh, I wasn't working, wasn't going to school, my health sucked. But that doesn't matter to [the counselors].

Granted, Ozzy admits to enjoying recreational drug use on occasions, but still his point seems sincere. Analogous to the clinic's exclusive focus on methadone as a system for health is their emphasis on drug-testing as a system of evaluation, which studies suggest breeds institutional stigma and negative self-concepts (Anstice et al., 2009; Radcliffe & Stevens, 2008; Room, 2003, 2005). Bringing this statement in relation to the other cases reinforces my argument that health is of little concern for the clinic. Within participant narratives, patients speak about the clinic not caring about their recovery, not teaching them about the process of recovery, and making little to no effort to help them rebuild their lives and selves (Doukas, 2011; Gibson et al., 2004; Hughes, 2007; McIntosh & McKeganey, 2000).

Once again, health is commonly couched in terms of other social structures such as employment, housing, and education. From this perspective, health is dependent on social and cultural capital, which has direct implications for identity construction. Too many times to list are instances in which participants explicate on the ways in which they feel better after achieving these significant milestones. However, almost always these articulations are communicated as an individualistic endeavor that had nothing to do with the fact that they are in methadone treatment beyond being able to live day-to-day without experiencing opioid withdrawals. In turn, this individualist and disciplined mindset, which I argue is shaped by the clinic's lack of health resources or collectivist effort, is also what reinforces patient attitudes about feeling hopeless in their recovery. While participants raise criticisms about the clinic, for the most part they attribute their life struggles and/or failings to their own psychological or moral inferiority (Hughes, 2007).

In contrast, like we see in Ozzy's way of defining his recovery apart from what Lighthouse demands, he inverts the power relations in order to navigate his health in his own right. Although I don't suggest this method for individuals or treatment programs, it is relieving to see patients bringing their agency into the fore in a place that exercises such demanding structural constraints on health and construction of recovering selves.

More than just assimilating or reinserting oneself into mainstream society, there is also the need to belong—or, the longing to *be*. Both Leo and Ozzy give particular accounts about belonging. For Leo, it is more about work: getting a job and providing for him and his mother. Leo embraces his “master manipulative” side to put on a performance of what he thinks that particular hiring manager wants him to be. Indeed, as an academic, I think of the ways in which we are constantly performing, and support Leo in his performances in spite of him feeling shameful about his “fake” attitude. He offers another example of how when small-talk strikes, he is forced to make up stories about his younger years and “pretend [he] was there” in order to “fit in” with non-drug using people. Remember, for Leo, it's all about getting a job, stability, and earning his “model” citizenship status. For Ozzy, he seeks to belong in his interpersonal relationships, of which he mentions he is trying to expand. I can tell Ozzy is a fairly social guy, and perhaps that is why he kept going back to NA until he finally realized the shame and guilt of slipping-up was making him miserable. In Ozzy's later accounts, he describes how much happier he is with his life now that he has defined and accepted his own way of recovery—mind you, this man has been in recovery for 20 years, so I think he's earned this right—and much of it has to do with, quite literally, recovering his self. That is, rebuilding his punk-rock music collection, going back to school, watching movies, and doing new things that he missed out on during his addiction.

In another light, June and Tilly make explicit references to their strong efforts of avoiding the clinic and, in particular, not making friends at the clinic. The latter, of course, reinforces the stigmatizing nature of the clinic as well as how the organization ingrains negative self-concepts within patients. Moreover, June and Tilly's elucidations serve to also point to the ways in which they continually differentiate themselves from "other addicts" and distance themselves from addict culture. For instance, June argues that she is a "model patient" in defense of the negative treatment and lack of health support that she receives. In this way, participants also demonstrate a longing to *be*, to exist in a realm outside of addiction and to be respected and recognized as such.

Worth noting within these narratives is the (re)construction of identity in the context of methadone treatment. To my mind, methadone constrains identity construction insofar as patients are classified by their dose, which in turn limits the possibilities for patient identity construction. At the same time, methadone muddies identity construction by doing little to help patients navigate through their own personal struggles and growths. Participants explain that they often use their experiences with addiction to move through mainstream society (Leo) as well as how they become their own health teachers, counselors, and advocates—or, what Yamasaki (2017) presents as being health citizens (see also Geist-Martin, Ray, & Sharf, 2002) in that participants engage with a full range of health-related activities, many by the participants' own means. Yamasaki uses the term *health citizen* to "convey this sense of universality among all members of a society, as well as the rights, responsibilities, and privileges that accompany such participation" (Yamasaki, 2017, p. 22). What emerges as a constraint particular to the methadone clinic, however, is the inability for patients to become dynamic health citizens in the context of methadone treatment. Therefore, participants are guided by their own way of knowing and

navigating health while simultaneously using these self-advocated methods for assimilating into and belonging in mainstream society.

### **Summary**

An analysis of how participants communicated about and made meanings of health, addiction treatment, recovery, and identity reveals how health is both propelled and constrained by the organizing systems of methadone treatment. In many cases, participants drew from popular discourses of recovery and addiction treatment (Frank, 2011) to make meaning of their experiences. Unlike past research (Anstice et al., 2009; Bourgois, 2000; Fraser & Valentine, 2008; Freidman & Alicea, 2001; Harris & McElrath, 2012; McElrath, 2018; Parker & Aggleton, 2003), there were no obvious themes about the supervision practices of methadone as impeding health and recovery. However, this study's findings were in line with methadone patients in search of living normal, routine, and structured lives (Nettleton et al., 2012; Vigilant, 2005, 2008), yet contributes to theorizing methadone as a way into accessing desires of normalcy. This enabled a reading of participants' criticisms of the methadone clinic as a lacking in basic capacities of healthcare rather than a forms of institutional stigma and social control, as much as these issues are still prevalent in methadone treatment. To that point, this research shows that methadone patients are motivated by their own individual definitions of health and recovery—though, recovery is constrained in the sense that it does not encompass health as a complete system—to self-navigate their personal meanings of health, belonging, and health citizenship (Yamasaki, 2017). Further, participant narratives highlight the many identities and roles that characterize their lived experience at the cornerstone of health that are shaped, influenced, and often governed by the complicated practices of the methadone clinic (Gibson et al., 2004;

Gourlay et al., 2005; Hughes, 2007; Keane, 2001, 2002; Lloyd 2010; McIntosh & McKeganey, 2000; Redden et al., 2013).

### **Limitations and Considerations for Future Research**

As I reflect on the entirety of this project, I would be remiss not to mention the several quagmires of limitations I experienced along the way. In the early stages of my research design, I intended on recruiting a total of 20 participants for this study—10-15 MAT patients and 5 treatment clinic employees—however, I was only able to accomplish 9 interviews (8 patients and 1 counselor). To this end, I was limited by the number of participants that ended up taking part in the study. Future research examining the communicative patterns of methadone patients should incorporate the perspectives of clinic and medical staff—counselors, nurses, doctors, and program directors—to gather a more robust and well-rounded understanding of the inner workings of the methadone clinic as an organization. At the same time, researchers should be cognizant of the ethical dilemmas in research involving vulnerable populations and sensitive topics and be ready to approach these tensions with flexibility and sensitivity.

By the same token, using a case-centered thematic narrative analysis meant that, practically, it was not feasible for me to include all 8 patient interviews in a master's thesis while keeping to the narrative commitments. As seen in chapter 4, each case was about 10 pages in length. Thus, I made the decision to exclude 4 patient interviews from this study. Because of the trickling participant recruitment, as well with unstructured interviewing, interviews lasted far longer than I originally anticipated which added a depth to the interviews and supplemented the relatively small dataset. Participant narratives were rich, extensive, and detailed. For these reasons, I felt the need to preserve narrative features rather than splinter extended accounts in

coding processes. Regardless, the 4 patient interviews of which are excluded from this study pose limitations as well as an ethical consideration about privileging the multiplicity of voices.

Further, this study would have benefitted from including more kinds of data, such as ethnographic observations and texts published by health organizations (e.g., CDC, SAMHSA) about methadone and methadone distribution. Cain's (1991) study provides a great example for this: To explore the social construction of identity among members of Alcoholics Anonymous (AA), Cain analyzed and related written documents published by the AA organization and field notes from her ethnographies of meetings at AA groups in addition to audio-recorded interviews with individuals she met at AA meetings. Although Lighthouse does not hold social support groups or meetings, several methadone clinics throughout the U.S. do, and observing these groups would be one way to locate meaning-making with relation to other patients recovering from opioid addiction. Future research looking at the interplay of methadone and articulations of health should follow the works of Cain and others.

I have discussed several of challenges I encountered, such as recruitment dilemmas, transcribing, and data interpretation and re-presentation, but another point of interest is interview location. I do not explicitly address why participants and I chose the locations we did, mainly because those were pre-interview conversations. In this project, for instance, holding interviews at the treatment center seemed to be the most convenient option for both myself and participants, since a great majority of clients visit the clinic every day for dosing—but only 2 out of 8 participant interviews took place at the clinic. Of course, there will always be conflicts with scheduling, work, and/or personal reasons, but there is also an analytical significance of interview sites. Taking the methadone clinic as an example, though empty office rooms seem viable in practice with respect to anonymity and confidentiality, is this a pleasant place for the patient? In many ways, the clinic is still a location that surveils the client, including visits for

dosing, counseling, and drug screens. Accordingly, future research should consider the implications for interview locations and how they are influenced by our recruitment methods and participant subjectivities. In addition, I encourage researchers to address the ways in which power, positionality, and performance of self are constituted in the places where we conduct interviews (Elwood & Martin, 2000), which would be a salient topic of investigation for the methadone clinic.

## **Conclusion**

The three themes—health as normalcy, health as lack of resources, and recovering the self—that echo throughout the participant narratives are communicated around tensions between methadone posing limitations for opportunities to secure health and methadone becoming the potential for creating health opportunities. As I have shown, there are many aspects to understanding the relationships between social structural constraints and individual experiences of health. In doing so, I have explored the multiple, simultaneous, and often fragile communicative acts about health and recovery in addition to the paradoxical nature of methadone treatment and the impossibilities for health that it presents for methadone patients.

The structure-centered approach to health communication illuminates these issues by asking us to engage with how structures influence and determine how people communicate about health. Participant narratives are concentrated on methadone treatment as defining and governing their health in the form of creating opportunities for health transformation as well as posing limitations for securing health and recovery. The practices and functions of methadone treatment and individual experiences with such practices and functions make clear how methadone, as a system of organizing, limits the resources made (un)available to communities (Dutta & Basu, 2011). Therefore, methadone offers a precarious form of treatment—if at all beyond the extent of

pharmacological maintenance therapy—and emerges as a salient point of interest for examining how methadone as a structure constitutes health.

What remains clear from participant narratives are that methadone clinics pose constraints to addressing the health—in the full-bodied sense, not just an absence of sickness—of people recovering from addiction. Participants articulate a need for more health *care* and *resources*, particularly with jobs, housing, financial aid, social and relational support, and identity construction for their own well-being. Indeed, methadone can be effective in helping people curb illicit opioid use, however, there is still much work to do.

Drug addiction is an ugly, sad, and tragic way of living, or better yet, not living and trying to survive. It is not by any means a fun or adventurous life. Accordingly, people experiencing addiction should be treated as *deserving* of compassionate health care and social support, and health research dedicated to this area should continue to eliminate the stigma and health barriers associated with addiction and illness. Tilly gives a particular statement near the end of her interview:

It's hard to wrap your mind around the labyrinth that is addiction. Unless you've experienced it, or seen a loved one, like you have. I don't think a lot of people understand that the chase of the next high isn't to get a rush ... it's to keep up with being able to avoid being sick. The rush was, as I like to say, gone with the wind, you know? It's been long gone. It becomes a 24-hour, 'round the clock job. The depths one will sink to in order to score a few bucks, that is not who we are. We aren't monsters and we aren't stupid. We are not sick and twisted either .... We are just not well.

Indeed, these people are *people*. Let them not be reduced to “addicts,” let us figure ways to help them. The knowledge we construct from analyzing and understanding the complexities of communicating matters of health should motivate us to change policy (Zoller, 2005), especially in the context of addiction and the contemporary U.S. opioid epidemic. Personal stories can raise social awareness, destigmatize dis-ease, celebrate survival, and inspire or affect policy decisions (Sharf, 2001). Sharf's (2001) research on breast cancer demonstrates how survivors' narratives

can work as a catalyst for health reform and activism. I believe, too, this project invites us to consider the power of narratives for alleviating the stigma surrounding addiction and recovery as well as illuminating several complications within the methadone clinic that obstructs health and wellness.

Thus far, little research in health communication scholarship has examined the communicative processes of health, addiction treatment, recovery, and identity. This project helps address this urgent theoretical and practical calling by bringing forth the stories and experiences of people experiencing addiction and using them to illuminate issues with health care in the context of methadone treatment and recovery. Harm reduction is a focus of this project in the sense that it looks at methadone treatment, but also from my political standpoints as well. I encourage this for future research and social advocates alike. Medication-assisted treatment is just *one* aspect of harm reduction—we need needle-exchange programs, Narcan sold on every corner store, and people making an effort to become involved in the community of people experiencing addiction. Considering the increasing number of people dying from opioid overdose (CDC, 2018a) and the increased outbreak and transmission of bloodborne diseases such as hepatitis C, HIV, and endocarditis (CDC, 2018d, 2018f), the stakes are larger than ever.

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This thesis project officially began in spring 2018, my second semester of my master's program. However, while reflecting upon the research experience and writing the finished text, I believe this project really started to unfold in my early adolescent years. While I make known the personal investment of my research, the exhaustive reading and re-reading of this project, namely the participants' stories, demands me to also revisit my own complicated process of healing from living with addiction in the family. Truly, I am overwhelmed with more emotion than ever before. As I write the "closing" of this thesis, I find myself coming to my own terms of closure in my personal life and in a sense, regaining a piece of myself. Words will never fully

capture how thankful I am for those who have been a part of this research journey. Though it is time to “close,” this is not the end.

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## APPENDIX A:

### USF IRB STUDY APPROVAL LETTER



RESEARCH INTEGRITY AND COMPLIANCE  
Institutional Review Boards, FWA No. 00001669  
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799  
(813) 974-5638 • FAX(813)974-7091

7/6/2018

Barbara Stanley  
Communication  
4121 E. Busch Blvd  
Apt 306  
Tampa, FL 33617

RE: **Full Board Approval for Initial Review**

IRB#: Pro00034298

Title: Narratives on addiction, health, and identity among persons living with opioid use disorders and addictions

**Study Approval Period: 6/15/2018 to 6/15/2019**

Dear Ms. Stanley:

On 6/15/2018, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents contained within, including those outlined below.

**Approved Item(s):**

**Protocol Document(s):**

[Protocol, Version 1, July 3 2018](#)

**Consent/Assent Document(s)\*:**

[Employee, Version 1, July 3 2018.pdf](#)

[Opioid User, Version 1, July 3 2018.pdf](#)

\*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) business days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

A handwritten signature in black ink, appearing to read "Kristen Salomon", is written over a horizontal line.

Kristen Salomon, Ph.D., Chairperson  
USF Institutional Review Board