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**“YOU DON’T KNOW WHAT IT’S LIKE”:
THE LIVED EXPERIENCE OF DRUG DEPENDENCE**

A thesis presented in fulfillment of the requirements
for the degree of
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Margaret A Adams Williams
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Abstract

This phenomenological study describes the lived experience of drug dependence and relates the understanding gained from this description to drug dependence practice. The participants in this study were 25 adults who had a recognized dependence on one or more psychoactive drugs as identified by the DSM IV criteria of substance dependence. Over a period of eight months the participants were interviewed about their lived experience of drug dependence and the effects of drug dependence on their everyday lives.

Interviews were audiotaped and transcribed into text. They were then analyzed and interpreted hermeneutically against a background of Heideggerian philosophy. Drawing upon Heideggerian concepts with great relevance to this study, three related themes emerged to describe the lived experience of drug dependence: Becoming and being drug dependent – the journey; Being with others; and Being with care. These themes point to the nature of drug dependence and the extent to which the experience affects the whole of the participants' Being-in-the-world.

Drug dependence was viewed as a powerful life experience that can be likened to a journey, one that the participants would go to any lengths just to carry on with. The longer they stayed on the journey the more drug dependence affected their whole Being-in-the-world in terms of feeling and being different, both physically and psychically. Through being drug dependent the participants were found to inhabit two worlds, a *We* world and a *Them* world. In both worlds the participants found themselves alongside others with whom they related. Such relationships were found to be significant in that not only did being with others impact upon the participants' drug dependence, the participants' drug dependence also impacted upon their being with others. Through their choices and actions each of the participants revealed what mattered to them, that which they were concerned with, and cared for. Encompassed within that which they care for, their Being with care, is the stand each is taking on their own Being in the world, their choice of self, and the meaning they give to their existence.

For the participants, the experiential sharing of their lived experience of drug dependence not only enabled them to reflect on their own Being and to find meaning in their lives, but also to provide important insights into the lived experience of drug dependence for all those, including health care professionals, who interact with drug dependent people.

Also illustrated in this study is the importance of acknowledging drug dependent persons as valuable human beings and of understanding their needs for the provision of effective care in drug dependence practice. Finally, the use of a hermeneutic data analysis approach has shown the relevance of this method for the unfoldment of new understandings of the human experience of drug dependence.

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Key to transcripts

The following abbreviations and conventions have been used in the presentation of research findings, including the excerpts from the interview transcripts.

<i>Italics</i>	the words used by the study participants themselves
Names	all study participants are identified by the use of pseudonyms
[square brackets]	comments added by researcher to provide explanation or clarity
bold	words or phrases emphasised by the study participants
.....	pause, contained in original material
...//...	material edited out

An explanation of the slang and drug terms referred to in this study is available in the Glossary, Appendix I

INTRODUCTION

In our society, drug dependence is a growing phenomenon. Psychoactive drugs, with the potential for creating dependence are available in wide variety, and drug use and drug dependence occur at all levels of society and in almost all cultures. Psychoactive drugs have been used by people since the dawn of civilisation. Along with historical accounts of the use of those drugs is evidence that some people have experienced many problems as a consequence of using psychoactive drugs. However, it is only in the last 200 years or so that psychoactive drug use and drug dependence have been defined as problematic and socially disruptive - reactions to major changes in drug use over this time and the changed status of many psychoactive drugs from legal to illegal.

Drug dependence, traditionally viewed as a disease, and as a moral, political, religious, legislative or social problem, but more recently as a public health problem and chronic medical disorder, is a perplexing phenomenon, not only for those who experience it in their everyday lives and their families, friends, colleagues and communities, but also for the many researchers, health professionals, policy makers, and others who have investigated it or worked with those who are drug dependent. Drug dependence is a phenomenon whose cause, or causes, is complex and multifactorial, and for which there is no cure. Like the cause, treatment is multifaceted, and although a range of treatments are effective in reducing drug use, improving psychosocial functioning and health, reducing crime and the associated costs, and in reducing health care expenditure, success rates vary according to the type of drug and the inherent variables in those undergoing treatment. Notwithstanding the many treatment modalities and treatment outcomes, drug dependence is not only a complex phenomenon but also a series of experiences that profoundly affects the person who is drug dependent and those who share in the experiences in one way or another.

As a matter of fact, one sphere of drug dependence that has been paid remarkably little research attention, despite the extensive research into drug dependence, is a phenomenological exploration of what it is like to live with a drug dependence from the unique perspective of those who actually live the phenomenon of drug dependence.

Other than autobiographical or anecdotal accounts there is limited knowledge about the ordinary everyday experiences of people with a drug dependence, the impact of drug dependence on their lives, their views and their interpretations of the available treatment services which are supposedly designed to help them, and the ways in which they manage to stop their drug use without medical or treatment intervention. In recognition of these gaps in knowledge, a phenomenological study of people's experiences of drug dependence was done, to understand from their perspectives, the subjective experience of drug dependence and the impact of drug dependence on those who live with it. Among the explanations as to why little research has been undertaken which specifically explores people's experience of drug dependence are the preferred funding of and bias toward qualitative research methods, the lack of political and institutional support, the complexities and difficulties of conducting research in this area, for example, drug users are a hard to reach population, and the negative attitudes and reactions toward drug users and the stigma associated with drug dependence (Einstein, 1969; Institute Of Medicine [IOM], 1997; Manderson, 1994; Walsh, Low & Sanson-Fisher, 1998; Wurmser, 1978).

Three decades ago, Wurmser (1978) expressed his views as to the lack of studies into the understanding of drug dependence *"from the context of the individual's life experience, his wishes and fears, his deficiencies and efficiencies, his conflicts in past and present - in short, from a psychological point of view"* (p.4). According to Wurmser (1978), *"There are good reasons, one being precisely the complexity of this problem [drug dependence], namely that psychological factors are so tightly interwoven with sociological, economic, and legal factors. More importantly, the field has been ruled by law enforcement bureaucrats and has traditionally been off limits to the core troupe of psychological investigations. When the values of power, expediency, public success, and cost efficiency are uppermost, and the required strategies of manipulation and control become so intermingled with therapeutic considerations, then the value of insight, inner change and control, and with them the methods of introspection and empathy, must take a back seat"* (p.4). Thirty years later, similar reasons are proffered. Walsh, Low and Sanson-Fisher (1998) cite reasons of complexities of design and methodology, unsatisfactory funding levels, and lack of political support. Likewise, the IOM (1997) cites lack of public funding and support,

the realities of studying often difficult and sometimes frightening “patients”, the stigma associated with drug addiction, and the low status of the addiction field. Implicit within these reasons is the decisive gap which exists between a drug dependent person’s understanding of drug dependence as a lived experience and the way in which researchers, professionals and members of the lay public (the uninitiated outsiders) understand drug dependence as a social problem, a complex phenomenon, a disease, a criminal offence, a moral weakness, or as a disorder. This fundamental difference in understanding is also evidenced by the widely divergent views held of drug dependence, the stereotypes and societal negativity of drug users and drug dependence, the difficulties in caring for, and the second rate care given to those who are drug dependent, the moral crusade and law enforcement extravaganza on drug users, the sensational media coverage demonizing drug users, and the controversy, confusion and anomalous research findings that abound in the drug dependence field (Beckett, 1994; Bell, 1985; Heath, 1992; King, 1998; Lewis, 1992; Miller, Ware, Shaw & Gascoyne, 1989; Peele, 1990; Shaffer, 1986; Trebach, 1987).

Both the person with the drug dependence and the uninitiated outsider (researcher, policy maker, professional, or lay person) understand the experience of drug dependence within the context of different worlds, each of which determines its own realm of meaning. In effect, drug dependence epitomises many different constructed realities, the meaning of one being significantly and distinctly different from another. Resulting from these many different realities embodied within the phenomenon of drug dependence is a general inability, or difficulty, of each perspective to communicate the truth¹ of drug dependence.

For the drug dependent person, the difficulty lies in making themselves heard, of having a voice. For many, the fear of not being heard, the unspeakable nature of drug dependence, or the shame or fear of being characterised as immoral or deviant, can stifle their voice. There is also the fear that those uninitiated outsiders whose purpose is to listen will not fully understand the drug dependent person’s experiences within the context of their world. Also, like members of other minority groups or underclass’s,

¹ Truth being perceived as a composite of the individual’s perceived realities.

the drug dependent person experiences shame, embarrassment, or paranoia about their status and withdraws from social contact with non-drug users. Relentless punishment and condemnation by non-drug users further increase difficulties in communication.

Similarly, this difficulty in communication is experienced by the uninitiated outsiders. Acknowledged by many researchers, professionals, and members of the general public alike, is a feeling of differentness, an unrelatedness of the life world of those who have a drug dependence, lifeworld being the “world as experienced by a living subject in his [or her] particular perspective” (Spiegleberg, 1994, p.146). This differentness, unrelatedness, is connected to the ways in which many of these people view drug dependence, their constructed realities of drug dependence from within the context of their own worlds which then directly influences their ability to communicate and fully understand the phenomenon of drug dependence. Among the societal factors influencing the attitudes or perspectives held by these outsiders are background, societal stereotypes, social prejudice, and negative and ill-informed beliefs. For many of these people, drug dependence is viewed as a major health and social problem that poses a considerable economic burden on community health and social and justice service systems. Additionally, the drug dependent person is viewed as an unclean, immoral, weak willed, mistrustful, and incurable deviant, a *persona non grata*, someone who lives in a world few care to understand and many wish would go away.

Thus, in undertaking this research I ventured to explore, to find out more about this different world, the world of the drug dependent person and to provide a germane description of being-in-the-world in this way from the perspectives of those who live the experience of drug dependence in the community.

As drug dependence, particularly among the young, is becoming more common in New Zealand the drug dependent person is becoming more visible in the community. With this increased visibility are the increased negative societal attitudes and stereotypes of the “drug crazed addict”, an escalation in the myths and misconceptions about drug dependence and a continued unabatement of drug dependence hyperbole and media exaggeration. Media reports which demonize drugs and drug users, label addicts as murderous and deviant, detail the debauched lifestyle of the addict and speculate on the

parasitic role of drug pushers not only reinforce a number of constructed realities or images in the public mind but also reflect and perpetuate the public's hysterical concerns, misconceptions, and fears about the drug "addict" and drug dependence. Among these constructed realities are the understandings that all psychoactive drugs have a deep seated capacity to possess and destroy the life and character of the person who falls prey to them, that drug use leads to crime, prostitution, dishonesty, fear, and pain, that the drug pusher is the devil in disguise controlling and promoting drug use, and that drug abuse and drug dependence are a pervasive and dangerous epidemic that needs to be eliminated. Consequently, not only does the drug dependent person have to manage their drug dependence but they also have to battle with the stigma and prejudice that they are constantly confronted with in the communities in which they live.

Although faced with many challenges as they live in the community, very little is heard from people who are drug dependent. Because of the stigma associated with drug dependence, the public perception of "addicts" as deviant, despicable, self destructive, and incurable, and the fear, both real and perceived, of prosecution and persecution, there is a certain hesitancy for the drug dependent person to speak out about drug dependence. As a result, self-advocacy is markedly constrained among drug dependent people. Likewise, advocacy groups that work for the drug dependent person, to help eliminate discrimination against drug users, safeguard their rights and dignity, create a more positive image about treatment, and empower drug dependent people with a strong voice are severely inhibited for the same reasons. An important part of the development of strong self advocacy and advocacy groups to help destigmatize drug dependence, change public attitudes, generate support for research, and increase understanding, is the willingness of people who are drug dependent to speak out, to go public, about their experiences of drug dependence, how it affects their lives and what it is like being-in-the-world in this way.

Essentially, if we are to be successful in meeting the needs of people who are drug dependent, in building trust, in offering support and caring that has meaning for them, in designing and evaluating more effective community treatment practices, and in forming drug policy that works, then knowledge and understanding of their reality is

vital. If we are to know and understand their reality, we must allow those with drug dependence the opportunity to describe it. However, because of the many different realities, each from within the context of a different world, the drug dependent person's often remains unacknowledged and misunderstood. Consequently, the care, management, and treatment practices aimed at helping and addressing the full complexities of drug dependence, and their effect on every aspect of the drug dependent person's life, may be misguided and inappropriate. In 1966, Stevie and friends (Stimson & Oppenheimer, 1982), heroin and cocaine addicts in the addiction unit of St Bernard's Hospital, wrote in response to the investigation of drug addiction at the time, "...no addict has apparently been interviewed...If help is expected of them in the running of these treatment centres, the authorities are making a big mistake in neglecting the wealth of information available from addicts...As an addict with a great deal of experience of other addicts, I cannot claim they know all the answers but they should be given the opportunity of giving what information they can. I feel that "experts" cannot have had much personal contact with addicts and, perhaps, not enough knowledge of the drug itself." (p.93). Three decades later, another Stevie is saying the same thing.

To increase our understanding of the lived experience of people with drug dependence and bridge the significant gap between the many diverse views and constructed realities we must look toward constituting a shared world of meaning. It is the shared world of meaning that bridges the decisive gap in understanding, that allows communication, and empowers those who are drug dependent with a voice to communicate their "wishes and fears, deficiencies and efficiencies, conflicts in past and present" (Wurmser, 1978, p.4), all of which are seldom sought, heard, or understood.

Indeed, as long as drug dependence is viewed in terms of disease metaphors, moral transgressions, or as criminal deviance, rather than as an innately meaningful human experience of pleasure and pain, optimism and despair, resilience and adversity, compulsiveness and loss of control in relation to the drug dependent person's reality, the complex phenomenon of drug dependence will continue to pose an anomalous and unsolvable problem. Understanding the experience of drug dependence is of great importance in addressing the issue of drug dependence and in beginning the process of

helping a person out of drug dependence, for it is in human experience that drug dependence resides, not drugs.

Understanding the human experience of drug dependence as a complex meaningful human phenomenon requires an approach that addresses the realm of human meaning, an approach that goes well beyond the familiar mechanistic/reductionistic approaches, an approach which views subjective experience as a viable resource of information, an approach that can most effectively give the outsider an insider's view of their world, basically, an approach that aims to "tell it like it is" from the perspective of those involved.

This thesis, based on such an approach, is a phenomenological study which set out to give an account of drug dependence as it is experienced in the daily lives of a heterogeneous community sample of drug dependent adults, and then through reflection and interpretation of the data to equate the findings to the world of drug dependence research and practice. The study was designed to research this very human experience, to "tell it like it is", to provide a milieu for these people to give voice to their experience.

Background to the research

My interest in this research topic developed over a number of years. As a health professional and non-drug dependent person, I have lived the experience of drug dependence through the drug dependent people I have worked with in clinical practice in a community alcohol and drug service and in penal institutions. Over this time period I have met many people with a drug dependence, some with a high degree of morbidity, some leading outwardly ordinary lives, some in a chaotic lifestyle, some self medicating, some who have made numerous attempts to come off drugs, some at rock bottom, some unwilling to do without drugs, some heavily involved in criminal activities to support their drug dependence, some just tired of the "life", some wanting to take back control of their lives, some who have overdosed on drugs, and some who wished to die or had tried to commit suicide. What they all had in common was a need to be listened to, to be understood.

Time and again in the course of my work I heard, “but you don’t know what I mean, **you don’t know what it’s like**, you don’t understand”. Because the health professional frequently understands the experience of drug dependence from within their own world, a world often far removed from that of the drug dependent person’s, the drug dependent person feels as if he/she is not understood, listened to, or of having their own rationality for explaining their meanings and behaviours that are different from those of the health professional. Through the course of their work, health professionals gain considerable knowledge of the drug dependent person yet little understanding of the drug dependent person’s everyday reality, of their life in its entirety, or of their ability to function – to take care of business. The health professional’s underlying perspective of drug dependence determines how they understand the phenomenon of drug dependence whereas the drug dependent person understands the experience in terms of its effects upon their everyday life. The health professional’s underlying perspective on drug dependence also determines the explicit choice of how they attend to, care for, or respond to the drug dependent person. Despite, in more recent times, a move away from early theories of moral turpitude, disease, and personality defects for understanding drug dependence to a more biopsychosocial theory, many health professionals in their work and in their behaviours toward drug dependent people still demonstrate a consistent tendency to be influenced by a combination of moralistic and medical beliefs (Shaffer, 1986; 1987). Often, because of these influences, seeing people when they are in the midst of their drug dependence has the effect that this is the only way they can be in the world, in essence, once an addict, always an addict, a view which can impede establishing a positive therapeutic relationship and hinder efforts for the drug dependent person to come off drugs. Given the plethora of perspectives that currently exist, it is not surprising that there is often an inability to communicate meaning and understanding, that the health professional and drug dependent person are often at cross purposes, discussing different things and attending to different aspects of the same experience.

As a health professional, I believe that to be effective as a caring, involved helper in working with people who are drug dependent, one must understand the meaning of the

drug dependence experience from the perspective of those who are drug dependent. Understanding the meanings that people believe for themselves is significant in helping them in ways in which they can recognise and to which they can connect.

Purpose and aims of the research

The aim of this study was to explore the lived experience of drug dependence as perceived by people who have drug dependence and to answer the question: what is it like to be-in-the-world in this way?

As I wanted to gain greater understanding of the complexities of these people's experiences, Heideggerian hermeneutic phenomenology presented itself as a useful methodology for this research. Heideggerian hermeneutic phenomenology (Heidegger, 1927/1962; Van Manen, 1990) is a combined method that describes the phenomenon as well as allowing for interpretation enabling the lived experience from text to be uncovered, to be brought to the light of day. As an interpretative methodology, the success of Heideggerian hermeneutic phenomenology lies in its capacity for the researcher to gain greater understanding of an experience while upholding the context of everyday lived experience where meaning resides. A better understanding of the experience of drug dependence is of interest in itself as well as having other practical benefits. Understanding provides the health professional with added insight and a greater comprehension of the everyday realities of the person experiencing drug dependence, both of which are essential in the provision of holistic and humane care, and of assisting these people to return to more productive lives and positive relationships. Understanding also informs theory, drug policy, treatment practices and services, and research.

It is with the aim of extending the understanding of health professionals and all others in the community of the highly complex phenomenon of drug dependence and the profound effects which drug dependence has on all areas of the lives of those who have a drug dependence - physical, psychological, social, emotional, and spiritual, that the research findings are presented in this study. Because of the widely divergent views, attitudes, and values held in public consciousness about drug dependence, it is hoped

that the findings of this study might enable health professionals and others who read this research report to explore and reflect on their values, beliefs, and attitudes about drug dependence, the way in which they are influenced by societal factors and societal stereotypes of persons who are drug dependent, and their own practice with regard to drug dependent persons.

Organisation of the thesis

This thesis is organised into 8 chapters. The Introduction provides a framework for the present research project and outlines the purpose and aims of the research. Chapter I, II, and Chapter III provide essential background information to the study taking into account the extensive literature on drug dependence. More specifically, Chapter I describes the philosophical approach that forms the foundation of the study, and Chapter II offers fundamental information about drug dependence. Included is a sampling of the major theoretical perspectives offered to explain the phenomenon of drug dependence, an introduction to treatment approaches and an overview of the drug dependence situation in New Zealand. In Chapter III, a review and a discussion of subjective perspectives on the experience of drug dependence are presented and in Chapter IV a discussion of the phenomenological research approach and the particular methods utilised in this study is provided. Chapters V, VI, VII, the data chapters, are organised around specific concepts from Heidegger's seminal work, *Being and Time* (1927/1962). Finally, in Chapter VIII, the findings of the study are reviewed, implications are considered, and suggestions for further research are made.

Chapter I

BACKGROUND TO THE STUDY

Following a brief explanation of the choice of a qualitative research method and how it can be used to complement quantitative research in the effort to better understand the phenomena of drug dependence is an introduction to the philosophical underpinnings of phenomenology, in particular, hermeneutic phenomenology as described by Martin Heidegger (1927/1962) in his best known work, *Being & Time*. In his work, Heidegger gives us an impressive analysis of human existence, of what it means to be a person, the central premise of which is understanding, the gaining of insight into the nature and meaning of human experience as it is lived.

Health professionals, in their clinical practice, are intrinsically concerned with understanding the intricacies of their clients' lived experiences of drug dependence. Such understandings can provide the health professional with added insight into the everyday world of the individual experiencing drug dependence and direct their manner of care in ways that their clients can appreciate and to which they can relate. Thus, Heidegger's phenomenology, with its emphasis on understanding human experience, offered a particularly useful approach to the question "What is it like to live with drug dependence?"

As part of the background to the study, Heidegger's analysis of human existence, his fundamental ontology, is of importance. Basic to an understanding of a Heideggerian phenomenological approach to inquiry is knowledge of Heidegger's notions of human existence, of what it means to be a person. Hence, an overview of Heideggerian concepts relevant to the study adds to not only understanding of the approach but also to understanding the lived experience of drug dependence.

The choice of a qualitative method

Although qualitative research methods have gained increasing importance as a means of data collection and analysis in drug dependency and drug use research, much of our

existing knowledge about drug use and drug users comes from quantitative research conducted in institutional settings, for example, prisons, universities, hospitals and rehabilitation centres, using data obtained mostly through surveys, questionnaires, and analyses of public domain records.

While such strategies offer important data, the systematic and objective methodology of quantitative research isolates and reduces aspects (or variables) of the human experience to the measurable and empirical. From these variables a set of theoretical statements are constructed to integrate, explain, and predict a multiple of facts about human behaviour (Hathaway, 1995). However, they often ignore the qualities of humans that differentiate them from material objects (Maslow, 1966).

The use of empirical methods in researching deviant behaviour, for example, illicit drug use, often places a restriction on the nature of the reality under investigation thus markedly limiting the understanding that results. When human experience is reduced to variables through reductionistic approaches, the insights necessary for understanding complex human phenomena are precluded. Although such empirical epistemologies and methodologies are necessary for the study of the human realm, they alone are insufficient because they do not address lived experience and meaning (Polkinghorne, 1983; Wilber, 1983). This is markedly so in research on “hidden” populations (Lambert, 1990) such as illicit drug users. Because of the often private and illegal nature of using illicit drugs, and the recurrent illegal activities surrounding illicit drug use, many drug users are not only secretive, suspicious, deceptive and paranoid, but also withdrawn or isolated from the straight world, consequently they are often omitted from much research that relies on large scale sample sizes to produce acceptably reliable estimates such as those needed for quantitative research. Nonetheless, some questions pertaining to illicit drug use such as the prevalence and incidence of psychoactive drug use in New Zealand (Black & Casswell, 1993a, 1993b; Field & Casswell, 1999a, 1999b) are best explained by quantitative methods in which the researcher predetermines categories of meanings, and observations are quantified and analysed to determine statistical probabilities on the certainty of a particular outcome.

However, this reductionism limits the understanding of illicit drug using behaviour as a meaningful behaviour embedded in our culture (Peele, 1985) and offers little insight into the subjective nature of the drug using experience as it is lived. As stated by Thorne (1997), “*Conventional empirical approaches have proven to be of limited service in answering some of the most challenging and pressing clinical questions, especially where human subjectivity and interpretation are involved.*” (p.287).

With the increased awareness over time that the dominant reductionistic approaches are insufficient in addressing the human world of meaning, particularly on sensitive topics, there has been increased use and acceptance of qualitative epistemologies and methodologies as strategies for uncovering and making sense of phenomena in terms of the meanings people bring to them (Dennis, Fetterman & Sechrest, 1994; Denzin & Lincoln, 1994; Griffiths, 1996; McKeganey, 1995; Smith, 1996; Thorne, 1997).

Unlike quantitative research with its focus on theory testing, prediction and control, qualitative research, largely an inductive process, focuses on the description, interpretation, and understanding of behaviour within the context in which it arises, with no experimental controls or variables manipulated (Field & Morse, 1985).

Based on a relativistic ontology, much qualitative research assumes that there is no objective reality. Instead there are multiple realities constructed by people experiencing a phenomenon (Guba & Lincoln, 1985). Derived from subjective experience, these constructed realities are based on a person’s stock of knowledge (Holstein & Gubrium, 1994) handed down to them through history, language, and cultural and social practices, consequently, reality is constructed and understood differently for each person. Existing only in the mind of the person, these constructed realities are investigated holistically (Guba & Lincoln, 1985). Each person is acknowledged as a complex whole continuously interacting with others and their environments with the consequence that each person’s perception of their reality is constantly subject to change and influence within the context of their social and natural world. Through interacting with the person, the researcher aims to try and capture the person’s ever changing constructed reality with the intention of making sense of, or interpreting, phenomena in terms of the meanings that are ascribed to them from the person’s own

frame of reference or point of view (Denzin & Lincoln, 1994). For the most part, qualitative research is concerned with exploring, interpreting, and “understanding the complex world of lived experience from the point of view of those who live it” (Schwandt, 1994:118) and within the context of their natural environment. Consequently, much qualitative research is conducted in natural settings (Denzin & Lincoln, 1994).

Within a qualitative paradigm these ontological and epistemological beliefs guide the methodology used. As a rule, in qualitative research, the researcher attempts to bring as few presumptions and as little preconceived structure as possible to the phenomena being investigated. Rather, it is through interacting with the participants that themes or conceptualisations emerge. In this sense, the researcher’s own self becomes part of the research, an instrument through which a rich data base is collected that supports an analysis which reveals the everyday reality of real people who experience the phenomenon of interest, reality which is interpreted and described by the researcher using the concepts and categories that the participants themselves use.

Basically, the researcher’s main goal is to interpret or reconstruct subjective meanings (Schwandt, 1994) regardless of whatever qualitative design, data collection and data analysis technique used. As such, qualitative research methods are invaluable in illicit drug use and dependency research for providing researchers with the perspectives of drug users, for delineating the psychosocial and cultural contexts of drug use, for helping to explain high risk behaviours, for informing intervention and prevention initiatives, for behaviour change, and for the design and evaluation of questionnaires for use in quantitative research and treatment (Booth, Koester, Reichardt & Brewster, 1993; Wiebel 1990).

While there are many different qualitative research methods, the purpose of this study and the exploratory nature of the research question supported the use of phenomenology, in particular, Heideggerian hermeneutic phenomenology, as an appropriate method of inquiry. Heideggerian hermeneutic phenomenology seeks not only to uncover the meaning of what it is to be human but also uniquely contacts the

individual's experience of a given phenomenon. In this study, the phenomenon was people's experiences of being a dependent drug user.

Husserl's phenomenology

The work of Martin Heidegger (1889 - 1976) arose from the work of the German philosopher Edmund Husserl (1859 - 1938) whom Heidegger assisted during the 1920's. Phenomenology was conceived of by Husserl in the early 20th Century as a reaction to the reductionist and objectivist approach to studying human phenomena and as a consequence of his concern about the weakening position of philosophy brought about by the emerging experimental sciences (psychology) and the relativism of *Weltanschauung* (world view) philosophy which had risen to dominance (Husserl, 1910-1911/1965).

In advocating a return to the pursuit of absolute knowledge, Husserl set about developing a new method of logical reasoning that would serve as the foundation for a rigorous science of absolute knowledge. It was Husserl's belief that philosophy should be concerned with "essence" (a fact or entity that is universal, eternally unchanging over time and absolute [Jennings, 1986]) and that the goal of philosophy must be the "clear comprehension of the essential nature of reality" (Jennings, 1986, p.1232). As such, the new method would provide a clear understanding of the fundamental nature of reality and of consciousness. For Husserl, consciousness is always consciousness of something, is always about something, or it will always intend something (Jennings, 1986)

For Husserl, the philosophy, or "naturalism" as he termed it, of the emerging experimental sciences did not provide a complete and accurate picture of reality because it not only failed to include entire realms of essences but also equated consciousness with physical nature. Naturalism, as perceived by Husserl, postulates that reality ultimately consists of the "natural" - things of a physical nature, including human consciousness, and that all facts about it must be based on objective experimental data (Jennings, 1986). In assigning all physical phenomena to the measurable and observable, naturalism ignores the fact that consciousness, and other

forms of essences, do not have the properties of physical material and therefore are not subject to the same casual laws as physical phenomena (Jennings, 1986).

In describing “essence”, Husserl, originally a mathematician, used mathematical axioms and numbers to illustrate his meaning. As stated by Jennings (1986), “*mathematical axioms are universal, have no exceptions, are not derived from logical construction, and constitute realities that can be “grasped” in their essence. Thus, for example, $2+2=4$ and the sum of the angles of a triangle is 180° are essences that are eternally the same in all activities and historical eras and are not dependent on personal opinion or logical reasoning.*” (p.1132). Essences are not independent from conscious experience, “*essences do not ‘float around’, so to speak, waiting for a mind to behold them and thereby actualise them as real “being”. Rather, essences are immanent, meaning that they are grasped in an act of reflective consciousness*” (Jennings, 1986:1232). Respectively, an essence, like a mathematical principle, is a real form of being that has a definite reality, regardless of any conscious thought.

Acutely aware that the problems caused by naturalising consciousness would be of no consequence on the rising tide of positivism and experimentalism, Husserl set about creating his alternative to the experimental study of consciousness. In his efforts, Husserl did not negate the achievements of the experimental approach, rather, he wanted those achievements to have a more human context, to provide a complete picture of reality that consisted of both the concrete world of human experience and the abstract world of the physical and social sciences; in essence, to understand the world as it is experienced through consciousness rather than through the experimental methods of measurement and observation.

Subsequently, Husserl’s alternative to the scientific naturalistic approach was phenomenology, not only a research method, but also a philosophy and an approach to understanding human experience from the perspective of the person who has the experience (Keen, 1975). For Husserl, phenomenology supported a return to subjectivity and experience, to understanding meanings and arriving at the essential structures of consciousness through which experience is made meaningful, to

discovering, exploring and describing phenomena - the “things” themselves as they are immediately given (Cohen, 1987; Kocklemans, 1967; Taylor, 1993b; Polkinghorne, 1983). In his phenomenology, the starting point is with the “things” themselves, “things” being the phenomena of interest. To Husserl, phenomena can not exist apart from the conscious experience of beholding them, therefore the only way to access the phenomena is through a person’s personal perceptions or account of the phenomena as it is consciously experienced, as it is lived, in the person’s own words (Cohen, 1987; Knaack, 1984; Omery, 1983; Polkinghorne, 1989).

Central to Husserl’s phenomenological philosophy are his concepts of intentionality, essences, epoche, and phenomenological reduction. Intentionality to Husserl was “the title of the problem which in its scope covers phenomenology in its entirety” (Husserl, 1913/1931, p.373). To Husserl, every act of consciousness is “intentional” in that the mind is always directed toward some “object”, object being physical things, concepts, facts, dreams, data – in fact, anything. Consciousness is always consciousness of something, is always about something, or it always intends something (Jennings, 1986). Husserl based his concept of intentionality on the supposition that one could always be certain of one’s conscious awareness, consequently one’s knowledge of reality originates with conscious awareness.

Essences, previously mentioned, are Husserl’s way of describing what are commonly referred to as concepts or universals, the structures that constitute consciousness. Evident in the search for essences is elements of objectivism through Husserl’s idea of intentionality; that awareness is undeniably awareness of an object. It was Husserl’s intent through phenomenology to understand the relationship between awareness of an object in the physical; and awareness of it in the consciousness. In essence, the external world could be brought into internal consciousness.

Consequently, Husserl’s phenomenology presupposes the objective and the subjective notions of Cartesian dualism that split the world into bodies and minds: an objective world and a subjective world. The objective world being that which is always perceived in consciousness and the subjective world as consciousness that constitutes the objective world. In the process of developing his alternative to the experimental

study of consciousness, Husserl was aware of the pervading and unequivocal assumptions of the natural attitude: the common acceptance of the nature and existence of things in the world, and the assumptions that they provide a fixed reality shared by others (Jennings, 1986). These assumptions, Husserl believed, needed to be put aside, eliminated, or suspended in order that the thing, or idea (phenomenon) under inquiry could be understood as it is given in consciousness, in the way that it appears, as it is experienced by the individual rather than scientifically which relegates all things as being subject to the laws of time, space, and causality (Jennings, 1986).

By putting aside, or suspending all preconceived assumptions of the phenomenon being investigated, the basic nature or essence of the phenomenon is brought into pure consciousness. This is what Husserl termed phenomenological reduction. The first steps in the phenomenological reduction - the process of viewing the phenomenon naively, without preconceptions, prejudices or biases, without either confirming or denying its reality, not being concerned with actual empirical content in the uncovering of the essence of the phenomenon is the *epoche*, a philosophical tool which negates the natural attitude and establishes the circumstances for the interpretation of the experience.

Synonymous with the *epoche* is bracketing - placing the natural attitude towards the phenomenon in brackets - a process based on the mathematical strategy of bracketing used in solving equations in which the bracketed component of the equation is treated differently from the other unbracketed components while being examined. As quoted by Jennings (1986) from Natanson (1973), “[Bracketing] means refraining from positing the existence or non-existence of some object or event in experience. It does not mean thinking or saying that the object or event is or maybe real or illusory, true or false. With the performance of the *epoche*, the real world does not change in any way, nor does the phenomenologist undergo any type of transformation. Everything continues as it did before, with the decisive exception that the world which hitherto had been straight forwardly accepted as real is no longer viewed in terms of or on the basis of...the natural attitude.” (p. 58). Hence, in the performing of the reduction, nothing is taken away or destroyed, rather, as Jennings (1986) states, there “is a shift in focus from studying the specific objects of a given conscious experience to studying

the essential character of the acts of consciousness, which "intend" or "give meaning to" various events or objects." (p.1237). Following the process of reduction is a focused understanding of the phenomenon under inquiry from which an exact phenomenological description is produced - a description from the accounts of those who have experienced it. To Husserl, primarily interested in epistemological issues, these concepts of essences, intentionality, epoche, reduction, and the resulting description are necessary for a rigorous philosophical inquiry.

Reacting to both the idea of intentionality and to the Cartesian subject - object dualism evident in Husserl's phenomenology, Heidegger re-interpreted and extended Husserl's phenomenology and its method and developed a phenomenological method (hermeneutics) in which the emphasis is on ontological issues (what does it mean to be a person, what is the nature of being) rather than on epistemological issues (how do we know what we know). It was this aspect of Heidegger's phenomenology that guided the choice of methodology for this study, the shift from epistemology to ontology. Unlike Husserl's phenomenology which has as its focus a description of the lived world in which people are conceptualised as detached subjects existing in a world of objects (Dreyfus, 1987), Heidegger saw people as existing in and of the world, involved in the world, being in the world.

In the course their work, psychologists, counsellors, clinicians, and other health professionals working with drug users are fundamentally concerned with their client's lived experiences of dependency, health and well being. Alcohol and drug work, in particular, is grounded in relationship building with clients, a relationship that "both expresses and promotes the exploration of the possibilities of 'being.'" (Spinelli, 1994, p.288). Heideggerian phenomenology provides an analysis of Being, of what it means to be a person, of existing in the everyday world. It offers a way of coming to an understanding of what it means to live life as a dependant drug user, of how drug users feel about themselves, about others, and about happenings in their lives. In wanting to understand the intricacies of drug users' experiences, Heideggerian phenomenology presented itself as a particularly relevant and useful phenomenological approach, in that it respects the drug user for self knowing and of having their own rationality for explaining their meanings and behaviours, and that many of Heidegger's concepts of

being-in-the-world could provide a framework for the analysis and organisation of data from which implications for clinical care could be drawn.

The Fundamental Ontology of Heidegger

Heideggerian phenomenology centres around the most important question of philosophy - what does it mean to Be? In his major work, *Being and Time*, Heidegger (1927/1962) elucidates the nature of Being, what it means to be a person, and the ways in which these meanings manifest themselves in the ordinary everyday existence of people. For Heidegger, an analysis of *Being* is achieved by studying the ordinary everyday existence of people, of human-being-in-the-world. In Heidegger's view, human beings have their own particular mode of being, a being Heidegger calls existence (*Existenz*). According to Heidegger (1927/1962), human beings alone exist, nothing else exists. Being is always one's own, a unitary phenomenon. In being, human beings are unique, for they alone have an understanding-of-being. Among all beings, only human beings are aware of their existence, an awareness that reveals an inseparable relationship between one's own existence and the world - the world being not a world of things but rather an intersubjective aspect of the human beings themselves.

In describing human existence, Heidegger uses the word *Dasein*, referring to human existence itself, to being-there, to being in the world, that which one is born into, that which one is a part of, that which one belongs to. *Dasein* is always-as-a-whole, human existence is always existence *in* the world (Heidegger, 1927/1962). In Heidegger's view, the world becomes real through contact with it, through living in it, through interacting in it. Human beings make sense of and understand the world through their perceptions, interpretations, and ascribed meanings, which are influenced by their history or background - values, theories, rules, feelings, attitudes, that which is handed down to them through their cultural, social and linguistic practices. By means of background, human beings are provided with a pre-understanding (meaning and organisation of one's culture) through which they are able to interpret experiences, attain understanding, understand human action, motivations and intentions, and act themselves. Background generates a common world, one that human beings already

feel familiar with, one that is reflected in common meanings and constructs (Holstein & Gubrium, 1994), however, these, according to Heidegger's view, cannot be made fully explicit. Pre-understanding is part of the framework of being-in-the-world. The world is already there, it is *a priori*, and from birth, the person is in the world, participating within the cultural, historical, and social framework into which they were born and exist, and which at the same time they construct from their own experiences and background (Heidegger, 1927/1962). As Packer (1985) states, "*we understand human action - and act ourselves - within a background of practices (bodily, personal, and cultural) that is always present, although it can never be made fully explicit.*" (p. 1087).

To Heidegger, it is our own being as participants in a shared world that gives us understanding in to our existence and ourselves. Understanding exists neither solely within the person nor between the situation. Understanding is an exchange between the two so that the person both constitutes and is constituted by the situation (Allen, Benner & Diekelmann, 1986). In this sense, person and world are co-constituted. Person and world do not exist apart from one another. A fundamental condition of being a person is to have a world around you. The person is indissolubly linked to the world, and either the world is acting upon them, or they are acting upon their world, and through this interaction, the person and the world become one. Dasein is as-a-whole. The world is constitutive of Dasein and an understanding of the person can not take place separate from the person's world, "from the outside". Because of this relationship between person and world, there can be no objectivity or value neutrality in understanding. This view of person and world as unity, where there is no outside detached vantage point from where presuppositionless understanding can take place is where Heidegger differs from the subject-object dualism evident in Husserl's phenomenology.

Heidegger's (1927/1962) aim was to make visible, "to bring to the light of day" (p.29) that which has been concealed, to uncover aspects of being when one is involved in the situation, not standing outside of it (Benner & Wrubel, 1989). According to Heidegger, we make sense of the world from within our existence, not detached from it. Understanding happens because we are involved in the world. Understanding is

reached through Dasein, and it is to Dasein and its everyday involvement in the world that we look for understanding-of-being.

Accordingly, our capacity to understand the question of being, of what it means to be, is dependant on our being-in-the-world, of our pre-understanding of our existence in its everydayness and the way in which meanings manifest themselves in our everyday lives (Gelven, 1989). In recognising and understanding our existence, we also recognise and understand it in a particular world; one is “always already” in a world. “Dasein ‘lives’ in a world, in some particular world, in some place, at some time, for some duration of time” (Soloman, 1972, p.213).

The world in which we find ourselves is the world around us as we experience it in its everydayness. Our being-in-the-world is a “thrownness” (Heidegger, 1927/1962, p.135). It is a world into which we are “thrown”, a world not of our making but into which we are “given” over to, and with which we are stuck. A world which not only projects possibilities but which also has certain limitations. The world into which we are *thrown* is what Heidegger refers to as Dasein’s *facticity* (p.56). Facticity is Heidegger’s *thrownness*, our simply finding ourselves in a situation which is not of our choosing, that we exist in a particular world. An existential structure of Dasein, our facticity is that set of facts, those circumstances, about ourselves that determine our situation in the world. Facticity, one’s situation, is *there* as it is given.

For each person in the world there is a set of facts that are true of each person and of each person alone, over which there are no choices - facts such as date of birth, inherited traits, culture, physical appearance, parentage, and so on. Facticity is that which makes us what we are. Our facticity, our circumstances are always determined, there as given. They, however, can be given meaning, made sense of, interpreted or confronted as we choose, the manner of choosing being our possibilities. For Heidegger (1927/1962), a possibility is any likely goal, intention, plan or undertaking that one wishes to think up, that “what is not yet actual and what is not at any time necessary” (p.144). Each person has a set of possibilities to which they are oriented and which characterise their individuality, possibilities not only for experience or knowing, but also for attitudes, moods, feelings, and actions (Soloman, 1972). Like

facticity, the possibilities that the world projects are structures of Dasein, of being-in-the-world, open horizons of being into which we project ourselves, our Existenz.

Our possibilities, like our facticity, are also limited by situational factors, both in the past as they are *given*, and in the future as it is presented, in that the decisions and choices of the past shape or determine what choices are open in the future. It is through understanding Dasein in terms of its facticity, its everydayness and its possibilities that Heidegger makes known his concept of temporality, the way in which time exists in human existence. To Heidegger, time is not a linear thing made up of an endless sequence of moments, each of which is now. Rather, it is a single entity in which past, present, and future are one, a unity, temporal parts that can not be understood apart from one another. *“Dasein’s past can not be understood apart from Dasein’s present and future, its present apart from its past and future, or its future apart from its present and past”*. (Oaklander, 1992, p.183). Dasein is what one has been, what one is and what one will be. One can only understand what one is doing if one connects it with what one has done in the past and what one intends to do in the future.

This conception in time is one in which the present is a position from where we view both the future and the past. Dasein does not live in the present, Dasein continuously projects and acts on possibilities for the future whilst viewing the past, not as something over and done with, but as something that is considered in deciding future possibilities. *“Time is the projection of Dasein’s possibilities and the facticity of his origins”* (Soloman, 1972, p.225).

Dasein, as temporality, is living within the context of an entire life, both toward goals and origins. In this way, the past, present and future each have an effect on the choices and possibilities with which Dasein is confronted. As Oaklander (1992) explains, *“I am now past because what I am now is in part determined by my past. At this moment my past has some reality, since my past is part of me. Similarly, I am now in the future, in that what I will be is part of what I take myself to be. In other words, my present conception of myself depends in part on what I intend to be in the future. So even my future is now, insofar as what I am now is in part determined by what I take*

myself to be in the future. In short, Dasein is now (and always) past, present, and future." (p.191).

To know of possibilities for the future is to know freedom, to have free choices. Although we are limited by the temporality of our existence, shaped by our facticity, our thrownness into a particular world, we have, according to Heidegger, within the framework of our given situation that the world has presented to us, a *situated* freedom, within which we have the freedom to make decisions and choices as to what we make of ourselves and our lives, of the possibilities that await our future.

In accepting our freedom to make decisions and choices, we take full responsibility for our lives, for the meaning we give to our lives, our existence. We become products of our own choices. "Dasein is a Being whose essence is determined by what it makes of itself. What I am is what I have created, what I am creating, and what I will create." (Oaklander, 1992, p.175).

For Heidegger, death is the "end" of Being-in-the-world, and it is only at death that Dasein reaches its wholeness, a totality of being, a Being-as-a-whole sculpted by the day-to-day choices made over the course of a lifetime. As a structural whole of man's everyday being-in-the-world, a totality of being that is past, present, and future, Dasein is further characterised as *care*, or concern (*Sorge*).

To Heidegger, the basic relationship between human beings and the world is that of care. An extension of temporality, care is the significance which being in the world has for human beings (Warnock, 1979). Care represents a concern for all the entities that have importance and value to us, including a concern for one's self and others - a solicitude. "[Dasein] finds itself primarily and constantly in things because, tending them, distressed by them, it always in some way or other rests in things. Each one of us is what he pursues and cares for. In everyday terms we understand ourselves and our existence by way of the activities we pursue and the things we take care of" (Heidegger, 1982, p.159). For Heidegger, this concern for things and people enables us to become involved in the world, and, as such, is an important concept in this study.

Through our involvement in the world, an involvement that is shaped by our stock of knowledge (including the cultural, historical, and temporal context within which we exist), we come to understand human experience, what it means to be a person in the world. The world in which a person finds their self is a world where understandings, shaped and handed down through culture, history, and social practices, influence the ways in which we are toward others, our attitudes, beliefs, and behaviours. It is a world in which drug dependence is attained and maintained. It is a world in which those with drug dependence live. Thus, Heidegger's phenomenological approach, with its focus on the ontological foundations of the understanding which is gained through being-in-the-world - the tempory, existential and relational basis of our everyday lives and understanding of the world, an understanding of what it is to be human, an everyday understanding of ourselves and our existence presented itself as a useful way of coming to an understanding of the experiences and social reality of those who live with drug dependence. As such, Heidegger's work forms an important background to the way in which the research question has been asked and answered in this study.

Review and summary

In summary, discussion in this chapter has focused on the choice of a qualitative methodology to explore the research question followed by an introduction to the philosophical underpinnings of Heidegger's phenomenology. The basic principles of Heidegger's fundamental ontology were then delineated with some consideration given to relevant Heideggerian concepts as they apply to this study. In the next chapter essential background information against which drug dependence can be understood is presented. The chapter begins with a discussion of the historical understandings of drug dependence followed by a review of the relevant definitions and concepts in the drug dependence field. An overview of the main theoretical models proffered to explain drug dependence is then presented followed by an outline of the current treatment philosophies and approaches to drug dependence. The chapter then concludes with an examination of the contemporary drug dependence situation in New Zealand.

Chapter II

THE NATURE OF DRUG DEPENDENCE

Humans from earliest recorded time have used psychoactive drugs, however, it was not until the 19th Century that the nature of drug dependence began to be more clearly understood. These understandings, initially based on a “classic” conception of addiction, have varied considerably over time as well as across social and cultural groups giving rise to a plethora of theories and perspectives to explain the complex phenomena of drug dependence.

Historical Understandings of Drug Dependence

Implicit in these theories and perspectives are many assumptions and biases about what drug dependence is and what can and should be done to deal with or manage it, assumptions and biases which greatly influence the way in which we *are* toward those who have a drug dependence. Accordingly, in this chapter, a brief review of the main theoretical models and perspectives that have developed over time to explain drug dependence in their historical and cultural context will be presented as it is these theories and perspectives which provide the landscape against which the phenomena of drug dependence can be understood

As an area of inquiry and a scientific discipline, the field of drug dependence is relatively new, and although there have been many advances in knowledge of drug dependence over a short period of time, there is no one comprehensive theory or perspective that adequately explains the complex phenomena of drug dependence. Rather, the field of drug dependence is besieged by controversy, confusion, and conflict to the extent that it is in the midst of a conceptual crisis (Shaffer, 1986), a crisis emanating from such determinants as the lack of understanding about the multiple factors involved in the phenomena of drug dependence, the intense emotions surrounding the topic, the anomalous research data, and the difficulties involved in conducting research in this area (undervalued, stigmatised, often misunderstood,

lacking in public funding and support), the diverse and polarised views held by members of a variety of disciplines, and the numerous theories about drug dependence which differ greatly both across and within disciplines (IOM, 1996; Peele, 1985, 1986, 1987; Shaffer, 1986:). For example, widely divergent views about drug dependence are held across disciplines by psychiatrists, doctors, psychologists, sociologists, anthropologists, politicians, lawyers, policy makers, law enforcement personnel, researchers, drug workers, depending on their orientation and background learning. From a sociological perspective, drug dependence is a social problem caused by family, peer, and environmental factors. Psychologists understand drug dependence as a problem involving coping mechanisms, personality functioning, learning, and reinforcement. Lawyers, politicians, and law enforcement personnel posit problems of control, criminality, policy development, containment, and harm reduction. Medical personnel view drug dependence as involving withdrawal, tolerance, metabolism, neurotransmitters, and drug categories. Drug workers see processes of detoxification, treatment, and relapse. Within disciplines, there are also diverse views, for example, in the alcohol and drug field, there is much controversy over the etiology and treatment of drug dependence (Kellehar & Cvetkovski, 1998; Shaffer, 1986). Some health professionals working in the field advocate drug treatment (for example, methadone maintenance) whereas others support drug free treatment, some promote controlled use and others argue for abstinence (Brower, Blow & Beresford, 1989). Some health professionals hold moralistic views and see drug dependence as a sign of weak will and immorality in which the drug dependent person is responsible for their downfall and must gain control of themselves in order to return to respectability and a drug free state. Others adhere to a disease perspective positing that drug dependence is a progressive, inescapable process, which occurs in people whose biochemistry makes them susceptible, and which progresses through recognisable stages (Gabe & Bury, 1991). Contributing also to the confusion, and conflict in the drug dependence field are the ambiguous definitions or conceptualisations of various terms such as *drug*, *drug dependence*, *drug addiction*, and *drug abuse*. How any one of these terms is defined or conceived of depends on one's perspective and one's understanding of the phenomenon, hence, for the purpose of this study and to maintain consistency throughout, these terms are thus defined.

What is a drug?

In this study, the term “drug” refers primarily to any non food, psychoactive substance (other than alcohol, nicotine, or caffeine) taken through any route of administration, that acts in the brain to alter mood, thought processes, the level of perception, or behaviour (Goldstein, 1994; Goode, 1993; Julien, 1995; Knipe, 1995). The current *Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV)* (APA, 1994) has identified a typology of drug dependence based on 11 classes of substances. The focus of this study is on six of these classes of drugs: cannabinoids, opioids, inhalants, hallucinogens (including phencyclidine), stimulants (including cocaine, amphetamine and related drugs), and depressants (including sedatives, hypnotics, and anxiolytics), these being commonly abused drugs and highly dependence producing. Consequently the term “drug” is used generally to encompass all six classes unless specific reference is made to a particular drug or class of drugs.

Drug dependence and drug addiction

The term *addiction* is derived from the Latin *addictus* meaning to surrender or enslave, to sentence or condemn to a particular fate. Although the term did not originate in relation to the use of drugs, it came to be connected with them when it was recognised that users of various drugs experienced a set of physical symptoms known as *withdrawal* after prolonged use and abrupt discontinuation (Goode, 1993; Zoja, 1989); in effect, they became enslaved to the drug. Over the years, concepts of addiction have changed depending on the political and social environment and the changing legal status of specific drugs. In the early 20th century, the terms *drug addiction* and *drug addict* had some semblance of approval within the medical profession, both terms being used in the description of a person who had developed a pattern of habitual use by using one or more drugs over a period of time and who would experience withdrawal symptoms after abrupt discontinuation. However, with the changing legal status of particular drugs (e.g. the Harrison Act of 1914, the Jones-Miller Act of 1922, the Marijuana Tax Act of 1937, the Volstead Act of 1919 [Buchanan, 1992], the Quakery Prevention Act of 1908, and the Dangerous Drugs Act of 1927 [Eldrid-Grigg, 1984]) public attitudes about addiction hardened and addiction came to be

viewed more as a moral, social and criminal problem and less of a medical problem. Consequently, with these changing attitudes, *addiction* and *addict* became largely emotive terms used in a derogatory manner toward people who use drugs and people who have problems that are related to or exacerbated by drug use. These terms were also equated with disapproval of particular drug use, especially the illegal drugs, and carried much social stigma.

Adding to the stigma was the gradual recognition that certain drugs, e.g. cocaine, LSD, and cannabis, were not physically addictive despite frequent compulsive use, and that some long term users of these drugs did not fit the World Health Organisation's description of an addict and addiction. In order to discredit the use of these drugs, it was necessary to devise a new concept, or terminology, to label as many widely used non-addicting drugs as possible with a term that characterised them as being just as "bad", and just as addicting as the truly addicting drugs (Goode, 1993, p.29). Thus, in 1964, the World Health Organisation Expert Committee (WHO, 1964) in their efforts to come up with a term that could be applied to the "abuse" of all drugs (Goode, 1993, p.28) recommended that the terms *addiction* and *habituation* be replaced by the term *drug dependence*, a concept which encompassed both physical dependence and psychological dependence on one or more psychoactive drugs. Drug dependence was thus defined as a state of psychic or physical dependence ensuing from repeated administration of a drug on a periodic or continuous basis and with characteristics that varied according to the drug involved. Under this concept, each drug had its own characteristic type of dependence which needed to be made clear in each specific case, e.g. drug dependence of the morphine type (Eddy, Halbach, Isbell & Seevers, 1965; Goode, 1993; WHO, 1964).

After the emergence of crucial facts and research findings on some correlation between physical and psychological dependence in the years after their 1964 definition of dependence, the WHO, in 1981 (Edwards, Arif & Hodgson, 1981, 1982) reviewed their earlier work on the concept of drug dependence. As a result they redefined dependence as a syndrome manifested by a behavioural pattern, in which the use of a given psychoactive drug, or class of drugs, is given a much higher priority than other behaviours that once had a higher value, with the word "syndrome" implying an

association of a number of different phenomena that need not always be present at the same time or with the same intensity (Gossop & Grant, 1990). This newer definition, in which the term *neuroadaptive* state was proposed as an alternative to physical dependence, acknowledged drug dependence as a combination of behavioural and contextual symptoms occurring on a continuum, with gradations between drugs (e.g. heroin ranking higher than cannabis), rather than an all-or-nothing categorisation (Goode, 1993). In effect, drug users are viewed as existing on a continuum of dependence in that the greater the dependence on drugs the more symptoms exhibited.

In their shortened version of the WHO 1981 memorandum, Edwards, Arif & Hodgson (1982) profiled seven elements that constitute the drug dependence syndrome. These are:

1. a subjective awareness of compulsion to use a drug or drugs usually during attempts to stop or control drug use
2. a persistent desire to stop drug use
3. a stereotyped pattern of drug taking behaviour
4. evidence of neuroadaptation (tolerance, cross tolerance and withdrawal symptoms)
5. continued use of the drug to relieve or avoid withdrawal symptoms
6. important activities given up or reduced because of the salience of drug behaviour - time spent obtaining, using and recovering from the drug, and
7. rapid reinstatement of the syndrome after a period of abstinence.

Correspondingly, the American Psychiatric Association (1994) in their Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV) conceptualised drug dependence as a maladaptive pattern of drug use leading to significant impairment or distress as manifested by a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug taking behaviour (p.76). In their definition of psychoactive drug dependence, three or more of the following symptoms are required to be present at any time in the same 12-month period:

1. larger amounts of the drug taken than intended
2. one or more unsuccessful attempts to control or cut down drug use

3. increased time spent obtaining, using and recovering from drug use
4. increasing priority given to drug use over other important activities
5. continued use despite problems
6. withdrawal symptoms
7. acquired tolerance, and
8. relief use.

Hence, for the purposes of this study, drug dependence is defined in accordance with the WHO definition (Edwards et al, 1982) and the DSM-IV definition of drug dependence (APA, 1994) - a complex syndrome identified by a cluster of psychological, behavioural, and physiological (neuroadaptive) characteristics that suggest that the person continues to use drugs compulsively and repetitively despite knowledge of related problems associated with the use of drugs. Although the term drug dependence has gained acceptance internationally in the past two decades, the terms *addict* and *addiction* are so deeply rooted in our everyday language that undoubtedly they will continue to be used by many for some time (Gossop & Grant, 1990). Consequently, on occasion in this study, these terms are used along with other highly emotive value laden terminology such as junkie, dope fiend, or freak, when used by the participants themselves.

Drug use and drug abuse

Like the terms addiction and dependence, the terms drug use and drug abuse are used arbitrarily and need to be well delineated. The criterion for defining these terms is determined by the context in which they are used, for example, medically, non-medically, legally, socially, culturally, politically, et cetera, as well as the background of the definer (Goode, 1993). Consequently, definitions vary considerably from person to person, and society to society. In this study, drug use refers to the non-medical use of any psychoactive drug, the use of which may range from one time experimental use to dependent use, including recreational use, functional use that serves a specific purpose, dysfunctional use causing social and psychological impairment, and harmful use causing physical or psychological damage.

Drug abuse, as defined in the DSM-IV (APA, 1994) is a maladaptive pattern of drug use manifested by recurrent and significant adverse consequences related to the repeated use of drugs. Encompassed within the definition are categories of use, for example, excessive and recurrent use, inappropriate use, use by unauthorised persons, and use by particularly vulnerable persons, with each category of use being affected by social values, mores, and rituals. Over time, these categories of use are subject to changes and to differences in the views held by people in a society - views generally shaped by such factors as the morality and legality of the drug used (APA, 1994; Goode, 1993; Gossop & Grant, 1990).

In our society, any non-medical usage of psychoactive drugs is seen as abuse of those drugs, particularly usage of illegal drugs that is also equated with immorality, criminality, condemnation, and undesirability. Often used inconsistently and with uncertainty, the term *drug abuse* “conveys the notion of social disapproval and is not necessarily descriptive of any particular pattern of drug use or its potential adverse consequences” (Jaffe, 1985, p. 532). Goode (1993, p.39-40) also notes that the term conveys the distinct impression that “something very much like a disease, a medical pathology, a sickness in need of a cure” is being referred to. He also comments that the term seemingly implies harm, danger, and damage. Similarly, the National Commission on Marihuana and Drug Abuse (cited in Goode, 1993, p.42) considers that the term *drug abuse* has no functional utility and has become no more than an arbitrary code word for that drug use which is presently considered wrong. Nevertheless, for the purpose of this study, the term *drug abuse*, when used, refers to the use of any psychoactive drug in a way that differs from generally approved medical and/or social practices within a given culture, in a way that the continued use of the drug means more to the user than the problems caused by such use.

As can be seen, the way in which the terms drug addiction, drug dependence, and drug abuse are conceived of, and defined, greatly influences the way in which we identify, understand and respond to people who use drugs. The youthfulness of the field and the underdeveloped state of knowledge relating to drug dependence in turn, compound these divergent views. Although drug dependence has been described and

reported in medical and religious treatises for over 2000 years (Knipe, 1995), early knowledge of drugs and drug dependence was limited by the fact that psychoactive drugs were only used in their natural form, for example, cocaine and morphine were available only in coca leaves or opium poppy plants that were either chewed, dissolved in alcohol, or taken in a way that diluted the effect of the active chemicals (Musto, 1991). Knowledge of drugs, drug use and drug dependence changed very little over thousands of years, until the beginning of the Industrial Revolution and the resulting technological advances such as increased speed of travel, speed of communication, the advent of the printing press leading to increased dissemination of information and duplication of knowledge, the advent of organic chemistry and scientific discovery.

With the advent of organic chemistry, the available forms of cocaine and morphine were changed. In 1805, morphine was isolated from the opium poppy exudate giving a concentrated form of opiate analgesic, and in 1860, the alkaloid cocaine was isolated from the coca leaf. In 1874, diacetylmorphine was synthesised from morphine but it was not until 1898 that its value as a powerful analgesic was recognised and it became known as heroin. Other scientific discoveries that contributed to our knowledge of drugs and drug dependence were the invention of the hypodermic syringe in 1834 which allowed for the injection of drugs directly into the bloodstream which increased the drug's effects, and also hastened the onset of dependence, and the production this century of new compounds such as barbiturates, benzodiazepines, amphetamines, and hallucinogens (Knipe, 1995; Musto, 1991).

Improved means of land, sea, and air travel, lower transport costs, and increasing international trade contributed to the spread of drug technologies, drug imports, and drug subcultures. Similarly, mass communication and greater educational opportunities have contributed to changes in cultural and social values related to drugs and drug use, for example, when rural people move to cities or other countries for education, urban or cultural customs of drug use, and/or different attitudes toward drugs may return with them to their home town. Greater affluence, increased disposable income, increased opportunities for purchase and sale, low production costs through technological advancement, and high profits have also led to changes in drug use and drug dependence. Along with these many drug related scientific and

technological advancements that have changed our knowledge and attitudes toward drugs and drug dependence over the past century has been a steady progression of explanations and theories about drug use and drug dependence behaviour.

In the mid 19th to early 20th century, the prevalent belief about drug dependence centred around self-responsibility. As increasing numbers of people fell under the influence of drugs, religious and temperance groups, who viewed drug dependence as evidence of spiritual weakness, depravity, and wickedness, launched a moral crusade. Around the 1920's, theories suggesting psychological factors began to appear. These theories attributed tendencies toward drug dependence behaviour to such factors as ego and super ego, oral fixations, and depression. Environmental and social theories, which emphasised family and peer interactions or community and cultural/societal norms in explanations of drug dependence behaviours, began surfacing in the 1930's, with this range of theories increasing over the next 20 years. Emerging in the 1960's were the first behavioural and learning theories that suggested drug dependence was a product of instrumental conditioning. Research at this time also suggested a biological vulnerability to drug dependence with the biologically based theories emphasising such factors as genetic predisposition, metabolic imbalances, and disease processes.

More recent theories, for example, the biopsychosocial model, have attempted to explain drug dependence in terms of multiple causality, that drug dependence develops as a result of complex interactions between a drug, the physical and psychological makeup of the user, the situation in which the drug use takes place, and the cultural expectations surrounding the use (Arif & Westermeyer, 1988; Bachman, O'Malley & Johnston, 1984; Buchanan, 1992; Cadoret, 1992; Coleman, 1993; Dean & Rudd, 1984; Goldstein, 1994; Goode, 1993; IOM, 1996; Knipe, 1995; Merton, 1968; Musto, 1991; Shaffer, 1986; Soloman, 1977).

Despite the shift to a more multidimensional view which incorporates factors from numerous theoretical models and perspectives concerning drug dependence, the disease or medical perspective and the moral perspective have been the most influential, with many people, including health professionals, still holding a combination of these moralistic and medical beliefs about drug dependence. These beliefs, in turn,

form the basis of their clinical practice and decision-making, and determine the way they are toward individuals who have drug dependence. In effect, theoretical models and perspectives provide the background from which health professionals define and diagnose, choose treatment strategies, set therapeutic goals, and conduct research, regardless of whether or not they are aware of the basis or structure of these perspectives. As such, these theoretical models and perspectives also form part of the landscape against which drug dependence can be understood. Therefore, an overview of the main theoretical models of drug dependence is provided in the following section.

Models of drug dependence

The main theoretical models of drug dependence essentially fit into four frameworks - biological, psychological, sociological, and biopsychosocial. Each framework focuses on a different spectrum of factors that contribute to our understanding of drug dependence. However, within each broad framework, there is also a range of theories, each of which include one or more factors from each of these frameworks as no one single theory sufficiently explains the complex multifactorial phenomena of drug dependence. Rather, most recent theories or models recognise the contributions and interplay of biological, psychological, and social factors and include elements of each in explaining drug dependence. Basically, most theories include different aspects of the same phenomenon and are inter related rather than opposing (Goode, 1993). The importance in the main theoretical models is not in explaining the etiology of drug dependence but the way in which they have influenced and shaped the attitudes and behaviours of health professionals, researchers, and members of the public with regard to working with, living with, and researching people who are drug dependent. These models also offer a more expansive foundation for better understanding drug dependence regardless of the fact that some may not be as acceptable as they once were.

Biological models

The biological models of drug dependence focus on physiological and genetic factors and includes the disease, genetic or hereditary, and neurological theories. Proponents

of the disease perspective posit that drug dependence is a primary predisposing disease that is progressive, incurable, and eventually fatal if not arrested, essentially, a disease very similar to other chronic relapsing conditions such as diabetes and heart disease (IOM, 1996, 1997). As one of the more popular models guiding treatment today, the disease model represents the drug user as a vulnerable host and drug dependence as an infectious disease which spreads to other vulnerable hosts (Brower et al., 1989; Gabe & Bury, 1991).

Theoretically, the disease model, in viewing drug dependence as a sickness, an illness, shifts personal responsibility from the individual to some external agent, accordingly, individual guilt and remorse are reduced. Although the main objective of the disease model has been to exclude personal responsibility for both the cause and the cure of drug dependence, in practice, the individual is still perceived to be personally and morally responsible for contracting the disease. Consequently, underlying the disease view is a foundation of moralistic judgement along with a belief that, even though people refer to drug dependence as a disease or an illness, they do not regard it as a disease in the same way they do biological diseases such as measles or cancer, the reason being that one is personally and morally responsible in contracting the disease of drug dependence whereas the biological diseases are acquired through viral and bacterial infections (Shaffer, 1987). Despite being considered by many researchers and health professionals to be theoretically weak and unscientific (Marlatt, Baer, Donovan & Kivlahan, 1988), the disease model has allowed many dependent drug users to make public their sickness/illness and seek and receive treatment without fear of contempt and derision.

In the genetic models, genetic factors are considered to play a large part in the occurrence and development of drug dependence. According to these models the genetic make-up of some individuals predisposes them toward drug dependence, in that a gene or a combination of genes influence specific biological mechanisms relevant to drug dependence (Goode, 1993). Biological mechanisms influenced as such could be patterns of behaviour, personality, and individual responses to, and metabolism of, different drugs. The familial nature of drug dependence has also contributed to speculation about genetic predisposition. Evidence from family, twin and adoption

studies support the view that genetic factors play a role in drug dependence (Cadoret, 1992; Farrell & Strang, 1991; Goodwin, 1985; Hill, 1993; Schuckit, 1980), however, the magnitude and mechanisms of such factors are not clear. No unquestionable evidence or firm answers yet exist that separate genetic and family environmental contributions to drug dependence, or exactly how a predisposition is transmitted. Even though research indicates that genetic predisposition appears to be a contributing factor for drug dependence, other factors, for example, environment, personality, biochemistry, can affect the influence of genetics.

As an explanation of drug dependence, the genetic model presents some limitations. The present state of knowledge about the role of genetics in drug dependence is insufficient to assist in prevention and treatment programs, and in fact, may even undermine treatment for many of those who need it by disregarding the significance of environmental factors. In these models it is also presumed that individuals with a family history or drug dependence are genetically vulnerable for developing drug dependence themselves, that it is their unchangeable destiny. As such, there is a quest for genetic markers, so that those labelled as incipiently predisposed to drug dependence can be warned in order to avoid falling into that way of *being* (Heath, 1987).

The neurobiological models encompass metabolic imbalance, biochemical and neurotransmission theories. Metabolic imbalance theory, developed by Dole and Nyswander (1965) argues that the drug dependent person suffers from a metabolic imbalance that can only be relieved by the use of drugs much the same way as a diabetic needs insulin. Once a person is dependent on a drug, they need repeated doses of the drug to maintain their metabolic cycle, their equilibrium. Effectively, the drug provides what the body is not able to. Unlike the role of insulin in diabetes, no exact biological mechanism for metabolic balance has been found. However, as the background theory upon which methadone maintenance programs are based (Goode, 1993), it has provided many dependent drug users with an improved lifestyle in which the need to engage in illegal practices to obtain money for drugs is reduced.

The neurotransmitter and receptor site theories concentrate mainly on the many ways in which psychoactive drugs alter or interfere with the transmission of electrical or chemical messages in the central nervous system. The discovery of the endorphins - endogenous opioid like compounds, and the subsequent knowledge that all psychoactive drugs, although chemically different from one another, alter the brain's chemistry by mimicking or enhancing the actions of one or more neurotransmitters in the brain that are involved in the activity of the brain reward pathway (IOM, 1997), for example, the opiates mimic endorphins and amphetamines enhance the actions of dopamine, led to the hypothesis that people who become drug dependent may have an in-born or acquired chemical deficiency or abnormality in their neurological functioning. With long-term use of psychoactive drugs, the brain's ability to manufacture neurotransmitters on its own is depleted or blocked. Without the availability of essential neurotransmitters to maintain normal chemical functioning in the brain, the chronic drug user may experience changes in both body and mind such as chemical depression, anxiety, cravings, increased heart rate, and constriction of blood vessels. Thus, to maintain homeostasis, normal chemical functioning in the brain, and a normal physiological balance, the individual needs to use external chemicals.

Essentially these theories suggest that self-induced changes in neurotransmission through repeated use of drugs are responsible for drug dependence behaviour (Milkman & Sunderwirth, 1983). Although these theories provide a better understanding of the effects of drugs on the brain's chemistry and how a drug dependence may develop, they are inadequate as a sole explanation of drug dependence as evidenced by research documenting the maturing out process (Granfield & Cloud, 1996; Waldorf & Biernacki, 1981) and the high attrition rates of replacement drug maintenance programs (Cole, Lehman, Cole & Jones, 1981).

Psychological Models

The psychological models of drug dependence focus on psychological factors and can be grouped into psychoanalytic, personality, and behavioural theories. The psychoanalytical theories based on the work of Freud and his followers suggest that drug dependence is primarily the result of an interaction between external events and

repressed or unconscious conflicts that originate in early childhood. Postulated as the cause of these conflicts or ego functioning defects that lead to drug dependence susceptibility are such events as inadequate early relationships, unhealthy maternal bonding, lack of a nurturing environment, and oral fixation (Khantzian, 1975; Treece & Khantzian, 1986). To correct or compensate for the resultant internal emotional conflicts and defects in ego functioning the individual uses specific psychoactive drugs, which are chosen for their specific pharmacological effects and capacity to reduce the inner turmoil and conflict, experienced. Essentially, the individual self medicates through their drug of choice.

Within psychoanalytic models, treatment revolves around uncovering and bringing to awareness the internal conflicts through such techniques as personal history taking, interpretation of the individual's concerns and dreams, free association, resistance and transference. Other methods of treatment are considered ineffective in that they do not resolve the internal conflicts. If the conflicts are not resolved the drug dependence behaviour will manifest again through either relapse or symptom substitution. Treatment is considered successful if the individual gains insight into and resolves their conflicts as they have been reflected in their drug dependence behaviours.

As a treatment modality, the behavioural models, based upon various forms of learning theory, basically hold that drug dependence is the result of the individual over learning maladaptive ways of coping with environmental events, which once learned are maintained by reinforcing contingencies, essentially, drugs are powerful reinforcers of the learned set of dysfunctional behaviours. Incorporating elements of classical and operant conditioning and positive and negative reinforcement, the behavioural models have been influential in providing a more scientific approach in understanding and treating drug dependence. One of the most significant behavioural theories has been Wikler's (1965, 1973, 1980) conditioning model of drug dependence in which the acquisition, maintenance, and extinction of drug dependence are viewed as products of operant and classical conditioning. For example, in the acquisition of drug dependence behaviour, factors such as a syringe, a thought, the ritual, or a particular room may act as a conditioned stimulus for euphoric feelings which induce pleasant memories of drug using which in turn lead to the desire to use a drug again.

Other behavioural theories suggest that drug dependence is the product of both positive and negative reinforcement. Positive reinforcement occurs when the drug user experiences pleasure from drug use and as a result, is motivated to repeat the activity. Negative reinforcement occurs largely as a result of the drug user developing a physical dependence on certain drugs and in order to avoid experiencing the distress of withdrawal, or to continue feeling normal, is motivated to continue drug use (Goode, 1993). Although conditioning principles have been applied in the form of cue exposure and counter conditioning methods in the treatment of drug dependence they are not frequently used nowadays, however the concept of drug dependence as a learned behaviour is still popular (Goode, 1993).

Another example of the psychological model perspective is the view that drug dependence is related to personality factors. Theories within this model have attempted to depict an “addictive personality”, a personality that is inadequate or pathological to explain why some people develop a drug dependence and not others. Among the personality inadequacies and characteristics identified are state and trait anxiety, depressive mood, sensation seeking, hostile dependence, low self-esteem, low frustration tolerance, compulsive and conduct personality factors, apathy, pessimism and others (Andrussi, Archer, Pancoast & Gordon, 1989; Arif & Westermeyer, 1988; Goode, 1993; Hawkins, Catalano & Miller, 1992; Igra & Irwin, 1996; Kazdin, 1989; Nathan, 1988; Petraitis & Flay, 1995, Smith, 1986; Teichman, Barnea & Ravav, 1989).

According to these theories, drug dependence is a response to deficits in the drug user’s personality. The greater the deficits, the greater the possibility of becoming involved with or predisposed to using drugs which in turn leads to eventual drug dependence. Drugs and drug use become a way of avoiding, coping with, or adapting to problems in one’s life (Goode, 1993). This perspective, in which drug dependence is viewed as an adaptation or defense mechanism (Wurmser, 1980, cited in Goode, 1993) suggests that different personality types get different things from, or are satisfied in, different ways by the use of different drug types, for example, opiates relieve anxiety, stimulants palliate depression, and psychedelics alleviate boredom.

While some personality characteristics have been linked with drug dependence and may play a causative role in its development, many of them are also very common and most people who possess them do not develop, or have, an “addictive personality” (Nathan, 1988). Of the personality characteristics associated with drug dependence, many appear to be acquired in the process of becoming drug dependent and with abstinence, often seem to disappear (Arif & Westermeyer, 1988). Consequently, the personality characteristics delineated in the addictive personality theories may be the result of drug dependence and not the cause. The problem is how to separate personality characteristics that are consequences of drug dependence from those that are the causes of drug dependence.

Sociological models

The sociological models place emphasis on social interaction, social structures, and social settings in explaining drug dependence. Included in these theories are social learning, social control, and socialisation. Social learning theory, based on Sutherland’s (1939) differential association theory, and extended by Bandura (1977), postulates that delinquent behaviours are socially learned in small groups through processes of reinforcement, examples of small groups being friends or family. If the behaviour is reinforced, if value is placed on the reinforcement, and the individual regards him/herself as being able to perform the behaviour, they will continue to carry out the behaviour. Essentially, reinforcement determines whether the behaviour is pursued or not. Social learning theory, when applied to drug dependence, argues that drug dependence is determined by the drug specific attitudes and behaviours of people who act as the drug user’s role models, that observation and imitation of drug specific behaviours are socially reinforced through the influential role model’s support and encouragement. This then culminates in the drug user’s expectation of more positive reinforcement, socially and physiologically, from future drug use (Akers, 1977; Akers, Krohn, Lanza-Kaduce & Radosevich, 1979). Although drug dependence in this theory is determined by the drug specific beliefs that the drug user acquires and the reinforcement received from their role models, it does not explain why some individuals when involved or associated with drug dependent role models, do not

become drug dependent even though they have the same opportunities to associate with them (Goode, 1993).

With its origins in the study of delinquency, social control theory (Hirschi, 1969) focuses on the bonds that an individual establishes with conventional society and conventional role models. Bonding with society is influenced by such factors as attachment to those who adhere to conventional norms, commitment to and involvement in conventional activities, and belief in and acceptance of society's values. For most people, their bonds to social institutions are strong, consequently they conform to society's rules, and are subsequently less likely to engage in deviant behaviour. However, for some people, the bonds are weak, broken, or non-existent, thus they are free from society's rules to participate in deviant behaviours, in this case, illicit drug use (Goode, 1993).

According to Elliot, Huizinga and Ageton (1985), possible causes for a weak commitment and attachment to conventional society and conventional role models are strain, social disorganisation, and lack of effective socialisation. Strain occurs as a result of a discrepancy between the individual's aspirations and their perceptions of the opportunities to achieve those aspirations. Consequently strain will weaken attachments to conventional role models and encourage attachments with peers who may encourage drug use. If the individual experiences social disorganisation, for example, disorganised family, neighbourhood, school, or workplace, and little hope is offered by these institutions, then the individual will feel uncommitted to conventional society and be more likely to develop drug dependence. Likewise, if the individual has not been effectively socialised to adhere to conventional values and standards, the individual may become attached to drug dependent peers and subsequently develop a drug dependence.

Essentially, the basic thesis of social control theory is that drug use and drug dependence are caused by the absence of social controls that produce conventionality (Goode, 1993). As an explanation of drug dependence, social control theory has many followers, however, it does not address many of the other factors such as personality

traits, intrapersonal characteristics, and affective states that are considered to play a role in the acquisition and maintenance of drug dependence (Goode, 1993).

Linked with the social control and the social learning theories are the socialisation theories. These theories, as applied to drug dependence, suggest that individuals, even before they use drugs for the first time, are initiated into, prepared for, or socialised into drug use through friends, family, the media/school, and/or subcultural groups who use drugs (Goode, 1993). Through the process of socialisation the individual learns the rules, the language, and a drug specific worldview of the drug subculture and how to defend those rules compulsively. In sharing similar values and behaviours with others in a drug subculture, the process of socialisation is validated and the boundaries between “them” and “us” are defined (Knipe, 1995).

Of the socialisation agents, family and peers both play an important role in influencing drug use and drug dependence behaviours. Among the family factors consistently implicated in drug dependence are parental modelling, poor family relationships including low bonding to family, abuse, emotional distance, ineffective parenting and family management techniques, negative communication problems, and parental absence (Gfroerer, 1987; Goode, 1993; Kandel, 1982; Oetting & Beauvais, 1987a, 1987b; Pandina & Schuele, 1983).

As contributing factors to drug dependence, family influences are stronger early on in the life of the child before initiation or socialisation into drug use. As the child ages, the family’s influence lessens and peer influence increases (Kandel & Andrews, 1987).

Peer influence and peer relationships have been postulated as powerful social factors in drug dependence (Oetting & Beauvais, 1987a, 1987b; Dinges & Oetting, 1993; Goode, 1993; Newcomb & Bentler, 1989). Associations with peers who use drugs and are drug dependent plays a significant role in initiating and maintaining drug use, particularly among adolescents. Nearly all drug use occurs in a peer context, with peers assisting in the provision of drugs, modelling drug use behaviours, supporting each other’s use, and reinforcing beliefs, values, and attitudes about drugs and drug using behaviours (Oetting & Beauvais, 1987a). However, drug dependent peers do not just suddenly appear in one’s life or are chosen at random. Through the

socialisation process people choose and are chosen to associate with and to participate in certain social circles or groups of like minded people who tend to encourage and reinforce particular values and behaviours. Hence, participation in and association with a drug subculture socialises one toward the use of illicit drugs and maintenance of drug dependent behaviours (Goode, 1993; Kandel, 1978).

The biopsychosocial model

Although each of the biological, psychological, and social models focus on a different range of factors as being important in explaining drug dependence, no one single model adequately explains the varied and highly complex phenomena of drug dependence. However, many of them do acknowledge the complex underplay of biological, psychological, and social factors which subsequently has led to the postulation of a biopsychosocial model which holds that a combination of various biological, psychological, and social factors such as altered brain chemistry, genetic predisposition, personality traits, depression, peers, culture, and family dysfunction all interact to bring about the initiation and maintenance of drug dependence (Arif & Westermeyer, 1988; Chiauzzi, 1991; Donovan, 1988; Engel, 1977; Peele, 1989; The Substance Abuse and Mental Health Series Administration, 1994). Essentially, the fundamental assumption of the biopsychosocial model is that drug dependence is not the result of a brain disease (IOM, 1997) or the sign of weak will and immorality (Dean & Rud, 1984) but rather, a consequence of a complex interaction of biological, social, and psychological influences and factors. In this model, it is presumed that a thorough understanding of drug dependence behaviour must be based on a comprehensive and integrative analysis of all three domains. This model also maintains that recommendations for treatment must examine all three domains, the individual differences within and the commonalties across each, and in doing so, it should be possible to target treatment uniquely to a particular individual. As a framework within which to understand the causes of drug dependence and determine the focus for interventions and treatments, the biopsychosocial model has emerged to provide a more holistic perspective of all aspects of drug dependence. As a model it more adequately explains the multidimensional nature of drug dependence.

Despite the fact that drug dependence has been the subject of much research for well over a century, to which considerable monetary resources, time and energy have been invested, there is still no one model or theory that fully explains the highly complex phenomena of drug dependence or sufficiently guides treatment. Rather, research and treatment continues in all directions, from approaches which focus on one characteristic (Polkinghorne, 1983) to multifactorial explanations which emphasise the complex interactions between biological, psychological, and social factors (Chiauzzi, 1991; Engel, 1977), all of which further contribute to the controversy, confusion, anomalous research findings, diverse views, and lack of clarity present in the drug dependence field (IOM, 1996; Peele, 1985, 1986, 1987; Shaffer, 1986). That there are so many diverse views is not only a matter of concern but also worrisome in that an understanding of the lived experience and meaning of drug dependence as a meaningful behaviour embedded in our society is limited, particularly through these mechanistic reductionistic models (including the biopsychosocial model) which hold that drug dependence is caused and maintained by whatever factor(s) that happen(s) to be the object of focus (Peele, 1981). Although such models and approaches are important in drug dependence inquiry, a shortcoming of the prevailing reductionism in these approaches is that they do not address the human world of meaning thus limiting the possibility of understanding why such dependency occurs (Peele, 1981). These approaches also often present a view of drug dependence in which the person and their lived experience is lost from sight. However, the importance and relevance of all these models lies not so much in their proposed ability to explain the etiology, pathology, maintenance, or treatment of drug dependence, but in the way in which they influence and shape, both consciously and unconsciously, the perceptions and attitudes held by health professionals, researchers, and members of the lay public, and the ways in which research and treatment are carried out. In essence, these diverse approaches and models that have predominated in drug dependence inquiry are not sufficient to address or understand the complexity of drug dependence behaviour.

Rather, if we are to come to an understanding of drug dependence as a highly complex, meaningful, and distinctly human phenomenon, comprising of both matter and meaning (Gadamer, 1975; Polkinghorne, 1983, 1989) then an approach that is better oriented toward understanding meaning is essential. Such an approach is

hermeneutical phenomenology, an existential method of inquiry that emphasises lived experience as it is given in consciousness (Polkinghorne, 1983) and the discovery of meaning through the explication of context (Allen & Jensen, 1990; Smith, 1983). Accordingly, “the phenomenological approach focuses on the structure of experience, the organising principles that give form and meaning to the lifeworld, while the hermeneutic approach concentrates on the historical meaning of experience and its developmental and cumulative effects at both the individual and social levels” (Polkinghorne, 1983, p.203). Hence, an understanding of drug dependence can be furthered through the use of phenomenology and hermeneutics, approaches that recognise the lived experience of drug dependence as being symbolic and meaningful in relation to the consciousness of the individual concerned. In this context, the underlying intention of this study is to suggest that the varied and highly complex phenomena of drug dependence can be more fully addresses with the addition of a hermeneutic phenomenological approach that recognises lived experience and meaning, for if we are to better understand and help people in our country in ways that they can identify with, and to which they can relate, then we need to know their everyday lived experience of drug dependence and what drug dependence means to them.

The diagnosis of drug dependence

Initially described as a moral disease, an expression of immorality and weak will, then as a medical disease or illness similar to other progressive incurable and ultimately fatal conditions, and more recently as a brain disease manifested by a complex set of behaviours resulting from biological, psychological, and social interactions (IOM, 1996, 1997), the concept of drug dependence (still commonly referred to as drug addiction despite WHO [1964] recommendations that it be replaced by drug dependence) has gained wide acceptance internationally (Gossop & Grant, 1990). However, many diverse and archaic definitions are still widely held by members of a variety of disciplines and the lay public, with the term *drug dependence* often being confused with other aspects of addiction. Accordingly, the literature, both scientific and lay, contains much reference to the confusion, controversy, ambiguity, lack of clarity, discrepancies, and misuse of terms in defining and conceptualising drug dependence (IOM, 1997) and the various forms of drug dependence as distinct entities.

Further, because the terms *addiction* and *drug dependence* are used interchangeably, there is a need for consistency, clarification, and definition of the criteria, characteristics, and symptoms of drug dependence. Using the term drug dependence as equivalent to addiction, medical diagnostic systems have defined drug dependence as compulsive use of a drug that is not medically necessary accompanied by impairment in health or social functioning (APA, 1994; WHO, 1992a). At the present time there are several formal diagnostic systems available for use in research and clinical assessment. The most widely accepted diagnostic system used throughout the medical and mental health fields for diagnosing drug dependence in New Zealand is the criteria formulated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994) followed by the International Classification of Diseases (ICD-10) (WHO, 1992b).

The DSM-IV provides health professionals, researchers and other treatment personnel, regardless of whatever theoretical perspective they hold, with a common language for not only diagnostic purposes but also for communicating about drug dependence and for making clinical decisions based on current knowledge. Although it is complicated, the DSM-IV is a relatively precise diagnostic system. There are around 200 adolescent and adult diagnoses, the criteria for each being very detailed. In most definitions of the diagnoses, criteria elements are grouped into requisite patterns of symptoms, ages of onset, and specific time duration of symptoms. They also contain inclusion and exclusion criteria. A culture specific section is also provided to enhance the cross-cultural applicability of the manual in culturally diverse populations. Despite the comprehensiveness of the DSM-IV diagnostic information for each disorder, the manual does not delineate the etiology of the disorders, rather, it focuses on providing “clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study and treat people with various mental disorders” (APA, 1994, p.xxvii). For this reason, drug dependence – the phenomenon of interest in this study – is defined according to the criteria specified in the DSM-IV. Using set criteria allows for more effective communication in that one knows what the other means when they both conform to the same definitions. In having a standard definition, biased and idiosyncratic diagnoses are greatly eliminated in research and practice. Although such a diagnosis can be a pejorative label if used

insensitively, it can, if used professionally, effectively convey a great deal of information about a person.

In the DSM-IV (APA, 1994), drug dependence is described as an often progressive process that typically includes the following symptoms: tolerance and/or withdrawal, a compulsion to acquire and use drugs and preoccupation with their acquisition and use, loss of control over drug use, continued drug use despite adverse consequences, and unsuccessful attempts to cut down or control use. For the diagnosis of drug dependence, three or more of these symptoms must occur at any time in the same 12-month period. A diagnosis of drug dependence can be applied to every class of drugs other than caffeine, with symptoms being similar across the various drug categories. However, some symptoms are not so salient for some drug classes, and in others, not all symptoms are applicable. In evaluating this criteria the main issue is not the existence of drug dependence but rather, the individual's failure to abstain from drug use despite evidence of the problems drug use is causing.

According to the DSM-IV (APA, 1994, p.188), drug dependence can occur at any age, but typically, initial onset is in the 20's, 30's, and 40's. For each class of drugs listed in the DSM-IV specific culture, age, and gender features are outlined along with prevalence and course data, each of which shows wide variations. In general, across the drug types, higher proportions of males than females show drug dependence, but however, there are variations depending on drug type. Drug dependence is seen throughout all levels of society and in all geographical regions. The course of drug dependence is variable and is influenced by the class of drug, individual characteristics, the environment, and the route of administration. Although generally long lasting for years with periods of intensification and partial or full remission drug dependence can occur in relatively brief and self-limited episodes (APA, 1994). During the course of drug dependence there may be periods of abstinence and remission, periods of non-problematic drug use through to periods of heavy use and severe problems. During periods of abstinence and remission the individual is highly vulnerable to relapse risk. Drug dependence is also associated with spontaneous self-recovery in which the individual recovers from drug dependence without seeking professional or lay intervention (APA, 1994; Granfield & Cloud, 1996).

Within the DSM-IV, the APA (1994) has refined the concept of drug dependence to allow classification of different psychoactive drugs according to a set of identical criteria. As an objective, empirically based reliable diagnostic classification system, the DSM-IV is useful in that it can provide the health professional with a basis for planning treatment, it can exclude false positives and borderline cases, it can assist with prevalence estimates for epidemiological research and consistent reporting of statistical data, and it can enhance research on drug dependence through ensuring that study participants meet the standard criteria for drug dependence.

Basically, the DSM-IV emphasises the role of diagnosis as one of classification in which the focus is mainly on the disorder more so than on capturing subjective realities. Drug dependence is, according to the DSM-IV, a disorder, but it is also a series of experiences that profoundly affect the person who is drug dependent and those who share the experiences. As one of the roles of the health professional is to help people with drug dependence live a life that is as good as possible, information about the lived experience of drug dependence is necessary. This information can enable the health professional to offer treatment and support that has meaning for the person with drug dependence. This information is also needed for research into drug dependence, particularly in New Zealand, if the three priorities of the National Drug Policy (Ministry of Health, 1998a, p.29) are to be realised, these priorities being:

1. to enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of drug use
2. to reduce the prevalence of cannabis use and the use of other illicit drugs, and
3. to reduce the health risks, crime and social disruption associated with the use of illicit drugs and other drugs which are used inappropriately.

Drug dependence treatment

Also forming part of the background of the study from which understanding of the complexity of drug dependence can emerge are the current treatment approaches in drug dependence practice. As with the literature and research on theories of drug

dependence, the literature and research on drug dependence treatment is both vast and controversial, much of which is founded on quantitative research techniques that study large samples of people through experimental or survey research designs. Similar to the multiple theoretical models of drug dependence are the multiple treatment philosophies and approaches to drug dependence, each of which are also influenced by a wide range of different factors including the underlying assumptions and viewpoints of treatment providers with regard to the causes of drug dependence. Drug dependence treatment is provided both publicly and privately by a diverse group of health professionals and other people. Consequently, there can be a wide difference in experience, expertise, and knowledge in each of the providers. Regardless of the many types of treatment approaches and systems, there is no definitive treatment. Rather, types of treatment can be viewed on a continuum that moves from treatment for least severe problems such as brief intervention and motivational interviewing to treatment for the most severe problems such as pharmacotherapy and inpatient residential treatment. Also existing along this continuum of treatment is the pragmatic approach of harm minimisation, an approach embracing a wide variety of programs and techniques designed to reduce drug-related harms (MOH, 1995; Preston, 1999). In the treatment of any type of drug dependence problem, it is essential that the treatment is tailored to the needs of a specific individual, however finding the most appropriate treatment for a particular person is often difficult given that there is not any single best treatment for drug dependence and not every type of treatment is available.

For all types of drug dependence problems that require treatment, the nature of the problem needs to be identified through assessment, followed by the development of a treatment plan, which identifies and targets problems, treatment goals, objectives, and interventions. Types of treatment goals range from abstinence from all drugs through to controlled non-dependent non-problem drug use to improvement in various areas of psychosocial functioning. Although a desirable goal, complete abstinence from all drugs is often an unrealistic goal and in recognition of this, the Institute of Medicine of the National Academy of Sciences Committee (Gerstein & Harwood, 1990) agreed that an achievable goal of drug dependence treatment is a substantial reduction in the individual's consumption of drugs relative to what would be expected without treatment, with other goals focusing on psychosocial functioning, including reduction

of street crime, improvement in general health and family life, restoration of employment, reduction in the spread of infectious diseases associated with injecting drug use, and removal of barriers to treatment.

Among the many factors involved in drug dependence treatment, both in New Zealand and world-wide, are both individual client factors such as severity of dependence, readiness for change, the presence of dual diagnosis (the co-existence or co-morbidity of drug abuse and other psychiatric disorders), social support; and treatment factors such as the setting in which treatment takes place and the intensity and length of treatment. Treatment generally occurs in a variety of settings. These settings fall into four categories: outpatient, inpatient, aftercare, and residential/therapeutic communities. Decisions regarding treatment setting are generally based on the overall status of the particular individual and through such guidelines as The American Psychiatric Association's (1995) Clinical Practice Guidelines and the American Society of Addiction Medicine's (1997) Patient Placement Criteria. Also to help guide treatment decisions and settings are many evaluation instruments and measures such as the Addiction Severity Index (ASI) (McLelland, Luborsky, O'Brien, Woody, 1980; McLelland, Lushner, Metzger, Peters, Smith, Grissom, Pettinati & Angeriou, 1992), the Leeds Dependence Questionnaire (LDQ) (Raistrick, Bradshaw, Tober, Weiner, Alison & Healey, 1994) and the Opiate Treatment Index (OTI) (Darke, Hall, Heather, Wodak & Ward, 1992).

Identified in drug dependence treatment are three main stages: detoxification (or acute stabilisation), rehabilitation, and follow-up care (McLellan, Bender, McKay, Zanis & Alterman, 1997). Detoxification, or stabilisation, is dependent on the types of drugs used and can be accomplished in a variety of ways and settings. However, it is seldom effective in itself as a treatment because of the short-term focus of detoxification and the high term frequency of relapse that follows. Essentially, detoxification can be considered a gateway to treatment (McLellan et al., 1997: Warner, Kosten & O'Connor, 1997).

The rehabilitation phase of treatment includes a variety of modalities comprising education, behavioural and/or psychological therapies, medical treatment,

pharmacotherapy, and participation in support groups, each dependent on the individual's needs. Accordingly, treatment is more likely to be successful the longer the individual is in treatment particularly as attrition is high in the early stages of treatment (O'Brien & McLellan, 1996; McLellan, Arndt, Metzger, Woody & O'Brien, 1993). The final phase, follow-up care varies considerably in terms of length of time and frequency, again depending on the types of drugs used and the degree of dependency. The major goal of aftercare strategies is prevention of relapse (McLellan et al, 1997).

Although there are significant differences in the treatment of specific drug dependencies (for example, opioid versus cannabis), all drug dependence treatment involves the same stages and the same sort of types of treatment setting. Along with the widespread belief that the effectiveness of drug dependence treatment involves a complex interplay of biopsychosocial and individual factors is the belief that not only early identification and intervention, but also treatment matching and harm minimisation approaches lead to the best outcome whatever the type of treatment or treatment programs used (Carroll, Rounsaville, Gordon, Nich, Jatlow, Bisighini & Gawin, 1994; Carroll, Rounsaville, Nich, Gordon, Wirtz & Gawin, 1994; Crits-Christoph, Siqueland, Blaine, Frank, Luborsky, Onken, Muenz, Thase, Weiss, Gastfriend, Woody, Barber, Butler, Daley, Bishop, Najavits, Lis, Mercer, Griffin, Moras & Beck, 1997; Gastfriend & McLellan, 1997; Hester, 1994; Higgins, Budney, Bickel, Hughes, Foerg & Badger, 1993; Hubbard, Marsden, Rachal, Harwood, Cavanaugh & Ginzburg, 1989; McLellan & Alterman, 1991; McLellan, Grissom, Zanis, Randell, Brill & O'Brien, 1997; O'Brien, 1994; O'Brien & McLellan, 1996; Simpson, 1981).

In the literature, both pharmacological and psychosocial/behavioural approaches are documented as having evidence of effectiveness in the treatment of drug dependence. In most cases multimodal therapies that combine psychosocial and behavioural approaches are the first line of treatment. For those individuals who have been unable to succeed with drug free forms of treatment, pharmacotherapy is used as an adjunct (Anglin & Hser, 1992; Anton, Kranzler & Meyer, 1995; APA, 1995; Hester, 1994; IOM, 1995a, 1995b; Senay, 1985; Warner, Kosten & O'Connor, 1997). Also

congruent with traditional drug dependence treatment approaches is the harm minimisation approach which rests on the principle that many individuals will misuse/abuse drugs and that reducing or minimising the harmful consequences of the use of illicit drugs is more appropriate than abstinence from drugs (MOH, 1995; Marlatt & Tappert, 1993; Preston, 1999).

Psychosocial therapies.

Although there are many psychosocial and behavioural therapies and programs for treating drug dependence, there is a relative paucity of research into the effectiveness of these types of treatment, in part due to the fact that there is little agreement on how to measure the efficacy of treatment, for example, treatment effect versus maturing out effects, or what comprises successful treatment outcome, for example, controlled use versus abstinence. In addressing treatment efficacy, Hoffman, Sonis & Halikas (1987) identified six difficulties that need addressing before assessment of treatment efficacy can be achieved. These difficulties are the differences in the way in which drug related problems are perceived and defined by referral sources, the differential characteristics of both client populations and of treatment programs, the lack of categorisation of patient treatment match, the lack of a patient's individualised treatment response, and the failure to identify and use appropriate outcome variables.

Despite the fact that research into treatment efficacy has been relatively sparse and not conclusive, recent studies have identified several psychosocial/behavioural approaches that have evidence of effectiveness when delivered in a graduated response to problem severity (Carroll & Schottenfeld, 1997; Carroll et al, 1994; Carroll, 1997; Crits-Christoph et al, 1997; Higgins et al, 1993; Hubbard et al, 1989; Hubbard, Craddock, Flynn, Anderson & Etheridge, 1997; McCrady & Epstein, 1996; McLellan et al., 1993; Simpson, Joe, Fletcher, Hubbard & Anglin, 1997; Strain, 1999; Woody, Luborsky, McLellan, O'Brien, Beck, Blaine, Herman & Hole, 1983). Among the psychosocial/behavioural approaches identified are marital and family therapies, behavioural and cognitive therapies, group and individual counselling, and brief motivational approaches, each of which are described below as part of the background from which understanding of the complexity of drug dependence stems.

Marital and family therapies include a range of specific approaches which are based on the assumption that family behaviours and drug use patterns contribute to a family member's decision to use drugs, and that active involvement from family members and significant others often is essential for treatment to be effective. Included in these approaches are family systems models which address family systems problems that promote drug dependence and interfere with positive change, behavioural models which view drug dependence in terms of family behaviours which maintain or precede drug dependence, and family disease models which focus on drug dependence as a disease and the family's role in enabling, or maintaining its homeostasis around the affected family member (McCrary & Epstein, 1996).

The efficacy of family based therapy for drug dependence is supported by several studies and reviews which provide evidence of the value of involving the family and significant others in the engagement and retention of drug dependent individuals in treatment (Coletti, 1994; Heath & Stanton, 1991; Joanning, Quin, Thomas & Mullen, 1992; Kaufman, 1985; Liddle & Dakof, 1995; Mackenson & Cottone, 1992; McCrary & Epstein, 1996; Stanton, 1997). For instance, Joanning and colleagues (1992) in their comparative study of peer group therapy, psychoeducation, and family therapy, found that family involvement through family therapy models of intervention resulted in greater engagement and retention rates for adolescents in drug treatment and in reducing drug use at termination of therapy. Drop out rates for family therapies were 13% compared to 53% for peer group therapy and 33% for psychoeducation. Behavioural and cognitive therapies comprise a wide range of specific interventions such as contingency contracting, systematic desensitisation, relaxation training, social and coping skills, assertiveness training, covert aversion, and token economies, all of which understand drug dependence in terms of its antecedents and consequences. Within the context of these therapies, drug dependence is seen as a learned response that is acquired, shaped, and maintained because of its rewarding consequences, rather than necessarily understanding the behaviour the goal of these therapies is to change behaviour. Included in the behavioural and cognitive therapies is also relapse prevention. Based upon the principles of social learning theory, the goal of relapse prevention is to teach individuals who are trying to change their behaviour how to

cope with high risk situations that commonly precipitate relapse (Marlatt & Gordon, 1985). The effectiveness of cognitive and behavioural therapies in drug dependence treatment has been addressed in numerous studies and reviews (Beck, Wright, Newman & Liese, 1993; Carroll & Schottenfeld, 1997; Higgins et al., 1993; Higgins, Delaney, Budney, Bickel, Hughes, Foerg & Fenwick, 1991; Marlatt & Gordon, 1985; Maude-Griffin, Hohenstein, Humfleet, Reilley, Tussel & Hall, 1998). For example, Higgins and colleagues (1993) compared cocaine dependent individuals randomly assigned to either a multicomponent behavioural treatment group using a contingency-management program in which incentives in the form of redeemable vouchers were earned for cocaine negative urine samples and a community reinforcement approach involving significant others or a drug abuse counselling treatment based on the disease model of dependence and recovery. In their study they found that 58% (11/19) of the individuals assigned to the behavioural treatment group completed 24 weeks of treatment compared to only 11% (2/19) assigned to the drug abuse counselling. Also, at 8 and 16 weeks respectively, 68% and 42% of the individuals in the behavioural group achieved documented continuous cocaine abstinence compared to 11% and 5% in the drug-counselling group.

Group and individual counselling are both critical components in any drug dependence program. Generally, in individual counselling, therapists practice whatever treatment philosophy they espouse with the goal of listening to and helping drug dependent individuals find solutions or cope with their everyday difficulties more effectively. Most interventions that are carried out on an individual basis can also be carried out in a group format, providing a more cost effective intervention. Group counselling often provides a milieu in which support is given and received where peer confrontation can undercut defensiveness and where, through listening to their peers, drug dependent individuals find they are not alone in their experiences. The group setting is also a powerful force in helping each individual recognise the impact of their behaviours on others. Although both individual and group counselling are the most widely reported treatment modalities in drug treatment agencies there is a paucity of evaluation literature. Comparisons of group and individual counselling reveal that group counselling is as effective as individual counselling and that overall, counselling is indeed effective, that client gains are made in a relatively short period of time and that

these gains are maintained over time, however, the best predictors of counselling outcome are client variables and relationship factors, not specific counselling approaches (Lambert & Cattani-Thompson, 1996; Seligman, 1996).

Brief motivational approaches are generally intended as early intervention for individuals at lower levels of severity of drug dependence. Requiring a lesser degree of specialist time and aimed at larger numbers of clients, brief motivational approaches are usually 1-3 sessions in which the health professional provides objective information and gives the individual the opportunity to take responsibility for changing their behaviour. Most brief interventions have the same basic components that can be described by the acronym **FRAMES**: Feedback of personal risk, Responsibility, Advice to change, a Menu of alternative options, Empathy, and client Self efficacy (Bein, Miller & Tonigan, 1993; Miller & Rollnick, 1991). Although brief motivational interventions have been well researched and have been found to be as effective as more intensive methods of treatment, much of the outcome research is alcohol related, however, a number of specific treatment interventions are just as applicable to a wide range of drugs as they are to alcohol (Babor, 1994; Bien, Miller & Tonigan, 1993; Heather, 1988; Hester, 1994; Miller & Rollnick, 1991; Prochaska, DiClemente & Norcross, 1992).

Psychotherapeutic therapies encompass both psychodynamic and interpersonal approaches that view drug dependence in terms of unresolved conflicts or self-medication of underlying maladaptive behaviour. Although not a frequently used modality because of the need to have professionally trained individuals, there is some empirical evidence that psychotherapy produces clinically and significantly better outcomes for drug dependence treatment both alone and in combination with other treatment modalities (Crits-Christoph et al., 1997; Rounsaville & Carroll, 1992; Woody et al., 1983; Woody, McLellan, Luborsky & O'Brien, 1987). For example, in their study on psychotherapy for opioid dependence, Woody and colleagues (1983, 1987) found that opiate dependants on methadone maintenance and receiving psychotherapy in the form of supportive-expressive therapy, when contrasted with cognitive-behavioural therapy and drug counselling, improved more than the counselling group in their psychopathology and in their use of less psychoactive drugs.

Pharmacotherapy

The treatment of drug dependence is multifaceted and often requires pharmacologic therapy in addition to psychosocial treatment. Unlike most psychosocial therapies that are applicable to a wide range of settings and modalities, and to users of many different drug groups, most pharmacotherapies are restricted in their actions and are applicable only to opioid dependence in the context of this study. In pharmacotherapy for opioid dependence, treatment is based on either agonist substitution which involves the substitution of the abused drug with a safer and more controlled drug with similar pharmacologic actions, or antagonist treatment which involves the use of a drug which blocks the euphoric effects of the abused drug, or symptomatic treatment involving the use of drugs during withdrawal of the abused drug (Warner et al., 1997).

Agonist substitution

Of the opioid agonists, methadone is the most commonly used and researched. A long action synthetic opioid with a half-life of 24 - 36 hours, methadone blocks the euphoric effects of opiates through acting on the opioid receptor sites in the brain. Methadone is used both for detoxification in which tapering doses are used to achieve a more comfortable transition from opiate use to a drug free state, and for maintenance in which varying daily doses are given to discourage illegal opiate use. A consistent finding in the literature on methadone is that it significantly decreases opioid use and criminal activity associated with illegal drug use as well as improving the general health of those receiving methadone maintenance and reducing the transmission of the human immunodeficiency disease (HIV) (Anglin & Hser, 1992; Ball, Corty, Bond, Meyers & Tommasello, 1987; Warner et al., 1997; O'Brien, 1994; Ball & Ross, 1991; Metzger, Woody, McLellan, O'Brien, Druley, Navaline, DePhillips, Stolley & Abrutyn, 1993). Methadone has been used in New Zealand as a treatment for drug dependence since 1971 and currently there are over 3,000 individuals on methadone maintenance (Preston, 1996). Other opioid agonists used in substitution are LAAM (levo-alpha-acetylmethadol) and buprenorphine - a partial agonist. Similar acting to methadone, LAAM is a synthetic orally absorbed opioid that reduces euphoria and suppresses

withdrawal symptoms for up to 72 hours. The primary advantage of LAAM over methadone is its slow onset and long duration of action thus requiring only three doses weekly instead of daily dosing (IOM, 1995a; O'Brien, 1994).

Buprenorphine, a partial agonist, is currently under investigation as an alternative or subsequent step to methadone for both detoxification and maintenance. The advantages of buprenorphine compared to methadone include less intensive withdrawal symptoms, longer lasting actions, and reduced abuse liability (Gold, 1993; Schottenfeld, Pakes, Oliveto, Ziedonis & Kosten, 1997; Warner et al., 1997).

Antagonist treatment

There are a variety of opiate antagonists that are used both in the treatment of opiate dependence and in the treatment of opiate toxic reactions. They are also used to test individuals who say that they are drug free (Jaffe, 1985). The most widely used antagonists are naloxone and naltrexone, both of which when used occupy opiate receptors in the brain and block the effects of heroin and other opiates (Jaffe, 1985). Naloxone, a pure opioid antagonist, has no known agonistic properties, and has little or no effect when injected into non-opioid dependent persons. However, when injected into opioid dependent persons, rapidly precipitates withdrawal. It is commonly used to reverse the respiratory depression that follows opioid overdoses and to reduce the opioid reduced respiratory depression in new-borns of opioid dependent mothers. Naloxone is not well absorbed orally and has a short duration of action (Julien, 1995; O'Connor & Kosten, 1994).

Naltrexone is an oral, long acting opioid antagonist that blocks the effects of heroin by competing for opioid receptors. There are no known withdrawal symptoms when use of the drug is stopped and it has few side effects (Atkinson, 1984; O'Brien, 1984; Schechter, 1980). Naltrexone is clinically used as a deterrent in the treatment of opioid dependent individuals. The use of naltrexone renders any opioids ineffective (Julien, 1995). Research has shown that naltrexone is relatively unsuccessful in practice and for those who are treated with it, there is a high dropout rate (Kosten & Kleber, 1984). As a treatment modality, naltrexone is more suited to highly motivated individuals who

have more to gain from being drug free than drug dependent (Kleber, 1985). In opiate withdrawal, clonidine has been found to block effectively much of the symptomatic discomfort experienced (Gold, Redmond & Kleber, 1978). For subjective symptoms such as insomnia and muscle cramps that are not alleviated by clonidine in opiate withdrawal, a benzodiazepine (for example, diazepam) may be given (O'Connor & Kosten, 1994). A combination of naltrexone and clonidine has been found to be effective, both in treating symptoms and in a lesser duration of time, than clonidine alone (Charney, Heninger & Kleber, 1986; Riordon & Kleber, 1980). For example, in their study of hospitalised patients, Charney and associates (1986) found that 90% of their subjects were successfully withdrawn from methadone in less than six days using a naltrexone and clonidine combination.

Symptomatic treatment

In a detoxification or withdrawal program, either on an inpatient or outpatient basis, symptomatic treatment allows for an easier transition to a drug free state for those who are not interested in long-term methadone maintenance (Warner et al., 1997). Basically, withdrawal pharmacotherapy consists of administering a substance to suppress withdrawal symptoms, with duration of treatment depending on the severity of physiological dependence, the drug used, and what state the withdrawing individual is in. Mild withdrawal symptoms, such as those occurring with cannabis withdrawal, generally do not require pharmacological treatment, however, medication is often given to alleviate associated symptoms, for example, tricyclic medication to treat symptoms of depression (Arif & Westermeyer, 1988).

Of the pharmacological treatments, methadone maintenance is the most rigorously studied treatment method and has had the most consistently positive results (Ball & Ross, 1991; Gerstein & Lewin, 1990; Warner et al., 1997). For cocaine dependence, no pharmacological drug, has to date, been found to effectively reduce cocaine use or cravings, consequently, pharmacotherapy for cocaine dependence is a priority research issue, along with continued research into other cost effective pharmacological treatments (IOM, 1995a ;O'Brien, 1994; Warner et al., 1997).

Although data from research studies have shown that pharmacological therapies are effective in the detoxification, withdrawal, and treatment of drug dependence, they are not viewed as complete treatments in and of themselves, or as a means of promoting permanent abstinence. If pharmacological treatment alone were sufficient there would be no need for expensive and time consuming psychosocial treatments, and greater numbers of people could be treated. Rather, given the complexity of the biopsychosocial aspects of drug dependence and its effect on every aspect of the individual's life, the best outcomes require psychosocial therapeutic support in addition to pharmacological treatment tailored to the social and psychological characteristics of the individual at whom treatment is directed (Carroll & Schottenfeld, 1997; IOM, 1997; Lipton & Maranda, 1983; McLellan et al., 1993; O'Brien, 1994; Warner et al., 1997).

Harm minimisation.

Although not a treatment per se, harm minimisation is any program or policy designed to reduce or minimise drug related harm without requiring cessation of drug use (Byrne, 1996; Des Jarlais, Friedman & Ward, 1993; Drucker, 1995; MOH, 1995; Preston, 1999). Although harm minimisation upholds that abstinence is the ideal goal for all those using illegal drugs, it recognises that abstinence is not the only goal and that any efforts taken towards reducing illegal drug use, the health risks associated with such drug use, and the negative social consequences are beneficial to both the drug user and to society as a whole. Harm minimisation, as a program or a policy, holds that the non-medical use of psychoactive drugs is inevitable in any society and that there will always be illicit drug use. This pragmatic view, however, varies widely according to the cultural values and culture of different societies. As such, the focus of harm minimisation programs/interventions is on minimising the risks and harmful consequences associated with illicit drug use without necessarily requiring any reduction in use (Byrne, 1996; Marlatt, 1998; Preston, 1999).

Inherent in a harm minimization approach is the belief that the rights of the drug user be respected with regard to their decision as to whether to use drugs or not without moral judgements or stigmatizing drug users as deviants (Byrne, 1996; Drucker, 1995;

Marlatt, 1998; Preston, 1999). Accordingly, the drug user's decision to use drugs is acknowledged as exercising personal choice for which they are responsible.

A harm minimisation approach recognises individual differences with most harm minimisation strategies involving a prioritisation of immediate and realistic goals which may range from abstinence through to drug substitution and interventions that promote safer modes of use such as needle exchange programs (Drucker, 1995; Marlatt, 1998; Preston, 1999). Additionally, harm minimisation philosophy recognises that drug users are an integral part of any society and that the protection of any society as a whole requires the protection of the health of drug users in terms of minimising the harms associated with drug use. Also recognised in harm minimisation thinking is that some of the harm experienced by drug users comes not from using illicit drugs but from social stigmatisation, marginalization, and legal repression, all of which make it more difficult for this group of people to change their drug using behaviours (Byrne, 1996; Des Jarlais, 1995; Marlatt, 1998). As such, harm minimisation presents an alternative as well as a challenge to the beliefs and principles of the more traditional approaches to drug dependence such as the disease model or abstinence models (Byrne, 1996; Des Jarlais, Friedman & Ward, 1993). In terms of evaluation, harm minimisation programs and policies need to closely identify what "harms" are being addressed and have definite tasks and goals such as a reduction in the transmission of HIV associated with illicit drug use, the provision of adequate treatment for persons with psychoactive drug use problems or reducing the marginalization of drug users (Byrne, 1996; Des Jarlais, 1995; Marlatt, 1998; Preston, 1999).

As an approach to minimising the harm incurred by people who use drugs in a problematic manner, harm minimisation has a long history worldwide. In the United Kingdom in the 1920's as an outcome of the Rolleston Committee Report (Preston, 1999; Stimson & Oppenheimer, 1982) heroin and morphine were provided to addicts who were unable to stop taking drugs as a means of helping them to lead more useful lives. The development of methadone maintenance treatment (MMT) (Dole & Nyswander, 1985) then led to a move away from the prescribing of injectable heroin towards prescribing oral methadone on the basis that it was more therapeutic to prescribe a non-injectable drug that was administered less (Preston, 1999). Although

perpetuating the individual's need for narcotics, MMT was considered a treatment that minimised the individual and social harms associated with heroin addiction (Dole & Nyswander, 1985) and is today considered the best harm minimisation approach (Byrne, 1996; Marlatt, 1998; Preston, 1999).

In the 1960's, MMT, as a harm minimisation approach spread worldwide in response to an epidemic increase of illicit drug use. In Europe, particularly in Amsterdam, "low threshold" methadone maintenance was incorporated into harm minimisation philosophy on the basis that it led to substantial reductions in illicit drug use, associated crime, and health and social problems (Marlatt & Tappert, 1993). In North America, MMT programs for injecting drug users were seen as harm reduction for society usually in terms of reducing crime or returning drug users to the work force (Marlatt & Tappert, 1993). MMT was first used in the USA in the early 1960's as a means of reducing illicit drug use and other problems associated with drug use. In New Zealand, methadone was first used in the treatment of drug dependence in the early 1970's, the main rationale being a reduction in chronic illicit drug use and limiting criminal activity (Preston, 1999). Further harm minimisation strategies were developed in New Zealand and Australia to the hepatitis C and HIV epidemic in the 1980's when it was understood that both hepatitis C and HIV were transmitted through contaminated syringes (Preston, 1999). These were in the form of needle exchange programs such as the program through which the participants in this study were recruited. Such programs also offer safer injection education, safer sex education, education about how to reduce drug related harm as well as providing clean injection equipment (Preston, 1999).

Essentially, harm minimisation is an empirically based approach toward minimising drug-related harm at both a micro and macro level (Byrne, 1996; Preston, 1999). Although controversial and commonly misperceived as encouraging not only illegal drug use but also violation of the law, harm minimisation programs and policies approach illicit drug use and drug dependence as health issues rather than moral concerns (Marlatt, 1998; Preston, 1999). As such, harm minimisation does not judge illicit drug use as good or bad, rather, it is concerned with encouraging safer drug using practices, improved health and functioning of drug using individuals, minimising

the harm in the community, and the individual's relationship to drugs. Accordingly, it is an approach that recognises that drug users have the ability to make choices with regard to stopping or changing risky behaviours and the right to represent themselves (Byrne, 1996; Des Jarlais, Friedman & Ward, 1993; Drucker, 1995; Marlatt, 1998).

On the whole, there is enormous variation in both treatment philosophies and approaches and types of treatment available along with considerable variation in the literature with regard to the effectiveness of various types of treatment. Just as treatment philosophies and approaches are influenced by a multitude of factors, so too is successful treatment outcome and subsequent behaviour. These factors include the type of drug used, the characteristics of the individual being treated, the social setting in which the individual lives and uses drugs, clinician/health professional characteristics, client-clinician interaction, the types of therapies provided, length of treatment, treatment matching and aftercare (Battjes, Onken & Delaney, 1999; Hubbard et al., 1989; Luborsky, McLellan, Woody, O'Brien & Auerbach, 1985; Najavits & Weiss, 1994; O'Brien & McLellan, 1996).

Each of the treatment approaches that have been briefly described provides a partial explanation of different aspects of treatment and evidence of efficacy of interventions, however, many studies also demonstrate that not all people with a drug dependence improve with treatment; many relapse after extensive treatment episodes, many do not engage in treatment a sufficient length of time to receive the full benefits of treatment, and many do not enter treatment (Battjes et al., 1999; Cunningham, Sobell, Sobell, Agrawal & Toneatto, 1993; Hubbard et al., 1989; O'Brien & McLellan, 1996; Prochaska et al., 1992). Overall, whether treatment is successful or not, there is general agreement and qualified evidence that treatment is cost effective in that treatment not only leads to a reduction in health care expenditure that is greater than the costs of carrying out the treatment, but it also provides greater benefits to taxpayers than the costs of providing treatment, such as reduced direct social costs and expenditure as a result of crime, reduced social welfare costs and increased direct net benefits to society through employment and demands for services (Anglin, Speckart, Booth & Ryan, 1989; Bushnell, Carter & Howden-Chapman, 1994; French & Martin,

1996; Gerstein & Harwood, 1990; Gerstein & Lewin, 1990; Harwood, Hubbard, Collins & Rachel, 1988; IOM, 1997; Ministry of Health, 1996).

Despite substantial evidence among the literature that drug dependence treatments are not only cost effective but also effective in reducing drug use, reducing criminal activity, and in bringing about improvements in client health and social functioning (Anglin & Hser, 1992; Ball & Ross, 1991; Gerstein & Harwood, 1990; Leshner, 1997; O'Brien & McLellan, 1996), a major shortcoming of much of the treatment research is that it focuses interest on treatment using quantitative research approaches such as structured questionnaires, multivariate inferential statistical techniques, and survey research designs almost to the exclusion of interest in the subjective experiences and identification of their own needs as perceived and described by drug dependent people themselves. Thus, to achieve a clearer understanding of the nature of treatment, to plan more systematically for the future, and to produce clinically and significantly better outcomes from drug dependence treatment, it is necessary to listen to and respond to what drug dependent individuals are trying to tell us about their subjective experiences and the issues that are of concern to them within the context of their everyday world.

Drug dependence in New Zealand

During the last decade, drug dependence in New Zealand has emerged as a national problem resulting in many health, social and economic problems (Ministry of Health, 1995, 1998a, 1998b). Although the prevalence of drug dependence in New Zealand is not well established, research indicates that it is increasing (Field & Casswell, 1999a, 1999b; Ministry of Health, 1998b). According to Health Funding Authority (HFA) statistics (Ministry of Health, 1998b, p.6) 40 to 50,000 people receive publicly funded alcohol and drug assessment and treatment services each year. Approximately 3,200 of these people have an opioid dependence and take part in the methadone program. It has been estimated that around 6-9% of the population in New Zealand meet the clinical criteria for drug dependence (Bushnell, Carter & Howden-Chapman, 1994; Chetwynd, 1997; Wells, Bushnell, Joyce, Oakley-Browne & Hornblow, 1992). However, this figure is debatable as reliable and valid incidence and prevalence data on

drug dependence is often difficult to collect. Given the illegal and often private nature of the drug using activity, drug dependent individuals are often omitted from national surveys and data often comes from secondary sources such as police arrests, community based agencies, justice statistics, and hospital admissions (Arif & Westermeyer, 1988). Also often absent from epidemiological data are the drug dependent individuals who choose not to use formal or lay treatment services or terminate their drug dependence through natural recovery (Granfield & Cloud, 1996). Contributing as well to the obstacles in collecting data from a hidden population is the problem in defining drug dependence and the lack of clarity, subjectivity, diverse views, confusion, and controversy present in the drug dependence field (Arif & Westermeyer, 1988; Lambert, 1990).

Rates of prevalence and incidence of drug dependence in New Zealand have been found to vary with drug type, ethnicity, gender, age, education, incarceration, geography, and employment (APA, 1994; Bushnell et al, 1994; Chetwynd, 1997; Field & Casswell, 1999a, 1999b; Ministry of Health, 1995, 1998a, 1998b; Sellman, Hannifin, Deering & Borren, 1996; Wells, Bushnell, Hornblow, Joyce & Oakley-Browne, 1989). In general, higher proportions of males than females are drug dependent and drug dependence is more common in the younger age groups than the older, however, dependence can occur at any age (Bushnell et al, 1994; Chetwynd, 1997; Field & Casswell, 1999a, 1999b; Ministry of Health, 1998a, 1998b; Sellman et al, 1996). Drug dependence is highest in larger urban areas compared with rural areas, however, there are regional and urban differences in drug dependence according to the drug type and patterns of drug use, for example, cannabis dependence is higher in the far North and on the East Coast whereas opiate dependence is higher in the large cities (Bushnell et al, 1994; Chetwynd, 1997; Field & Casswell, 1999a, 1999b; Ministry of Health, 1998a, 1998b; Sellman et al, 1996).

In New Zealand approximately 14.5% of the population is Maori, and 5.6% Polynesian. Compared with research on non Maori in New Zealand, there has been a lack of comprehensive epidemiological research of the health status of Maori (Sellman et al, 1997). Although some data is available from hospital admission and discharge statistics, it is recognised that the reliability of those data is questionable because of

inconsistencies in ascertaining and recording ethnicity and the incompleteness of data collection systems among other methodological problems (Chetwynd, 1997; Ministry of Health, 1998b; Sellman, Huriwai, Ram & Deering, 1997). According to hospital admission statistics, there are higher rates of admission for drug dependence for Maori than non Maori. Between 1989 and 1993 Maori were over represented making up almost one quarter of admissions (22%) to psychiatric hospitals for drug dependence. In contrast, Polynesians were under represented totalling just over 2% of admissions (Bushnell et al, 1994; Chetwynd, 1997; Huriwai, 1997; Ministry of Health, 1998a, 1998b; Pomare, Keefe-Omsby, Pearce, Reid, Robson & Watene Haydon, 1995; Sellman et al, 1996; Sellman et al, 1997).

Although hospital admission rates are high for Maori, especially Maori men (Ministry of Health, 1998b), data are incomplete (Ministry of Health, 1997) and do not describe the whole story with regard to drug dependence. In recent years measures have been taken to implement a new mental health data collection system (Ministry of Health, 1998b) along with initiatives to develop Maori drug and alcohol services which are more culturally appropriate and acceptable and more competent and effective with the underlying assumption that Maori will benefit from treatment which is based on their world view, cultural identity and cultural heritage more so than mainstream treatment programs which do not always address the needs of Maori (Huriwai, 1997; Pomare, 1986; Sellman et al, 1997). Although such initiatives offer both the possibility of development of dedicated Maori alcohol and drug services run by Maori for Maori using Maori health perspectives, and the potential for an integrated approach to drug dependence with spiritual, mental, physical, and family dimensions based on Whanau (family) and Iwi (tribe) obligations rather than Western trained health professionals and providers (Durie, 1994), there are some problems. Among these is the lack of a Maori workforce with the required skills and expertise for both research and clinical services and, for those Maori health professionals who have the skills and expertise, the demands on them as Maori (Durie, 1994; Huriwai, 1997; Sellman et al, 1997). In this study four participants self identified as Maori (16%). Two other participants defined themselves as Maori by descent but chose to identify as European (pakeha).

Costs associated with drug dependence

From an economic and social perspective drug dependence is costly, however, the true fiscal cost is difficult to estimate, particularly estimations of the cost of illicit drug use and dependence. Although the estimated economic costs and social costs of drug dependence have been documented in other countries (French & Martin, 1996; Healey, Knapp, Astin, Gossop, Marsden, Stewart, Lehman & Godfrey, 1998; IOM, 1997) there is a paucity of data relevant to New Zealand. Considered in the economic cost to society are the direct medical care expenditures for treatment of individuals experiencing the adverse health effects of drug dependence (perinatal care, professional services, in and out-patient treatment, drug associated diseases), the indirect costs associated with morbidity (loss of earnings, lost productivity) and mortality. There are also other related costs such as those associated with the social welfare system (benefits, research, intervention and prevention programs, education, training, and child care) and the costs associated with crime including prostitution, burglary, shoplifting, incarceration, crime career costs, and criminal justice costs (French & Martin, 1996; Healey et al, 1998; IOM, 1997).

According to a 1996 survey of opioid dependent individuals in Christchurch (Adamson, 1996), over \$1,000 a week was generated by each individual from various types of criminal activity in order to sustain their dependence on opioid drugs. In their paper on opioid dependants in New Zealand, Sellman et al. (1996, p.73) estimated the yield from crime by untreated opioid dependants to be in the range of \$2 - \$7 million per week. In comparing the costs of drug dependence with the costs of other disorders and diseases the IOM (1997, p.28) found the total cost to society of drug dependence to be higher than the costs of other highly prevalent and costly disorders and diseases such as diabetes, mental disorders, cancer, AIDS, and heart disease.

Drug dependence treatment services

In New Zealand, the majority of drug dependence treatment services are funded by the government through the Health Funding Authority (HFA). During 1997/1998

approximately \$40 million was spent on drug and alcohol treatment services (Ministry of Health, 1998b). The HFA is required to purchase treatment services for people diagnosed as abusing or dependant on psychoactive drugs. Included in these treatment services are both general drug services (health promotion, prevention and harm reduction strategies, intervention, assessment, treatment and rehabilitation services) and special needs drug services which include detoxification, methadone maintenance, residential treatment and rehabilitation services, and dual diagnosis services (HFA, 1998). Drug dependence treatment services are purchased from a variety of providers or agencies. These agencies are either operated by the publicly owned Hospital and Health services (HHS), or privately owned initiatives and national and charitable trusts (Department of Health, 1992). The HHS's, funded by the HFA, are the main providers of drug dependence treatment services in New Zealand, predominately through outpatient units. Included in their services are assessment, individual counselling and group work, referral to in-patient/residential programs, detoxification, case management for people with coexisting drug use and mental health disorders, and methadone maintenance. The non-Government organisations are the main providers of in-patient residential drug dependence treatment in New Zealand. They also offer a range of outpatient services. These trusts and privately owned initiatives are funded through a variety of sources including the HFA, donations and grants, user pays, Work & Income New Zealand (WINZ), Department of Justice, Alcohol Advisory Council of New Zealand (ALAC), and local body funding (Bushnell et al, 1994; Ministry of Health. 1995).

Review and summary

In this chapter, discussion has focused on various aspects of the historical background to the study, the importance of which has been outlined in the previous chapter. Over the past century a copious historical progression of definitions, theories and models of drug dependence have evolved, each of which forms an often underlying background of biases in professional practice, decision making, and service provision, as well as influencing the attitudes and behaviours of both health professionals and lay people toward drug dependent individuals. After delineation of explanatory concepts and definitions, an outline of the main theoretical models was presented. A brief discussion

as to some of the implications of each model or theory for clinical practice was included. Following an explanation of the diagnosis of drug dependence was an overview of the main treatments commonly used for drug dependence including harm minimisation and their effectiveness. In the lives of many individuals who are drug dependent, drug dependence treatment is a recurrent phenomenon and as such forms an integral part of the background understanding of the experience of drug dependence. A description of the contemporary New Zealand drug dependence situation including prevalence and incidence, costs, and the provision of services for drug dependence then followed. In the next chapter, the research and literature pertaining to the subjective experience of drug dependence is presented. Such research and literature also form important background to this study.

Chapter III

THE LIVED EXPERIENCE OF DRUG DEPENDENCE

The focus of this study is the subjective experience of drug dependence as described by drug dependent individuals living in the community. Accordingly, this chapter focuses on research and literature concerning the experience of drug dependence from the perspective of those who have lived it, thus further forming important background to the study.

As a result of the predomination of quantitative approaches in drug dependence research there is a paucity of literature and research which relates to the subjective experiences of those who live with a drug dependence. However, a review of the drug dependence literature over the last 50 years has revealed that there are a number of studies that have investigated the subjective experience of drug dependence, many of which have used ethnographic field research and participant observation methods, a few which have used grounded theory and focus groups, and several which have used a mixed quantitative and qualitative approach. Also found in the scientific and popular literature were a number of autobiographical or fictional accounts documenting the author's own personal experiences of drug dependence. Little evidence was found of similar studies addressing the subjective experience of drug dependence from a phenomenological orientation, yet one of the primary values attributed to phenomenology is its ability to help researchers, clinicians, and other health professionals have an empathic grasp of what the individual experiences and to understand the individual's perception of the phenomenon under investigation in a more holistic way.

Qualitative approaches to the subjective experience of drug dependence

Of the research studies reviewed investigating the experience of drug dependence, a variety of approaches have been used, including ethnography, grounded theory, phenomenology, and focus groups. Of the qualitative approaches the majority are

ethnographic which have investigated drug use/ abuse and dependence in natural settings using methods of intensive participant observation in the field and interviews to gather data, usually with a focus on a particular drug, a particular user community, or a particular aspect of the drug use/ abuse/dependence experience. Of these studies, the largest number address heroin use or some aspect of heroin use/abuse/dependence (Agar, 1973; Biernacki, 1979; Feldman, 1968; Hanson, Beschner, Walters & Bovel, 1985; Rosenbaum, 1981a, 1981b; Stephens & McBride, 1976; Lindesmith, 1947; Stephens, 1991; Sutter, 1966; Weppner, 1973; Waldorf, 1973; Preble & Casey, 1969; Sutter, 1966; Finestone, 1957; Gould, Walker, Crane & Lidz, 1974) whilst others focus on other drugs or related aspects such as drug dealing (Adler, 1985; Mieczkowski, 1986; Murphy, Waldorf & Reinerman, 1990), PCP (Feldman, Agar & Bescher, 1979; Jacobs & Miller, 1998; Tunnell, 1993), crack-cocaine (Williams, 1989; Bourgois, 1989; Waldorf, Murphy, Reinerman & Joyce, 1977), hustling (Lex, 1990; Fields & Walters, 1985), women addicts (Rosenbaum, 1983; Fraser, 1997; Rosenbaum & Murphy, 1984, 1987; Friedman & Alicea, 1995; James, 1972), pregnancy and addiction (Cloud & Granfield, 1994; Kearney, Murphy, Irwin & Rosenbaum, 1995; Rosenbaum & Murphy, 1991), recovery (Kearney, 1996, 1998; Banonis, 1989; Hutchinson, 1987), needle sharing (Grund, Kaplan & Adriaans, 1991), speed (Carey & Mandel, 1968), utilization of human services (Ashery, Carlson, Falck & Siegal, 1995), sexual behaviour (Macdonald, Waldorf, Reinerman & Murphy, 1988; Ratner, 1993), criminal behaviour (Faupel, 1987; Tonry & Wilson, 1990; Anglin & Hser, 1987), and methadone (Agar, 1977; Agar & Stephens, 1975; Preble & Miller, 1977).

The first study to investigate the subjective experience of drug dependence was conducted by Lindesmith (1947). Using intensive field observation and interviews in a natural setting, Lindesmith interviewed 62 opiate addicts over a two-year period about the processes of addiction. From his study Lindesmith concluded that addiction is a gradual process that occurs after people take opiates to forestall withdrawal symptoms after cognitively associating the use of opiates with the relief of withdrawal symptoms. Although focusing only on heroin users, Lindesmith's study contributed significantly to the understanding of the psychology of drug dependence, and the role of

reinforcement, cravings, personality, and classic conditioning in the development of drug dependence

The next ethnographic study of drug users was conducted by Becker (1953) who found, observed, and interviewed 50 musicians who used marihuana about “the sequence of changes in attitude and experience which led to [their] *use of marihuana for pleasure*” (p235). Unlike the prevalent view of that era in which marihuana users were viewed as drug fiends, Becker described the users and the experience of smoking marihuana less melodramatically, suggesting that an individual had to learn how to recognise the effects of marihuana and connect them with the drug use before they could smoke it for pleasure.

In another classical ethnographic study, Finestone (1957) discussed “what ‘manner of man’ is represented by the current species of young drug addict” (p3). In his study Finestone interviewed over 50 black male heroin users and concluded that the *cat* (a social type), in contrast to the *square*, tended to become an addict, through the greater value they attributed to *kicks* and the *hustle*, values congruent with the lifestyle of the addict. Although Finestone’s study attempts a description of the addicts’ value system from their own perspective and formed the basis of a theory of addiction (Cloward & Ohlin, 1960) in which heroin users were viewed as “double failures” who withdrew from life into heroin use, the study is narrowly focused on one ethnic group, the black ghetto life, the subculture of “cats” as a distinct addict world, and consequently does not portray a generalisable description of drug users and their subculture other than amongst black people.

Following these early ethnographers were Preble and Casey (1969), Sutter (1966), and Feldman (1968), each of whom challenged the existing predominant theories and views that portrayed street heroin addicts as retreatists, failures, or escapists with pathological traits, and concluded that heroin use comprised an everyday challenge that involved risk taking and daring, and that heroin addicts were involved in meaningful tasks and relationships in their daily lives.

In order to understand the culture of addiction from the insider's viewpoint, Sutter (1966) studied over 40 heroin users and over 100 adolescents involved in a world of non opiate drugs in either their own setting or in jail. Sutter published his findings under the title *The world of the righteous dope fiend*, in which he reviewed and critically evaluated some of the research and prevalent stereotypes ascribed to the addict role, as well as describing the different types and statuses of drug users and certain addictive behaviours. In his study he identified the "righteous dope fiend" as one who prefers heroin and who ranks himself above people who use other drugs. Status in the drug world was assigned according to success as a hustler and size of heroin habit. As an introduction to the content of the addict subculture, Sutter's anecdotal data provides invaluable insights into drug culture membership, the lifestyle and attitudes of drug users, and their associations.

After working with and observing young heroin addicts in a slum New York neighbourhood for almost 5 years, Feldman (1968) wrote *Ideological supports to becoming and remaining a heroin addict* in which he examined the social basis of and the role of ideology in heroin addiction. In his paper Feldman described how the heroin user, the *stand up cat*, acquired a new ideology as his heroin use changed and of how heroin was used to gain status and prestige and not to escape or retreat from problems and everyday life. Feldman's concepts and ideas challenged the existing medical view which emphasised pathology as the basis of heroin use through presenting a realistic account of heroin use from the users' perspective.

In a later study investigating status and drug use Feldman (1973) gave further support to the theory that drug use was an important activity in obtaining and enhancing a street reputation rather than a retreat from everyday life. In his study, Feldman described how the heroin use was a way of attributing status among street youths in that status was mainly a function of the amount of risk involved in an activity and heroin use had a high risk. The youths also conferred status upon themselves through a ranking system in which crazy and tough guys had the highest rank and jerks and faggots the lowest, with heroin use being denied to those of low rank.

Also challenging the then predominant narrow stereotypical view of heroin users as social and psychological failures was Preble and Casey's (1969) analysis of the lifestyle of 150 heroin users in the context of their street environment. In their report, Preble and Casey described how heroin use provided heroin users with the motivation and rationale for a meaningful life. The heroin user was likened to a businessman both relentlessly acquiring money and meeting challenges. The heroin users were not escapists from life, rather, they were engaged in meaningful activities and relationships, aggressively pursuing their heroin careers to the extent that the activities and relationships necessary to obtain heroin appeared to be of greater importance to the heroin user than the effect of the heroin itself. The findings from Preble and Casey's study of heroin users in their natural surroundings helped changed the focus of future research from the earlier theorists' emphasis on the pathological traits of heroin users to a more holistic approach in which the social and cultural context of drug use from the drug user's perspective was emphasised.

Up until James's (1976) study on prostitutes, addiction and criminality and Rosenbaum's (1981a, 1981b) ethnography of women heroin addicts, women were largely omitted from studies which investigated the lived experience of drug dependence. In the early ethnographic studies (Lindesmith, 1947; Becker, 1953; Finestone, 1957; Sutter, 1966; Feldman, 1968; Preble & Casey, 1969) little or no reference was made to women addicts and their experiences although the lifestyle conceptualised in these studies was equally applicable to the female addict (James, 1976). Although there now exists an extensive literature on women and drug dependence, the majority of studies to date are quantitative approaches centred around pregnancy, childbirth, and parenting (Rosenbaum, 1981a, 1981b), with only a few research studies focusing on women's lived experiences of drug dependence.

The first major study attempting to describe the subjective experience of women with a drug dependence was conducted by Rosenbaum (1981b) who looked at how the world of the female heroin addict differed from that experienced by male heroin addicts. Rosenbaum described the gender specific differences through the themes of risk, chaos, and inundation, and how they contributed to an inability of the women to "take

care of business". For the women addicts, it was this inability to take care of business that provided the impetus to break away from the heroin world.

Another ethnographic study focusing on women drug users was conducted by Taylor (1993a) who set out to describe the lives and experiences of female intravenous drug users. Using the concept of "career" which allows drug use to be viewed non judgementally as a process, Taylor found that women drug users resembled their male counterparts as active, resourceful people who responded rationally to their social circumstances as opposed to the long standing stereotypical picture of women drug users as pathetic, inadequate individuals. Like men, the women's drug use career provided them with the motivation, status, and purpose otherwise lacking in their lives despite the disadvantage of a drug dependent lifestyle. For the women in Taylor's study, "being a drug user entailed a busy, full life" (p.150) with structure unlike the women in Rosenbaum's (1981b) study who experienced a life characterised by chaos. Taylor's findings offer many insights into the social and cultural aspects of the female drug user's world.

Armstrong (1992) reported a retrospective phenomenological study that explored women's experiences of being addicted and pregnant. The research involved interviews with 11 women who were participating in a recovery program. For the women, being pregnant was a transformational experience that occurred within an isolative lifestyle characterised by mistrust of others, risk taking, deception, and self depreciation. The use of drugs whilst pregnant provoked feelings of guilt and self-hatred whilst paradoxically relieving loneliness and negative feelings. As little is known about drug dependent women's perspectives on their pregnancy, Armstrong's study adds a valuable contribution to the literature.

To explore and understand women's experiences of recovering from drug dependence, Banonis (1989) chose a phenomenological method in which she identified women's recovery as a process of change, of becoming, and of healing, in which previous patterns of living are changed and new patterns co-created in the inter relationship between person and environment. In her findings, the phenomenon, recovery from addiction, emerged as "a lived experience of struggling to pull self out of a well of

darkness into the comfort of light” (p.42). For Banonis, the struggle of pulling self out of the darkness is initiated through self-awareness, connectedness with others, acceptance and readiness to change. The findings of this study and other qualitative studies of women’s recovery from addiction (Hutchinson, 1987; Cloud & Granfield, 1994; Kearney, Murphy, Irwin & Rosenbaum, 1986; Kearney, 1996, 1998) not only reflect the importance of self insight as a catalyst in the process of recovery from addiction but also emphasise the value of first hand experiential information in understanding the psychological and social processes of addiction and recovery.

As evidenced by the available reviewed studies, there exists an extensive drug dependence literature, however, much of the research as previously mentioned has concentrated on one aspect of the drug dependence experience, some of the main topic areas being low income male heroin users, women’s experiences in recovery from drug dependence, and heroin in addicted pregnant and parenting women. Although each of the summarised investigations contribute to our knowledge and understanding of drug dependence, and provide valuable insights into the lives of illicit drug users, none of the studies focus on a comprehensive view of drug dependence as perceived by the drug dependent person or fully explore the phenomenon of drug dependence. Because of the fact that many of the studies focus on a particular aspect of the drug use/abuse/dependence experience and in-depth phenomenological approaches are under utilised, a wealth of experiential knowledge lies uncovered. What the findings of the studies reviewed do bring to light is the need to understand the inner experience of people who are drug dependent within the context of their everyday worlds and in terms of the meanings associated with their experiences.

Autobiographical accounts of drug dependence

In the literature there are many first person accounts which focus mainly on the writers’ own lived experiences of drug dependence - the passage into drug dependence, the settings of their experiences, the ecstasies and the ordeals of a drug dependent life, and their journey out of it. Among this literature are the writings of both males and females from a variety of backgrounds and professions: prostitute, poet, physician, professional writer, social reformer, criminal, teacher, actress, actor.

Although some of this literature emphasises the euphoria, the seduction, the adventurousness, the excitement, and the rebelliousness of being caught up in a different way of being, much of it also contains elucidations of depression, self loathing, loneliness, loss of control, psychic pain, feelings of despair, and a feeling that their humanbeingness is not recognised, that they rarely have a voice. These personal accounts offer the most direct means by which researchers, clinicians, health professionals, and other outsiders can come to understand the lived experience of drug dependence, an understanding from which policies and practices concerning drug use and drug dependence can be shaped, and from which a foundation for ongoing communication with those who are drug dependent can be built upon.

In *The Fantastic Lodge: the autobiography of a drug addict* (Hughes, 1961), the singer Janet Clark (a pseudonym) renders an intelligent and insightful firsthand account of her journey into heroin dependence, the vicissitudes of “the life”, and of her harrowing experiences in a treatment centre. Heroin, for Clark, made everything possible, everything good: “one of the biggest effects of horse is that you simply do not worry about things you worried about before. You look at them in a different way. You still think about them. I mean horse is a thinking op. You know, making all things possible and changing the entire outlook on all your problems. Everything is always cool, everything is all right.” (p.212). Although she became violently ill after each heroin use for the first six months, the body sensations, “the flash”, and “the feeling as though something good and easy and fine has happened” (p211) kept pulling her back to using. Clark details explicitly the conditions under which she tried to kick her drug habit at the controversial treatment centre in Lexington, “the bareness, and the bars at the window, the misery in everyone’s’ face” (p214), the prolonged withdrawal treatment consisting of watered down shots of opiates, and nothing to do except tell one another stories about junk. For Clark, the pull of heroin was too powerful and she left Lexington to return to her drug use, her relapse accompanied by feelings of despair, self-loathing and the need to anaesthetise herself from unhappiness. Clark’s articulate account of her addiction was self-therapy whilst trying to overcome her drug dependence but she died of a barbiturate overdose before it was published.

In his autobiography *Junkie*, William Burroughs (1969) gives a descriptive account of why he became addicted: “You become a narcotics addict because you do not have strong enough motivation in any other direction. Junk wins by default.” (p.11). Burroughs’ journey into addiction was a lengthy process, over six months and several hundred injections to get his first habit. For Burroughs, heroin became his life, gave meaning to his life, every thing in life was depicted through his need for heroin: “Junk is not a kick. It is a way of life.”(p.11), and the loss of that life when coming off, “When you give up junk, you give up a way of life” (p125). Descriptively written from an insider’s perspective, Burroughs’ account offers many insights into dependence behaviour, insights ranging from how dependence occurs to the unwritten rules of the addict culture, all of which have often been ignored by researchers and health professionals who seek explanations of drug dependence in theories of personality disorders or a dysfunctional family life. Rather than ask what sort of people become drug dependent, Burroughs suggests asking, “Why did you ever try narcotics? Why did you continue using it long enough to become an addict?” (p. 11).

Thomas de Quincey, in his narrative *Confessions of an English Opium Eater* (1978) describes his early use of opium as an anodyne, only later to be seduced by its subtle powers. Torn between both the pleasures and the pains of opium, de Quincey’s opium use spanned more than half a century. In this period he managed to wean himself “from the deep bondage of opium” (p299) only for four short periods of time. For de Quincey, addiction as a long process, after eight years of intermittent use, he “became a regular and confirmed opium-eater” (p269) taking opium daily. First published in 1821, de Quincey’s insightful and literate account of his addiction illustrates not only the qualities that make the use of opium attractive but also details the agonies and miseries of opium use. The moral of de Quincey’s narrative as directed at the opium eater “and therefore, of necessity, limited in its application. If he is taught to fear and tremble, enough has been effected” (p337).

In her memoir *The lonely trip back*, Florrie Fisher (1971) wrote a personal account of her 20-year career as a hard-core heroin addict. Progressing from “innocent, non addictive Mary Jane (marijuana)” to the “hard stuff” (p189), Fisher portrays her total addiction in a frighteningly realistic way, from becoming “so dreamy, so detached”

(p73) that nothing really mattered to her any more to becoming so desperate for a shot that she would use toilet water to prepare her fix, “I’d flush the toilet, reach in, pull the swirling water up from the commode into my syringe and put it into the spoon. Then I’d rationalise, “I’m heating the spoon. That must be killing the germs”, and I’d jam that needle, stool water and all, into my vein.” (p112). Fisher likened using heroin to a giant taking hold of her, grabbing her, lifting her higher and higher, kissing her, “the giant’s just kissed you and you feel as though the insides have been kicked out of all your problems” (p118), until the euphoria wore off and withdrawals began which she likened to the giant attacking and squeezing the last drop out of her, “you keep yawning and your eyes begin to tear, your nose starts dripping. Then you get sweaty.....you start itching. Your head starts thumping....if you don’t take a fix soon, you’re vomiting. You throw up and throw up...” (p119). It was “feeding that giant, keeping that big bastard happy and mellow” (p119) that cost so much. To support her habit Fisher turned to prostitution and crime, activities that led her to spending a significant part of her life in prison. Eventually she kicked her habit and became an anti-drug advocate lecturing young people about the dangers of drugs.

The biography *Piaf*, written by Simone Berteaut (1969), chronicles the life of her half sister Edith Piaf, a mainline addict for the last fifteen years of her life. Piaf became iatrogenically dependent on morphine, initially prescribed after a car accident to cope with the pain, and despite several attempts at kicking her habit, was not successful for long. In describing her habit, Piaf told her sister, “Being hooked on drugs is like being at a carnival in hell, with carousels and slides. You go up, you plunge down again, up again, down again. Everything is alike, it’s always the same; monotonous, grey, dirty. But you don’t notice it, you just go on. When the needle dug into my flesh I gasped, not with pleasure, but with relief. It comes quickly, as soon as you do it, not because it makes you feel good, but because you don’t hurt any more. But the more you take, the more you suffer; then you have to take more still to suffer less.” (pp.350-351).

In the extracts quoted, the writers’ meaningfully express their feelings about their experiences, extolling the pleasures of drugs whilst experiencing the pain of addiction, their everyday being dominated by their need and desire for drugs for a variety of different reasons, the drugs producing a euphoria so great that everything else is

irrelevant. It is clear from the accounts of those who have written or told of their drug dependence experiences that they have much they want to tell, far more than can be found in journal articles or official reports, and by doing so, offer much in increasing our understanding of drug dependence, drugs, the circumstances and consequences of their use, and the successes and failures of treatment. In presenting their stories candidly through autobiographies or memoirs, the writers were, in many cases, also actively contributing to their own rehabilitation.

As revealed from the studies and autobiographies described, being drug dependent is a series of experiences that profoundly affect the person who is drug dependent and those who share the experiences. For the drug dependent person, life in the community can be arduous. Not only must the drug dependent person cope with the every day hassles resulting from their drug use but also the present public policies with regard to illicit drug use, the professional and lay attitudes and reactions to illicit drug use and drug users in conventional life, and an altered cognisance of who they are in the world. People who are drug dependent often have much insight into the nature of their drug dependency, and many are able to function successfully in the community through building up a way of life around the use of their drugs which provides them with meaning and structure, yet they are seldom asked what is of importance to them or what their viewpoint is by those wanting to better understand the realities of their drug dependent lives and everyday experiences within the context of their worlds.

Currently, most of the qualitative drug dependence literature comes from the United States and although it is apparent that the subjective experiences of drug dependence have been well researched, no evidence of qualitative research which attempts to gain an understanding of the experiences of drug dependence from the perspective of those who are drug dependent and living in the New Zealand community was found. Thus, the overall goal of this study was to begin to address this gap in the literature. To gain a deeper understanding of the phenomenon of drug dependence as it is experienced in the daily lives of a heterogeneous community sample of adult drug dependent New Zealanders, a Heideggerian phenomenological approach was used.

Review and summary

The focus in this chapter has been on a review and discussion of the literature relating to the subjective experience of drug dependence. While many studies have provided us with knowledge and understanding of selected aspects of the subjective experience of drug dependence, personal accounts by people who have themselves experienced drug dependence suggest that their experiences are not always well understood by others. Those who live with drug dependence confront many unique challenges in our society, more than just those related to the lived experience of drug dependence. Encompassing practically every aspect of their lives are the biopsychosocial forces operating to pressure these people toward both using drugs and toward giving up drugs, the many diverse attitudes, values and reactions shared by the professional and lay communities about the drug user and drug use, the social stigma of being an illicit drug user, and the long term effects of drug dependence.

Although an extensive body of literature is available on particular aspects of the subjective experience of drug dependence, no studies specifically exploring the phenomenon of drug dependence and the everyday lives of drug dependent people in their community were found. Thus, there is noticeably a need for more research to be undertaken in this area, particularly of a phenomenological nature. Discussed in the next chapter is the appropriateness of a phenomenological approach to this study and the method used in conducting this research.

Chapter IV

METHODOLOGY AND RESEARCH DESIGN

The purpose of this chapter is to discuss the use of the qualitative method of Heideggerian hermeneutical phenomenology as the method of inquiry into the lived experience of drug dependence and to explain the procedures by which this study was carried out. Following a discussion on Heidegger's hermeneutical phenomenology is a description of specific research strategies and an introduction to the study participants.

Heidegger's Hermeneutics

For Heidegger (1927/1962) an understanding of everyday experience, of Being-in-the-world, is obtained through the process of hermeneutics, or interpretation. In Heidegger's view, understanding and interpretation constitute our foundational mode of existing. To exist is to find meaning, and because we exist hermeneutically, hermeneutics can be applied to our understanding of life and its everyday experiences. To Heidegger, hermeneutics embraces an undertaking to uncover and explicate lived experience as it is experienced in everyday life in a way that is as free as possible from prior theoretical assumptions. It is in making it explicit through explication that something is interpreted. Through the use of a hermeneutic approach to understanding human experience, the experience is regarded as though it has a semantic or textual structure (Ricoeur, 1981) in that the language used to describe the experience becomes the data that the method works upon during the analysis.

Hermeneutics was originally a method used by ancient Greek scholars for interpreting texts. These texts, usually of a religious nature, were examined by the scholars who would uncover and reconstitute the messages, from the Gods, that were believed to be hidden in the texts, for the good of the common people. Over time, hermeneutics became less restricted to the interpretation of religious works and more generalised as a method of textual interpretation in such domains as the law, linguistics, literature, and philosophy (Palmer, 1969). In the domain of philosophy, Husserl (1913/1931)

further generalised hermeneutics as a phenomenological method of examining, describing, and understanding meaningful human phenomena. Heidegger (1927/1962) further extended the method of hermeneutics for his analysis of Being-in-the-world, for understanding being. *“In interpretation, understanding does not become something different. It becomes itself. Such interpretation is grounded existentially in understanding; the latter does not arise from the former. Nor is interpretation the acquiring of information about what is understood, it is rather the working-out of possibilities projected in understanding”* (Heidegger, 1927/1962, p.148).

According to Heidegger (1927/1962) it is in the seeing of something and the interpreting of it *as something* that we understand it as anything at all, what it is for or what it means. “The ‘as’ makes up the structure of the explicitness of something that is understood. It constitutes the interpretation” (p.149). In interpreting something as something, Heidegger uses examples of practical objects and activities, such as seeing something as a hammer and hammering, to illustrate how understanding and meaningfulness are behind every interpretation. For Heidegger, the forestructure of understanding is in the background of every interpretation. Occurring on three levels, the forestructure is a circular structure, consisting of fore-having (*Vorhabe*), *something we have in advance*, a background grasp of the “totality of involvements which is already understood” (Heidegger, 1927/1962, p.150); fore-sight (*Vorsicht*), *something we see in advance*, where something is seen in its connection with something else, the appropriate way in which things can appear, the ‘as’; and fore-conception (*Vorgriff*), *something we grasp in advance*, the anticipated meaning already understood, the appropriate way to interpret something.

Within this forestructure of understanding all three levels are in operation simultaneously in any given act of interpretation. As Heidegger (1927/1962) explains, “Any interpretation which is to contribute to understanding, must have already understood what it is to be interpreted” (p.153). The interpretation, thus, always occurs against a background of previous understanding, within which the situatedness of the interpreter in the world, the background of historical, cultural, and temporal practices that are present, preconceptions and assumptions, are embedded. Pre-understanding is not something that can be bracketed, it is already with us in the world.

Unlike Husserl's phenomenological method, within which the researcher sets aside or brackets their own values, views, knowledge and preconceptions about the phenomena under investigation, Heidegger asserts that one's previous understanding is always brought to the interpretation of phenomena or experience. Interpretation is contingent on previous understanding and understanding is contingent on interpretation. This circular structure, within which all interpretation takes place against a background of previous understanding, characterises Heidegger's hermeneutic circle, a metaphor used to explain the dynamic movement between part and whole during the interpretative process. Within the circle, the interpretation of an experience or phenomena under investigation moves temporally backward and forward, beginning from the present. Encompassed within the interpretation is the interpreter's complete forestructure of understanding, an understanding co-constituted through pre-understanding and presuppositions shaped by their cultural, historical and social background.

Through moving back and forth between a complete interpretation and an interpretation of significant parts of the experience or phenomenon, the interpreter arrives at "the things themselves" (Heidegger, 1927/1962, p.154) which are then explicated in a different way so that they may be understood more clearly. By way of this circular process of interpretation a deeper understanding of truth is sought, not absolute truth as defined by the positivistic sciences or the Husserlian notions of reduction and intentionality but a tentative truth in which the meaning of the experience or the phenomenon of concern is not concealed, rather it is brought to the light and made intelligible.

Heidegger's notion of truth is a disclosure of Being, an un-hiddenness, an unconcealment (a-letheia) which happens when concealments are uncovered and when things come out into the openness. It is a discovery of what we know, a discovery of Being qua Being (Soloman, 1972). For Heidegger (1927/1962), "*There is truth only in so far as Dasein is and so long as Dasein is*. Entities are uncovered only *when Dasein is*; and only as long as *Dasein is*, are they disclosed" (p.227). To illustrate his notion of truth, Heidegger uses the example of Newton's laws of planetary motion. Until their discovery, the laws were not true, or for that matter false. Although the laws existed prior to their discovery, they were hidden, concealed, until Newton

uncovered them. The laws remain true only in so far as human beings exist, in that when there is no longer any human being to know of their existence, the laws will no longer be true (Kaelin, 1987).

Truth is how things are, and no account of truth can remain veritable for all time given the nature of existence. Through truth, understanding and knowledge is sought, not explanation. In seeking the truth, one does not ascend to a transcendent ground, rather one acknowledges their own background against which the phenomena appear and take shape. In this way, truth is relative to the being of human beings, it is grounded in existence, in Dasein. Things are true when their being has been uncovered, when they are allowed to be shown as they are. For Heidegger, truth is something that is concealed and must be uncovered. Truth does not just present itself as it is, it is disguised, hidden, and must be “wrested” (Heidegger, 1927/1962, p.225) from within its concealedness. This wresting of the truth, the uncovering of that which has been concealed, the showing of things as they are, is, according to Heidegger, undertaken through phenomenology, a methodology in which phenomena are uncovered, brought to light.

Phenomenology, as applied by Heidegger, is the “science of phenomena” (p28), the study of (ology) how things appear (phenomena), phenomena being that which shows itself, the manifest. In explaining his conception of phenomenology, Heidegger (1927/1962) states, “ ‘phenomena’ are the totality of what lies in the light of day or can be brought to the light” (p29).

Like Husserl, Heidegger saw the starting point of phenomenology as being with the things themselves, as expressed in the maxim, “To the things themselves!” (p. 28), the things being an example of what true phenomena are. By bringing to the light of day the phenomena, the things themselves which have been hidden, covered up or buried over, are perceived in a new way, a different light, one in which the phenomenon of interest stands out from the background, one which lets things be what they are in their various ways of being.

Because phenomena are, according to Heidegger (1927/1962), entities that go to make up Being, they are inseparable from the experience of them, therefore they can only be accessed or revealed through language, or “discourse” (p32) which makes manifest the phenomenon of interest. Accordingly, phenomenology is discussion on a phenomenon, a description of a phenomenon combined with interpretation, as revealed through the use of a person’s own words about their Being, their lived experience in its everydayness. Having both descriptive and interpretative elements (Heidegger, 1927/1962) hermeneutic phenomenology has, as its aim, the direct investigation and description of human experience that allows us to see and understand being, or Dasein, in its average everydayness as it is experienced, to make clear, to bring to light, that which is hidden, to “let that which shows itself be seen from itself in the very way in which it shows itself from itself” (Heidegger, 1927/1962, p.34). For Heidegger (1927/1962), the person is seen as ontologically hermeneutic. Interpreting experience and finding meaning is a basic part of “Being”. The essence of being, or Dasein, is embedded in everyday experience and thus needs hermeneutical extraction, hermeneutics being the process of interpretation (Heidegger, 1927/1962).

Hermeneutics involves both investigation into the nature of understanding and the interpretation of the phenomenological written description, or text, of human experience (Heidegger, 1927/1962; Van Manen, 1997). In this study, “text” refers to the transcriptions of the participants’ stories – the language they have used to recount their experience of drug dependence. As such, the main concerns of hermeneutics are understanding and interpretation and all that which is encompassed – what understanding is and how it comes into being, the myriad of meanings forged from a text, the multitudinous interpretations of the same text influenced by many different preunderstandings, and the correctness or truthfulness of such interpretations. Accordingly, interpretation is an attempt through the deliberate act of describing aspects of experience (phenomena) in textual form (Van Manen, 1997), to take hold of and recreate meaning in order that greater or different understandings occur.

For Heidegger (1927/1962), language is the means by which being is constituted. In other words, the text has explanatory power, through language, to describe and

illustrate the way in which an understanding of the participants' perceived realities came into being. For human beings, reality is lived subjective experience. Their realities derive from their individual experience. The world they see and experience is made sense of through their perceptions, interpretations, and ascribed meanings, all of which are guided and shaped by their stocks of knowledge (Holstein & Gubrium, 1994), stocks of knowledge being that which is handed down to them through history, language, and social and cultural practices and reflected in shared constructs and categories, a pre-understanding, or as Heidegger (1927/1962) calls it, a forestructure of understanding. Essentially, the social and cultural context within which human beings live and interact influences the construction of their realities, the meanings they attach to their lived experience, the interpretations that they give to their own life events. Because the participants' realities derive from their individual experience, there is no objective reality. Rather, the world becomes real for them through contact with it (Crotty, 1998; Holstein & Gubrium, 1994). As such, their perception of their lived experience is not passive, experience is consciously and actively constituted by each one of them as they are engaged in continually changing interactions with their environment, interactions which result in a continuous evolvment and refinement of their perceptions of reality (Crotty, 1998; Lythcott & Duschl, 1990). As Crotty (1998) states, "...All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (p.42).

Because realities derive from individual experience, truth is, in this study, viewed as a composite of the participants' perceived realities, realities based on their perceptual skills and preconceived stocks of knowledge (Holstein & Gubrium, 1994), with acquired experience, perceptual skills and knowledge evolve and are refined, and as such, truth is seen as continually changing, the changes determined by the context within which the experience takes place. Thusly, truth stems from the participant's interpretation of experience narrated through the lens of the one who experienced it. As the participant's experience is inalienably theirs, it therefore is what they say it is. Essentially, their narrative is "the mode in which, inevitably, truth and reality are

presented” (Schafer, 1992, pp. xiv-xv). In their simplest form and function, the narratives, or stories, told by the participants are their ways of letting others know who they are and of positioning themselves within the greater context of a social landscape. In order to narrate their stories of their selves, the participants had to review, analyse and assign meaning to their memories. The emplotment of their narrative was a conscious choice of what to include and what to avoid in the telling of their stories (Sarbin, 1986). Accordingly, in the construction of their stories, they assign roles for themselves in relation to the person they are in the narrative and in relation to the researcher listening to their stories. Their position within the story and towards the researcher is further complicated by the participant’s and the researcher’s position in the culture at large and the context of the situation in which the narrative is constructed.

In this study, the role the participants played in their narratives was that of protagonist, the insider, and I, as researcher, was the listener, a non-user, a “straight”, albeit a trusted one with authenticity and legitimacy through both my work at the Needle Exchange and validation via an endorsement from the manager of the Needle Exchange (an ex-user with much notability and authority) who played the part of cultural broker. Hence, I, as researcher, was never regarded as *suspect*. Gaining trust and respect is not a simple feat in the drug world. It is not a one-time phenomenon but an ongoing developmental process (Johnson, 1975). Because of the trust and respect that developed over my time of working at the Needle Exchange there were no concerns that the participants, in giving their accounts, left things out, had me on, or gave accounts that they thought fitted my way of looking at things, that of an outsider, a non-user. That some details of the participants’ accounts of their experiences may have been left out as a result of them thinking they were not of interest to me or emphasised in the hope that I may have reacted in some way to them was not seen as problematic or of concern. For any of these participants, some details may have just been forgotten, or their accounts may have been limited due to their inability to create a fit between the experience and their existing cognitive schemas in interpreting an experience narratively. As human beings develop newer and different schemas and gain life experience through which to interpret experience, the meaning of their stories can

change over time in that the addition of new experiences requires a new interpretation that “narratively connects the present with the past” (Hirst, 1994).

Because human beings tell their narratives over time to many different listeners, they are constantly being revised (Linde, 1993). Such revisions occur as past events are recollected in different ways based on the context of the present telling. Accordingly, recollections are assigned new meanings and new significance is given to them. However, such revision and significance need to meet the criteria of coherence in people’s lives (Linde, 1993). To be coherent, narratives, or stories, need to be ordered in a certain way. There must be some conceivable connection between past events and the self presented to the listener in the present. Stories must make sense to the speaker and the listener - a kind of sense learned early through listening to and telling stories that are subject to a social correction (Linde, 1993). Stories that lack coherence can represent a lack of a fit between a participant’s everyday lived experience and the words available for talking about their experience. As such, the participants’ use of language could have affected both the ways in which they express their life experiences and their narratives. Basically, the participants used their language skills to fit their experiences by either saying things that may not have been quite right, of trying to attach a more socially acceptable interpretation on to their experiences or working at using their language in non standard ways. According to Linde (1993), the listener must also be able to get a sense of coherence from the story through what is actually a negotiation of coherence between the narrator and the listener, essentially, the narrator works to construct a text whose coherence can be appreciated whilst the listener simultaneously “works to reach some understanding of it as a coherent text and to communicate that understanding” (p. 8). As such, the self presented by the participants in a story of negotiated coherence is a socially constructed self.

In the narration of stories of everyday lived experience, human beings attempt to interpretively construct versions that are desirable and acceptable to both themselves and the listener. Such narratives are enriched by retrospectively revising, selecting, and ordering past events so “as to create a self-narrative that is coherent and satisfying and

that will serve as a justification for one's present condition and situation" (Polkinghorne, 1988, p.106).

Human beings, as "naturally and primarily truth-seekers" (Schafer, 1992, P.54) will talk a coherent and continuous narrative of self or selves that they acknowledge at the time of telling (Schafer, 1992; Polkinghorne, 1988). Within the participants' constructions of their stories of their lived experience there is found a blurring of what is real, true, and imagined into what is believed to be (Sarbin, 1988). Their stories are a retroactive history of their lives - a reaching back in time through the web of memory and a reinterpretation of those memories, selves that that have existed, do exist and will exist. The selves they created are not separable from the experiences they narrate but are embedded in the intersubjectivity of past, present and future experiences (Ochs & Capps, 1996). Their acts of remembering and recollecting serve as the raw material for their narratives. Their interpretations of their recollections are filtered through the matrices of experience and are a function of who they are and their social circumstances - an interaction that results in the creation of meaning. In this study, the truth of the participants' stories was not for judging - it just was. The truth value lies in the uncovering of, the bringing to light, the phenomena of experiences as they are lived and perceived by the participants.

Essentially, the epistemology of hermeneutical phenomenology focuses on revealing and providing an understanding of the meaning of lived experience rather than on the believability of the text or on arguing a point. Understanding results both from the relationship that develops between the participant and the researcher and the relationship between interpretation of the text and interpretation of self - the "instrument through which data is collected" (Reu, Bechtel & Sapp, 1993, p.300 - 301).

The task within interpretations is to illustrate the way in which the horizons of the researcher and the participants come together and to bring to light the new horizon that comes into being through this process. In interpreting texts - the participants' stories - the researcher makes decisions with regard to the significance of specific

meanings within the text as evidenced through the use of textual exemplars to illustrate interpretations and the choosing of themes to describe and understand the meaning of the lived experience under investigation – in this instance, drug dependence. As such, the interpretative process is inescapably influenced by the researcher's own perspectives, beliefs, and biases, their forestructure of understanding (Heidegger, 1927/1962). This influence, however, provides for a deeper understanding, an understanding through which other horizons, albeit new horizons may come into view. As an interpretative methodology, hermeneutical phenomenology has the ability to gain insight into and greater understanding of the participants' reality and lived experience whilst maintaining the context of the lived experience where meaning lies.

In his preliminary conception of phenomenology Heidegger (1927/1962) asserts that the procedures of phenomenological investigation follow the proper method suitable to the question of inquiry, "*the way in which Being and its structures are encountered in the mode of phenomenon is one which must first be wrested from the objects of phenomenology. Thus the very point of departure for our analysis requires that it be secured by the proper method, just as much as does our access to the phenomenon, or our passage through whatever is prevalently covering it up. The idea of grasping and explicating phenomena in a way which is 'original' and 'intuitive' is directly opposed to the naïveté of a haphazard 'immediate' and unreflective 'beholding'.*" (Heidegger, 1927/1962, p.37). As a method which accesses the lived experience of given phenomena from the unique perspective of the individual engaged in the experience, hermeneutic phenomenology is ideally suited for the study of the more elusive questions that characterise concerns in the clinical practice of working with problem drug users.

Although phenomenology is well established in the fields of sociology, anthropology, medicine, education, nursing science, and education (e.g. Baron, 1985; Chessick, 1986; Daniluk, 1993; Jaspers, 1968; Nay, 1996; Omery, 1983; Porter, 1995; Schwartz & Wiggins, 1985; Seamon, 1982; Smith, 1983; Sparkes, 1991; Taylor, 1993b; Toombs, 1987; Varghese, 1988), it is under-utilised as a research method in the drug abuse field. However, with the increasing recognition of the important role of qualitative

approaches in the study of complex human behaviours related to drug abuse (Barnard & Frischer, 1995; Dennis, Fetterman & Sechrest, 1994; Lambert, Ashery & Needle, 1995; Sidani & Sechrest, 1996) there is a growing acceptance of phenomenology in the drug abuse field as a useful tool for gaining subjective, in-depth understanding of the phenomenon of interest, experiences, or behaviour, from the drug user's point of view.

As a subjective research method for studying human phenomena, with a focus on the lived experience of everyday existence, the qualitative research method of phenomenology presents an approach by which phenomena that are not readily accessible, observable or measurable can be investigated. As Wiebel (1990) states, *"Qualitative research is often the only means available for gathering sensitive and valid data from otherwise elusive populations of substance abusers. Given the recognised strengths of qualitative methods in exploratory and descriptive research designs, it would appear that applied substance abuse research will continue to value the potential contributions of this methodological orientation"* (p.5).

As such, the application of phenomenology to drug abuse research and the clinical practice of working with problem drug users goes together readily. Both have the goal of understanding human experience in everyday life, and view people as subjective beings, each of whom have a unique view of the world. In both, either the researcher or health professional is actively involved with the participant or client uncovering their lived experiences of 'being-in-the-world'; both are concerned with interpreting the nature of people's experiences in their everyday lives; both acknowledge and value the meanings people assign to their experiences; and both are concerned with gaining an understanding of the phenomenon of interest (Oiler, 1982). In essence, the use of phenomenology in drug abuse research and clinical practice signifies the attribution of value to the meaningful, patterned ways in which drug abusers behave and interpret their lived experiences (Carlson, Siegal & Falck, 1995).

Considerable literature has been produced describing phenomenology and the hermeneutic phenomenological method, particularly in psychology and the nursing disciplines (e.g. Colaizzi, 1978; Giorgi, 1971, 1975; Leininger, 1985; Merleau-Ponty,

1962; Munhall, 1989; Oiler, 1982; Omery, 1983; Salsberry, Smith & Oiler, 1989; Spiegelberg, 1975; Van Kaam, 1966, 1969; Van Manen, 1984, 1990).


Although the many proponents of the phenomenological movement have developed a variety of different methods to guide inquiry into the phenomenon under study and to describe human experience as it is lived, no one correct method is identified. Rather, as Gadamer (in Van Manen, 1990, p.30) states, “the method of phenomenology and hermeneutics is that there is no method!” One commonality of the numerous approaches to phenomenology is that they are connected and directed by the philosophical maxim which exacts the researcher to return “to the things themselves” (Heidegger, 1927/1962, p.28; Taylor, 1994, p.50).

On account of phenomenology being a fluid approach that is by its nature ever evolving (Spiegelberg, 1982), it is essential that researchers using phenomenology provide not only a detailed description of the philosophical underpinnings of the approach employed but also of the procedures used throughout the study and how these procedures shape “the patterns generated from the data.” (Alvermann, O’Brien & Dillon, 1996, p.116).

Accordingly, the research process utilised in this study is that as described by Van Manen (1984, 1990), an educational theorist whose structuring and practical use of the beliefs and ideas of Heidegger’s hermeneutic phenomenology is well suited to the nature of this research. The main assertions of Van Manen’s (1984, pp.37-38; 1990, pp.9-13) methodology are that the phenomenological research is the study of lived experience, the explanation of phenomena as they present themselves to consciousness, and the attentive practice of thoughtfulness.

To use a hermeneutic phenomenological method in research, Van Manen (1990, pp.30-31) identified six inter related procedural activities which provide the researcher with a methodological framework aimed at facilitating freedom of discovery and full elaboration of the phenomena under inquiry. Van Manen’s research activities are:

1. *Turning to a phenomenon which seriously interests us and commits us to the life world (turning to the nature of the lived experience).* This procedural activity involves the identification, thoughtfulness and questioning of a phenomenon of concern that is important to the researcher. This activity also involves the explication of assumptions and pre-understandings of the phenomenon under inquiry. In this study my concern is as a researcher and a health professional working with people with drug related problems. This activity also acknowledges the importance of context, in that all human experience is 'situated', grounded in their everyday life world through time, space, body, and relationality. For Heidegger, the situatedness of the person in the world is of central concern, for it is through this situation, one's thrownness, that the world is experienced. In the research findings, Van Manen's (1990) lifeworlds are drawn upon to highlight that the participants' experiences are situated in their everyday lifeworld. Through their stories the participants disclosed their experiences of becoming and being drug dependent, stories which, when hermeneutically analysed revealed an understanding of the experience from its beginning to the present day as lived by them. As such, the participants' experience of drug dependence can be seen as temporal in nature.

 2. *Investigating the lived experience as we live it rather than as we conceptualise it.*
X In this activity the researcher seeks access to the phenomena of lived experience from those who live it in their everydayness rather than conceptualising or theorising about it. In this study, access is gained through verbal descriptions of personal experience from interviews. In borrowing other people's experiences in order to understand the deeper meaning of them in the context of the whole of human experience (Van Manen, 1990) the researcher acknowledges that the people who actually live the experience are the experts. This aspect of Van Manen's method supports Heidegger's concept of being-in-the-world, of existence - Dasein. For Heidegger (1927/1962), to be-in-the-world is to constantly seek to understand and attach meaning to lived experience, to the many ways-of-being in the world.
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3. *Reflecting on the essential themes that characterise the experience.* Reflection is an integral research activity. Van Manen (1990, p.32) discusses a process of “reflective grasping” in which the researcher determines whether that which has been disclosed has some “special significance” in explicating that which is being investigated. Through reflection, insight is gained into some phenomena, some lived experience, by helping the researcher move beyond the appearance of an essence to the meaning of an essence while uncovering or discovering essential themes embedded in the participants’ stories. In this research activity, the aim is to uncover the essence and to identify themes that are related to the phenomenon of lived experience, to find the things that make something “what it is - and without which it could not be what it is.” (Husserl in Van Manen, 1990, p.10). In this study as a result of reflecting on themes, statements in the participants’ own words were isolated and themes that seemed to make up the experience of living with drug dependence were identified.

4. *Describing the phenomenon through the art of writing and rewriting.* Van Manen (1990) describes the work of phenomenology as the art of writing and rewriting, a thoughtful “*bringing to speech* of something” (p.31), a putting together of words, to capture an experience in its full richness and depth, “a poetising activity” (pp.31, 41). Through this process, encompassing much listening, reading, thinking, discussing, reflecting, and writing about the data, the researcher is able to come to a sense of understanding the essences of the phenomenon (an aspect of the lived experience) under investigation, of bringing it to light in a way that lets its meaning show through. It is through writing and rewriting that we return “to the things themselves” (Heidegger, 1927/1962, p.58), and it is in the things themselves that we find the world which precedes knowledge.

5. *Maintaining a strong and oriented relation to the phenomenon.* In maintaining a strong and oriented relation the researcher remains focused and committed to explaining the meaning of the participants’ lived experience without theorising or tending to abstraction throughout the process of analysing and interpreting the phenomenological text. This activity draws on Heidegger’s concept of the

hermeneutic circle in which the researcher comes to a sense of understanding the essence(s) of the phenomenon through a concerted effort of working through what is and what is not essential by repeatedly moving back and forth between parts of the text and the whole of the text and making a decision as to whether the interpretation is relevant to not only a part of the text but also the whole. Throughout all stages of interpretation the researcher maintains awareness of the relation between their orientation - where they are coming from, to the topic of inquiry, their consideration of the text - and to content and form. In this study, my orientation is as a researcher and a health professional working with people who experience drug related problems while the research focuses on the everyday lived experiences of those who use and are dependant on drugs.

6. *Balancing the research context by considering parts and whole.* In fulfilling this stage of the method the researcher is required to relentlessly appraise the whole against the parts in the total textual structure. Van Manen (1990, p.33) talks of becoming so immersed in the process of writing to the extent that one can no longer see the light, thus one needs to step back and consider the whole, the contextual givens and the ways in which each of the parts are instrumental in creating the whole. The process of balancing is a constant measuring, weighing up of many aspects of the research method against the whole of the method in such ways as questioning whether the method suits the question asked, and how does the data collected and the ways in which it was collected fit the “‘argued’ description’ (p165). In this activity, Van Manen also describes five varied ways of working text in phenomenological writing, these being thematically, analytically, exemplificatively, exegetically, and existentially. As alternative approaches, all are ideally suited to the uncovering of new understandings of the human experience, either singly or in combination.

Consequently, in exploring the research question I have been primarily guided by Heidegger’s hermeneutic phenomenological method of investigation as proposed in his seminal work, *Being and Time* (1927/1962) and by the writings of Van Manen (1984, 1990) whose six research activities are interwoven with many of Heidegger’s

philosophical theories and concepts, and whose conceptual framework helped in the organisation and interpretation of the data. In following Van Manen's (1990) set of six inseparable activities, three main themes were uncovered: Being in the world, Being with others, and Being with care. These themes are seen to reveal the nature of the experience of drug dependence as lived by the participants.

Purpose of the study and research question

The purpose of this research was to uncover and describe in a meaningful way the personal experience of everyday life of people who use psychoactive drugs and have a drug dependency in order to add to the knowledge and understanding of this human phenomena, of Being-in-the-world in this way, and to answer the research question: what is it like to live with a drug dependence?

As proposed by Heidegger (1927/1962) in the working out of the formulated question, that "*what is to be found out by the asking - the meaning of Being*" (p.7), people who have the experience of living with a drug dependency were asked ("interrogated") to reflect upon the meaning of, and discuss from their perspective, their lived experience as a dependent drug user and the effect of their drug dependency on their everyday lives in their own natural setting.

Acknowledging Assumptions and Pre-understandings

In accordance with Heidegger's (1927/1962) phenomenology and Van Manen's (1990) method of phenomenological research, the researcher makes all attempts to bring to awareness any beliefs, presuppositions or pre-understandings about the phenomenon under inquiry.

Unlike Husserl's (1913/1931) notion of bracketing in which the researcher acknowledges beliefs and prior knowledge about the phenomenon of concern and then, to avoid imposing preconceptions on the phenomenon, brackets or suspends past knowledge, preconceived notions and experience in an attempt to separate this experience from that revealed by the participants, Heidegger (1927/1962) contends

that bracketing of one's preconceptions is not possible, that the researcher is actively involved in the participants' uncovering of their lived experiences, their interpretations, and their meanings through a shared background of practices and understanding of being-in-the-world. To regard human reality objectively through the process of bracketing, according to Heidegger (1927/1962) is to neglect the participants' being-in-the-world, their historicity, their pre-understanding, conditions that are necessary for a true understanding of the phenomenon under inquiry. Through a shared understanding of being-in-the-world with the participants, the researcher becomes part of the contextual background in and against which the participants' subjective realities are constructed, thus interpretation of the meaning of everyday lived experience is by way of pre-understanding, the researcher's own historical existence, own preconceptions and experiences for being-in-the-world.

Because we are all beings with pre-understanding we are not able to put aside, or bracket, all beliefs, biases, presuppositions, and assumptions about the phenomenon under inquiry, rather we need to continuously acknowledge them and work with them to gain insights into the meanings associated with the phenomenon.

Consequently, in this study, I have not only been able to acknowledge the assumptions and pre-understandings I held about drug dependency and drug users at the outset, but also the evolvment of assumptions as the research progressed, and the recognition of assumptions I was not aware of at the beginning of the study. Although knowledgeable about the main theoretical models of drug dependency, and holding a multidimensional view of "drug use" and the "dependence syndrome", I was aware at the conception of this study, of my own personal beliefs surrounding the "dependence syndrome", "drug users", and their way of life.

In spite of my prior knowledge of the etiology and treatment of the phenomenon of drug dependency I had little real understanding of the meaning dependent drug users attach to their drug using experience, or the lifestyle within which their drug use is integrated. Before I began this study in my early days of working at an alcohol and drug unit I was confronted and challenged by a client who was seeking an increased dose of methadone. She told me that I did not understand her, that I did not know

what it means to be a “junkie”, that I did not know what it was like to live every day experiencing what she did, and that I was not dependent on drugs: she was. It was then that I became aware of a degree of ignorance on my part related to dependency issues. Underlying some of my early behaviours toward dependent drugs were a variety of beliefs about drug dependency, drug users, and drugs. Some of these beliefs were medical, some moralistic, some political, and some societal. Most of my beliefs had developed over time through exposure to the prevalent conscious and unconscious biases that pervade our society with regard to drug use and abuse, through the conceptual confusion surrounding the field of addictions, and through not understanding fully the social, physical and cultural setting of drug users’ lives, along with the social, political and economic forces affecting them.

Hence, it was through much self reflection and contact with drug users that I came to understand that drug dependency is not only a syndrome consisting of a combination of behavioural and contextual symptoms existing on a continuum, it is also a series of experiences that profoundly affects both the person who is dependent on drugs and those who share the experience, in one way or another, for example, family members and others in society. I came to believe drug dependency to be a stressful way of being which leads the person to experience psychological distress, demoralisation, anguish, pain, suffering, financial and/or legal difficulties and sometimes the possibility of death, that drug dependency is an unpleasant, unrelenting feeling which is relieved only by more drugs, that drug dependency has implications for all aspects of quality of life, and that people who are drug dependent are in an existential crisis in which everything revolves around buying, acquiring and using drugs.

I came to believe that a drug dependent lifestyle is a solitary way of being, one in which the drug user would on occasion need support and caring but generally would be able to survive on their own. To a certain extent I sometimes viewed them as victims of our society, and thus asked myself if this assumption would affect my interpretation of their stories.

As a researcher and a health professional, I believe that there is a need for more information about the lived experience of having a drug dependency, to help dispel the

social prejudice, the negative and ill-informed beliefs about drug users, and the high level of emotion surrounding any discussion of drug use, to add to the existing knowledge and understanding of this complex phenomenon and especially for those who work with this group of people, to enable them to offer support and caring that has meaning to the drug user.

In my belief that drug dependency is an unpleasant syndrome embodying aspects of the drug user's biological, psychological, spiritual and social being, and impacting on their everyday lives, I think it essential that their experiences are not reduced to insignificance through negative attitudes and stereotypes and social prejudice. When drug users are in need of help, specialised care and support, I believe it necessary to respectfully listen and acknowledge their realities as being valid experiences in order to come to a better understanding of their feelings and their situation in the world. In doing so, the underlying assumption is that people who live the experience of drug dependency are the source of knowledge for the understanding of this phenomenon, and that their descriptions are representative and reflective of their experiences as they are lived.

In recognising and acknowledging my personal assumptions, pre-understandings, and biases, and ongoing self-reflection upon these issues, I believed that any impact upon the interpretation of the participants' texts - the transcriptions of their stories - would be lessened. It is in this way that the researcher becomes part of the social, cultural, and historical context that influences the participants' constructed realities.

Access and participant selection

In undertaking an investigation into lived experience, Van Manen (1990) recognises that the only valid source of data are participants who have lived the experience or phenomenon being investigated. According to Van Manen (1990) there are a variety of ways of accessing this data. Among these are observation, personal writings, literature, art, and verbal descriptions. To Van Manen (1990) the point of the phenomenology is *"to 'borrow' other people's experiences and their reflections on their experiences in order to better be able to come to an understanding of deeper*

meaning or significance of an aspect of human experience” (p.62). In this study the main source of the data collected was through personal descriptions of people’s experiences of drug dependency and its effect on their everyday lives. Such descriptions were collected by way of taped conversational interviews.

In Heideggerian phenomenological research there is no attempt to seek neither absolute truth nor valid analyses as defined by the positivistic sciences, rather, understanding of human experience is sought. Consequently, individuals are selected for study participation based on their experience of having lived or living the phenomenon under inquiry. Thus, in this study, access to the phenomenon under inquiry – the lived experience of drug dependence and its effect on every day life – was gained through purposive selection of participants. As Patton (1990) says, *“The logic and power of purposeful sampling lies in selecting information - rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling”* (p.169).

Consequently, in this study, I sought participants who had a recognised dependence on one or more psychoactive drugs as identified by the DSM IV (American Psychiatric Association, 1994) criteria of substance dependence, and the WHO definition of dependence (Edwards, Arif & Hodgson, 1982) which includes evidence of tolerance and withdrawal symptoms, a compulsion to use the drug, increased importance over drug seeking and drug using behaviour relative to other important activities/priorities, use of the drug to relieve or avoid withdrawal symptoms, rapid reinstatement of dependence after a period of abstinence, and a relatively stereotyped pattern of drug taking behaviour. The participants’ drug dependence was recognised if they experienced three or more of the above symptoms occurring at any time in the previous 12-month period.

Other criteria for selecting participants were that they were over the age of 16 years (legal age for purchasing injecting equipment), were not receiving drug treatment at the time of participation, and that they were both willing and able to articulate their lived experience of their drug dependency.

As members of a “hard to reach” or “hidden” (Lambert, 1990) population, out of treatment drug users are often difficult to access, not only because of the private and often illegal nature of drug using and the surreptitious illegal activities many drug users engage in to support their drug use, but also because many are transient, without fixed addresses, lack telephone facilities, and have no regular employment.

Therefore, to gain access to participants who were not in treatment, the local Needle Exchange was approached with the possibility of recruiting participants through their service. After discussing the study with the co-ordinator, it was decided that in order to gain access to the drug using community, and establish rapport and credibility with drug users, I would work on a voluntary basis one night a week (and other nights on short notice if another worker did not turn up or was unavailable) at the Needle Exchange. To a certain extent the co-ordinator played the role of go-between, vouching for my legitimacy and authenticity as well as providing me with much background information and explaining many facets of the drug scene. Additionally, on account of my ongoing voluntary work at the Needle Exchange over a 14 month period, I not only established legitimacy for my role as researcher but also was able to develop rapport and trust with the participants to the extent that they continue to share ongoing information with me whenever we come into contact.

Whilst working at the Needle Exchange I received many queries about both my role as volunteer worker and the intended research. For those who asked, I openly discussed both issues. After a period of time (5 months) I actively began recruiting participants both by word of mouth and by placing notices of the study on the wall at the Needle Exchange along with pamphlets on the counter which described the study and the eligibility criteria along with an invitation to participate (Appendix III). Participants were also recruited via a network or snowball approach (Biernacki & Waldorf, 1981) in which participants were asked to refer another potential participant at the conclusion of the interview.

Each potential participant was contacted either personally, by telephone, or through the Needle Exchange, and after a brief discussion in which the purpose of the study

was explained, was invited to participate. On acceptance, an interview time as arranged, to take place either in a private room set aside at the Needle Exchange especially for interviewing or in a venue of their own choice. At the interview, each participant was given an information sheet (Appendix IV) describing the purpose of the study and informing them of their rights, in particular, confidentiality rights. Consent to participate (Appendix V) was signed by each participant.

After the interview participants were paid \$20 as compensation for their time and effort in contributing to this study, in appreciation for their personal stories, and for any costs that may have been incurred in attending the interview. In paying the participants, I held similar views as Preble (1980), *“Money is usually the sole motive for participants at the beginning, and this is often the cause for professional skepticism about the validity of research findings based upon such a foundation. But if money is a mean motive for those we recruit, it is the same for us who do the recruiting; and so we are even. The fact is that we can work with this motive and parlay it into honest, thoughtful participation”* (p.69).

In total, 25 people, 17 males and 8 females, were interviewed and participated in this research. Participants ranged in age from 16 years to 43 years, with an average age of 27. All except two were of New Zealand birth, 21 of European ethnicity, and 4 who identified as Maori. Socio-demographically, family backgrounds were widely divergent, from upper middle class professional to working class unemployed (defined by parents' occupations). Some participants had little secondary education whilst others had completed or were completing university degrees.

At the time of the interviews, 5 participants were enrolled in tertiary education and 19 were unemployed. All participants lived off, and supported their drug use, on either a sickness benefit, an unemployment benefit, or a student allowance, and in the majority of cases, a combination of profits from drug dealing, shoplifting, prostitution, and criminal activities such as theft, burglary, fraud, robberies, bag snatching and handling stolen goods.

The Study Participants

Although invited to use pseudonyms, only four participants chose to do so. However, fictitious names have been used for all participants to protect their identities. A brief description of each participant follows, outlining their living circumstances, age, and patterns of drug use at the time of interview.

Herman (NZ European) was 16 years old at the time of interview. He ran away from home at age 13 and slept either on the streets, at friend's places, or in charity collection bins. Herman had worked at several manual jobs over the past two years but after a week or so at each was either fired or did not go back. Because of his age he had been unable to get a benefit but at the time of interview had just started on the independent youth benefit. He usually participated in some form of crime - shoplifting, burglary, drug dealing, robberies, and prostitution in order to raise the money to buy his drugs and food. His first drug use (cannabis) was at age 12. He then used benzodiazepines, mushrooms (psilocybin), cannabis oil, LSD, poppies (opium), and morphine (morphine sulphate tablets) over the next two years. When interviewed his drugs of choice were poppies and morphine. He was using on average between 60 - 120 mgs of morphine a day. He had been arrested several times but had had no convictions at the time of interview.

Angus (NZ European) was 29 years old when interviewed. He was living with his parents. Angus received a sickness benefit and sometimes helped his parents in their shop. Angus's first drug use was around 12 years of age when he and some friends were given some cannabis. He then began to regularly use cannabis. At the age of 15 he left both school and home and started an apprenticeship. From age 15 - 18 years he smoked on average 9 or 10 cannabis smokes (joints) a day, everyday. He was then introduced to LSD, cocaine and speed (amphetamine). He continued to smoke cannabis and began to spot (method of smoking cannabis) cannabis oil. He then discovered morphine and subsequently left his job through his drug use. He began using morphine daily, and when it was not available, used temgesics. He also used mushrooms, Valium, street methadone, and cocaine when available. His parents were

aware of his drug use. To pay for his drugs Angus usually shoplifted or stole from cars. He also attended several different doctors, and through using false names, got scripts that he altered either to increase the quantity or add extra items. He also stole scripts if the opportunity arose. His drugs of choice were morphine and Valium.

Alistair (NZ European) was in his mid 30's and lived in his van at the time of interview. Although he was aware of the effects of drugs from an early age because his mother was dependent on drugs (Ativan - a benzodiazepine), this did not prevent him from trying them. His first use was at age 16 when a friend gave him cannabis. He then went to the library and researched other drugs, trying a whole range of readily available products, for example, nutmeg, cactus, datura, over the counter drugs such as cough medicines and sea sickness tablets. He moved out of home at age 19 and was introduced to morphine by a flatmate. Developing a dependency quickly, Alistair resorted to crime to pay for his drugs. In his early 20's he married, and had four children, but due to his continuing drug use, the marriage ended. Although he had been able to keep up with his job he increased his drug use at the end of the marriage and subsequently lost his job. For the last 15 years Alistair had used morphine almost every day. He spent between \$700 to \$1,000 weekly on his drugs. He was also on the unemployment benefit.

Wayne (NZ European) was a single 23 year old when interviewed. He began using cannabis at age 14 during the school holidays. After he left school and home he continued using cannabis daily. In between jobs he received the unemployment benefit. At age 18 he went to Auckland where he was introduced to duromine (amphetamine-like compound) and morphine, both of which he injected. He then began using intravenously anything he could - Ritalin, rivotril, Demerol, palfium, methadone, pipanol, and other drugs. When he developed lumps in his veins, he cut back on the intravenous use and began using mushrooms, LSD, and cannabis oil. When he was 20 he returned to his hometown and began using morphine and poppies. Over the past year Wayne has used between 60 - 100mgs morphine almost daily. To support his drug use Wayne does burglaries, buys and sells drugs, handles stolen goods, forges

scripts, commits fraud, and steals cars to order. At the time of interview, Wayne had enrolled at University and was receiving a student allowance.

Steven (NZ European) was in his mid 30's when I interviewed him. He has one son whom he looks after. He flats with another couple, both of whom are drug users, and their child. His drug use began when he was 10 years old when he and a friend started sniffing fly spray and other solvents. Steven then began using cannabis with his friends. At age 16 he left both home and school and began travelling around the country. His drug use consisted mainly of cannabis and pills (a variety of benzodiazepines). At 18 he was introduced to heroin which he used recreationally for two years. After being caught shoplifting he moved away from Auckland to the South Island where he met up with someone who had just robbed a chemist shop and had an enormous quantity of all sorts of drugs. Steven helped him use the drugs and when they were finished, they both grew poppies. Additionally, to support his drug use at this time Steven committed burglaries. He kept up his poppy growing for 4 years and during this time became a father. When his relationship ended he assumed responsibility for the child. At the time of interview Steven was using morphine (approx 100mgs daily) and also smoked cannabis daily.

Tony (NZ European) was in his early 40's when I interviewed him. From the age of four until he joined the army he had lived in 18 foster homes. His first contact with drugs was at age 16 when he was introduced to a range of drugs -Tuinal, Pentothal, Phenobarbital, Seconal, Amytal (barbiturates), LSD, Valium, and Mogadon by work mates. At 20 he began injecting barbiturates and heroin. When heroin was not available he used morphine, pethidine, and Temgesic. Tony has spent some time in prison and much time in psychiatric institutions. He has been using drugs for over 27 years, a career supported by fraud, theft, dealing, shoplifting, visiting doctors (he was a patient of over 20 doctors, each of whom he visited regularly for scripts), and other criminal activities. At the time of interviewing, Tony's drug of choice was Valium but he used whatever he could get. Tony received a sickness benefit and was living in a backpacker's hostel.

Brian (NZ European) was 26 years old and was in his last year of completing a degree at University when I interviewed him. Brian's first use of a drug (cannabis) was at age 12 when he and a friend found some growing on a farm. Throughout college he smoked regularly and in the last 6 years has smoked upward of 10 joints daily plus spotting oil. At age 16 he was a regular user of datura and mushrooms. At 20 he tried LSD and then heroin, methadone, and poppies (opium). By age 22 he had developed a dependency. Most of his drug use in the past two years prior to interview had revolved around poppies and poppy seed juice, Valium, and morphine when he could afford it. Brian did not commit crime to support his drug use. Mostly, his student allowance and his student loan, an overdraft, and friends' goodwill finance it.

Veronica (NZ Maori) was 18 years old when I interviewed her. Introduced to Ritalin and Tenuate (amphetamines) by her boyfriend when she was 17, she soon became a daily user, first snorting (inhaling up the nose), then injecting. Prior to her amphetamine use Veronica smoked cannabis regularly. After using amphetamines a short time she stopped using cannabis. Veronica was receiving an unemployment benefit that she spent on cosmetics and cigarettes. Her boyfriend paid for her drugs. Veronica was anorexic and at the time of interview weighed less than 45 kilograms.

Gerard (NZ European) turned 32 a few days before I interviewed him. At that time he was living with his mother who had custody of his son. Gerard left school at age 15 and worked in a shop where a work mate introduced him to cannabis. Through his increasing use he lost his job and was subsequently told to leave home by his father. He then went to live with a friend who was an intravenous drug user. This friend introduced Gerard to morphine. After using morphine he stopped smoking cannabis. At age 20 he was using anything he could get, for example, cocaine, a variety of benzodiazepines, opium, Palfium, Pethidine, Temgesic, Ritalin, and amyl nitrate. Grabbing doctors' bags, chemist shop and surgery break-ins, shoplifting and burglaries supported most of his drug use. When his wife became pregnant, both cut down on their drug use substantially, but after a few years it increased. After his wife was sent to prison, Gerard looked after their son. When Gerard went to prison, his mother was given custody. Although he used drugs in prison it was not on a regular basis and when

he was released he soon began using daily. At the time of interview his drug of choice was speed (methamphetamine) which he used intravenously.

Dan (NZ Maori) was in his late 20's when interviewed. He has received an unemployment benefit off and on since he was 18. He started smoking cannabis around the age of 8 years because every one in his family smoked it and it was always available. He left school and home when he was 14 and moved to the city where he was introduced to a variety of pills, LSD, mushrooms, and speed, from the gang members he lived with. When he was 21 he discovered poppies and morphine, and by 22 he was a full-time burglar as a means of earning money to pay for his drugs. He has been to prison several times, each time in which he stopped his intravenous drug use but continued with his cannabis and pill use. At the time of interview Dan was living in a squat (derelict house) with two other people and was using around 80 - 120 mgs morphine daily, along with whatever else he could get.

Paul (NZ European) was 20 years old and was using a minimum 30mgs-morphine daily when I interviewed him. He had been using drugs for nine years, first having used cannabis at age 11. At ages 13 - 15 he was growing his own and selling the surplus. Having endured a lot of physical abuse when he was growing up, Paul used cannabis to help make his life more bearable. He left home at age 15 and soon began using a variety of amphetamines, mushrooms, Valium and other benzodiazepines, and LSD. At 19 he was introduced to poppies, morphine, and methadone. Paul received the unemployment benefit and to pay for his drug use he shoplifted to order, did burglaries, petty thieved, and sold drugs. On average, he wanted at least \$200 a day for drugs to prevent withdrawal symptoms.

Trish (NZ European) was 41 years old when I interviewed her. She lived in her own home (left to her by her parents when they died). Trish was a postgraduate student attending University. She received a sickness benefit. Most of her drugs were gained through her repeated visits to several doctors in the area. She was first given Valium at age 5 by her mother who had a psychiatric history. Trish was also a diagnosed schizophrenic on psychiatric medication - Melleril, Depixol, Imovane, Prozac, Serapax,

and Valium. She first used cannabis at age 13 when she became involved with a bikie (motorcycle) gang member. On his instructions she would sell up to one kilogram of cannabis each week. At age 15 she began injecting heroin and by 17 was a daily user. To pay for her drug use, Trish prostituted herself. She stopped her heroin use at 23 after overdosing. Two years later she began using drugs intravenously again, heroin, morphine, speed, cocaine, and opiates. Over the next six years she overdosed four times, after which she stopped using drugs intravenously. At the time of the interview she used cannabis oil and benzodiazepines daily.

Lilian (European) was 19 years old when I interviewed her. Lilian emigrated here when she was 15. Her first drug use was in her early teen years when she regularly stole a variety of pills -Ativan, Valium, and sleeping pills, from a family member. At this age she also used heroin recreationally. After moving to NZ she began using cannabis on a regular basis, and then progressed to LSD and mushrooms. When she was 17 she was introduced to poppies and morphine by her boyfriend which she began using on a regular basis. At the time of the interview, Lilian smoked cannabis daily, injected poppies or morphine 3 - 4 times weekly, and used LSD and mushrooms whenever they were available. Lilian received an unemployment benefit. Money given to her and an overdraft helped to pay for her drugs. Her boyfriend also contributed by sharing his drugs with her.

Hugh (NZ European) was in his early 30's when I interviewed him. The people with whom he shared a flat when he was a university student introduced him to cannabis. Hugh spent much time in a university library researching drugs and soon he and a friend were synthesising drugs in the chemistry laboratory. On average Hugh was smoking up to an ounce of cannabis a day. After a few years of daily cannabis use he suffered from a severe bout of depression and attempted suicide. Several months later he began using mushrooms, cactus, and LSD daily in a self-discovery journey. He then began using poppies and morphine intravenously. He has been convicted of both drug possession and cultivation, and fraud, and consequently served a prison sentence. At the time of the interview he smoked cannabis daily and used opium whenever possible. He was receiving an unemployment benefit, worked on a casual basis, and had an

overdraft facility. After his incarceration Hugh did not commit crime to pay for his drugs.

Eliza (NZ European) was in her mid 40's at the time of interviewing. She lived by herself in her own home and received a sickness benefit. Eliza is HIV positive and Hepatitis C positive. She left home just before her 13th birthday and was introduced to heroin by the people whom she flatted with. Eliza lived with them for a couple of years, using heroin on a regular basis. At age 15 she became pregnant and got married. She did not use drugs when she was pregnant. For a long time her husband was unaware of her drug use. At age 18 began using heroin, Pethidine, Palfium, and morphine. To pay for her drug use Eliza sold drugs. In her mid 20's she was arrested for possession of a Class A drug for supply and went to prison for 15 months. Whilst in prison she occasionally used cannabis and Temgesic. After being released she started using heroin, morphine and opium intravenously again. Her drug of choice is pethidine.

Toby (NZ European) was 28 years old and lived by himself when I interviewed him. Whilst growing up he was severely physically abused by his stepfather. He began using cannabis at age 12, and at 13, he grew his own. He left home when he was 15 years old and went to live with two older women who supplied him with pills (Valium, Rohypnol, Ativan, and Halcion) and introduced him to heroin. To support his and their drug use, Toby sold drugs, stole motorbikes, carried out armed robberies and burglaries, and dealt in weapons with gang members. At age 20 he was imprisoned for armed robbery, and for the first year of imprisonment used Valium brought in by a friend. He also used cannabis daily in prison. On his release he continued with his cannabis use, Valium, LSD, and any other pills he could get. His drug of choice is Valium.

Jenny (NZ European) was 21 years old at the time of the interview. Her brother first gave her cannabis to smoke when she was 14 years old. At first she only smoked it on weekends then she progressed to daily use by age 16. She also used LSD and mushrooms when available. Whilst still at school she moved out of home and went flatting with some friends. Shortly after going flatting she left school. Her boyfriend

introduced her to morphine when Jenny was 19, which she then began using regularly. To help finance her drug use she shoplifted and did burglaries, needing at least \$150 to pay for drugs to get her through the day (to avoid withdrawal). Jenny was diagnosed as Hepatitis C positive over a year ago.

Simon (NZ European) was 24 years old with a young child when I interviewed him. He started using cannabis when he was 14, and at 15 was using a variety of pills given to him by a friend who worked at a chemist shop. He would read up about different drugs and tell his friend which ones to steal of the shelves. At age 16 years Simon had his first opiate use (poppies). He then used opiates, in conjunction with pills and cannabis, on a recreational basis until around age 19 when he then became a daily user. At 15, Simon was selling cannabis to his friends to finance his own use. Later on, to finance his opiate drug use, he shoplifted, did burglaries, stole from cars, stole poppies from gardens, bag snatched from offices, the hospital, and the university. When interviewed Simon had no fixed abode.

Rosemary (NZ European) was 32 years old and worked as a prostitute when I interviewed her. She had been a secret intravenous user for over six years before she realised she was very dependent on her drugs. She used heroin, homebake, morphine, and opium. Through her drug use she lost her job. Rosemary first used heroin at high school and remained a casual user until her mid 20's from when she began using daily. On average she spends around \$400 - \$700 weekly on drugs, money mainly earned through prostitution. She occasionally smoked cannabis, used cocaine when available, and Valium when she was hanging out (starting withdrawal). Rosemary has two children who live with her in rented accommodation.

Tui (NZ Maori) was aged 26 when she was interviewed. She began using cannabis at age 11. Her brother gave it to her after he raped her. As the abuse continued so did her drug use. At age 14 she took whatever pills she could get and had tried mushrooms and LSD. She had also had a period of sniffing glue and petrol. She left home at 15 and went to Australia where she became a prostitute. By age 22 she was a regular user of ecstasy. She also used cannabis, Valium and other pills. At 23 moved onto heroin.

After overdosing she returned to New Zealand, then shortly after began using poppies and morphine. Tui spent around \$400 - \$500 a week on her drugs, money she got from her Dominatrix business and fraud. Tui also received an unemployment benefit. She lives in a rented house on her own.

Jared (European) had been on an unemployment benefit for 4 years when I interviewed him. Prior to that he had been working as a sales consultant for over 10 years. He was 35 years old and lived in a boarding house. Jared began using cannabis around the age of 19 when he was flatting, although he never really liked it. When he was 20 he moved to Australia and began working in the retail industry. Apart from the occasional social use of cannabis Jared used no other drugs except alcohol. When he was 30 his wife left him and a friend offered him heroin one night. Devastated by his marriage breakdown he thought, why not? From that time on his use escalated to the extent he could no longer work and lost his job. He returned to New Zealand and for the last 4 years has used morphine, poppies, homebake, street methadone, Pethidine, codeine, and propoxyphene. Jared spent around \$500 a week on these drugs, money gained from burglaries, fraud, armed robbery, and shoplifting.

Willie (NZ Maori) was 19 years old when I interviewed him. He received an unemployment benefit (several, in fact, under different names) and was living in a friend's caravan. He began his drug use with solvents – petrol and carpet glue, and cannabis, at age 11. Up until the age of 13 most of his drug use was on weekends, but after that it became daily. Around the age of 14 he stopped his solvent use. Since then Willie had used mushrooms, LSD, and a huge range of pills, including Ritalin, Rivotril, Valium, and Duromine. By age 17 he had injected poppies (opium) and morphine. Willie has been arrested twice and has served one prison sentence of 4 months. He has also overdosed twice on morphine. At the time of the interview, Willie was using between 60 - 100 mgs of morphine or street methadone daily. Most of his drug use was paid for by benefit fraud, burglaries, selling stolen cars and motorbikes, and shopping to order (shoplifting to set orders).

Jimbo (NZ European) lived in his van most of the time. When I interviewed him (at age 22) he was staying with a friend for a few days having just recently come out of hospital after an overdose. He was 18 years old and at university when he first tried poppies (opium). Up until that time he had only smoked cannabis and had one LSD trip. After a year of recreational poppy and morphine use he became a regular user - 3 or 4 times weekly, and then finding he was spending more time looking for drugs and using them than studying, dropped out of university. He then went to live in a country house and grew a paddock full of poppies. After his stockpile ran out he turned to crime (mainly motor vehicle theft, buying, receiving and selling stolen property, shoplifting, and burglary) to pay for his drugs of choice, morphine mixed with Marzine (travel sickness tablets), street methadone, and opium. He has overdosed 4 times in the past year and is Hepatitis C positive.

Lauren (NZ European) was 24 years old at the time of the interview. When she was 17 a male friend offered her some magic mushrooms (psilocybin). He then introduced to cannabis and LSD, which she used on a regular basis. At age 22, she left home and travelled overseas. Whilst there she had her first intravenous use of heroin. Within five months she had become a daily user. When her mother died last year Lauren returned to New Zealand and became immersed in the drug culture here. She is a regular user of morphine, cannabis, opium poppies, and ecstasy. Lauren supported her drug use financially by dealing in all types of drugs, prostitution, and benefit fraud.

Timothy (NZ European) was 28 years old when I interviewed him. His first experience with drugs was as a result of a motorcycle accident when he was 19 in which he sustained multiple injuries. After the accident he remained in hospital off and on for over 12 months. He suffered severe pain from spinal injuries and was given morphine and pethidine to help with the pain. By the time he was discharged from the hospital he believed he had become dependent on these drugs. He then continued to be prescribed morphine, palfium, and pethidine for pain relief on a long-term basis by doctors and specialists. Timothy found that because of his injuries his requests for these drugs were never questioned and therefore he could obtain them easily. After a period of time he realised that he was receiving enough drugs for his pain but not his

dependence. Consequently, he often exaggerated his pain to legally acquire more drugs. He also supplemented his prescribed drugs with homebake, street methadone, cannabis, poppies, and opium derivatives from cough medicines. To fund these extra drugs Timothy carried out burglaries and shoplifted.

Ethical Issues

Prior to beginning data collection, an application for ethics approval was submitted to the Massey University Ethics Committee articulating details of the study, its aims, methods, and a description of the research approach. Before ethics approval (Appendix II) was given, some amendments were made with regard to informed consent and confidentiality issues.

Conducting research with drug dependent participants carries with it unique human subjects concerns. Specifically, research into illicit drug use and drug dependence inevitably involves the researcher being aware of and obtaining information about illegal activities by means of a confidential relationship with the research participants, disclosure of which information could put them in jeopardy with law enforcement. As such, specific safeguards must be built into the research protocol to protect participant confidentiality as well as assure the University that the researcher will protect and treat human participants ethically.

In protecting the participants in this research, I was committed to abide by a set of guidelines of professional ethics as approved by the University. These guidelines included making explicit to the participants the purpose of the research and any potential risks, of determining that no harm would come to each individual participant as a result of participating, and of ensuring that the resulting research could not be used in a way that was detrimental to the participants as a whole. Central to achieving these guidelines in the protection of the participants was the informed consent procedure in which the guidelines of the research and the participants' role were described to each potential participant along with an explanation of how the participants' confidentiality would be protected if they chose to participate.

Although each participant was given assurances that appropriate steps would be taken to ensure confidentiality (coded names, password protected computer disks, and destruction of tapes and transcripts on completion unless personally requested), no assurance could be given for legal protection. It was, however, stressed to each participant that my ultimate responsibility as a researcher was to the research participant and their welfare and that every precaution would be taken to protect their wellbeing and honour their privacy. Accordingly, the main risks perceived by the researcher for the participants in this study were legal risks. These risks were associated with disclosure of information about their illegal activities and behaviours. A general question concerning the ethics of illicit drug research is what one does with data in relation to law enforcement. Do police have a right to information gathered from research participants about illegal activities that might assist them in arresting people? From a researcher's perspective, my response would be negative in that the researcher's paramount responsibility is to one's research participants. According to Power (1989) and Fitzgerald & Hamilton (1996) the researcher's greatest concern is not only to protect specific individuals from the consequences of their study but also research populations and that providing information to police may violate notions of informed consent. Consequently, researchers must fully inform their participants of the confidentiality measures that will be taken to protect participant confidentiality.

All individuals who agreed to participate in the study were then given a clear explanation of the purpose and nature of the study, the method of recording information, the time commitment, and their rights as a participant. These rights included the right to refuse to answer any question(s), the right to stop the interview at any time, to withdraw from the study at any time prior to submission of the final draft, to request the tape recorder to be turned off at any time, and to be protected from harm by withholding any painful information. On agreeing to participate, all participants signed a consent form.

Each participant was then given assurances that appropriate steps would be taken to ensure confidentiality. Among these steps were the optional use of pseudonyms, password protected disks, locked storage for audiotapes and transcripts, and destruction of audiotapes and transcripts on completion of the study unless requested

by them personally. To help uphold confidentiality the typist who helped with the transcribing signed a confidentiality agreement (Appendix VI).

Despite being asked if they would like to use a pseudonym, only four participants chose to do so. The other 21 participants clearly indicated that they did not mind their real names being used, however, because it is difficult to provide contextual information about each participant living in a small city without threatening confidentiality, I decided to use a fictitious name of my choosing for each participant. Participant anonymity and confidentiality were further ensured in that the interview data were not linked to participants' identification. Participants' names on transcripts were coded with the participants' identities known only to myself. Any other names were also coded. Additionally, in consideration of the participants' rights, and due to the sensitivity of the phenomenon of drug dependence, counselling and debriefing were available for any participant who experienced anxiety, stress, emotional pain, or embarrassment as a consequence of disclosing sensitive and personal information. However, no instances arose which necessitated this service. Rather, most of the participants were very relaxed during the interviews and stated that they enjoyed speaking with someone "straight" about their lives as they had few opportunities to discuss their everyday lives with anyone other than their associates who were generally also drug users with a drug dependence. Several also remarked that participation in the study had benefited them and that it had been a validating and therapeutic experience, whilst others expressed the wish to help others in the same situation and believed that through their participation that was what they would be doing.

In contemplating this research, it was known that legal protection for research confidentiality was not available and that there would be no privileged relationship with the participants that would allow for evidence or information to be withheld from the courts should they subpoena it (Fitzgerald & Hamilton, 1996). For these reasons, any publicity about the research was withheld, no papers were written or published about the intended or progressive research, no local authority (police) was informed of the research and discussion with the University's Ethics Committee took place with regard to the protection of the participants' confidentiality. It was also believed that any risks to the participants' confidentiality were greatly reduced by putting in place specific

safeguards such as deleting names and locations in transcriptions along with coding of personal information. A further consideration in this research was the element of legal risk to the researcher. According to Polsky (1969), "If one is to effectively study adult criminals in their natural settings, he must make the moral decision that in some ways he will break the law himself. He need not be a "participant" observer and commit the criminal acts under study, yet he has to witness such acts or be taken into confidence about them and not blow the whistle. That is, the investigator has to decide that when necessary he will "obstruct justice" or have "guilty knowledge" or be an "accessory" before or after the fact in the full legal sense of those terms" (p. 133).

Inevitably, the researcher in studying drug dependence and illicit drug use must break the law in order to acquire participants' data through having guilty knowledge – information about criminal activities that have been committed. Essentially, awareness of such crimes makes one accessory to their commission since the police are not notified. However, unless required by statute there is no legal obligation to report an offence that one knows has been or is about to be committed. Taken into account in this research project was the fact that there has been no known conviction of researchers and no arrests in this type of research situation in New Zealand or Australia (Fitzgerald & Hamilton, 1996).

Although the issues surrounding the protection of the research participants and the legal obligations of the researcher especially in areas of confidentiality of data are complicated and emergent, the researcher's paramount responsibility is to their research participants with each participant being fully informed of the confidentiality measures that will be taken.

Data gathering

In this study, the principal source of data was conversational interviews with the 25 participants. Although I worked on a voluntary basis at the needle exchange for 14 months from May 1997 to June 1998, interviews with participants were conducted over an eight-month period from November 1997, when ethical approval was gained, to June 1998. Whereas I initially preferred not to disclose my personal telephone

number, I later decided it would be of more convenience to do so, particularly for participant recruitment. After some discussions with possible participants I discovered that many of them did not have their own telephones and more often than not made their phone calls whilst out on business. Also, many stated that they were reluctant to leave their name and a message with someone at the University phone number. Therefore, by having my telephone number on the posters and pamphlets (Appendix III), I was more able to be contacted by possible participants to discuss participation and arrange suitable interview times.

All individuals who agreed to participate were given a clear explanation of the purpose and nature of the study, the method of recording information, the time commitment, and their rights as a participant. These rights included the right to refuse to answer any question(s), the right to stop the interview at any time, to withdraw from the study at any time prior to submission of the final draft, to request the tape recorder to be turned off at any time, to be treated with respect at all times, and to be protected from harm by withholding any painful information. On agreeing to participate, all participants signed a consent form (Appendix IV). Each participant was also, at this time, given the option of having their audiotape destroyed or given to them on completion of the study. All participants requested that their audiotape be destroyed on completion. Participants were also asked if they would like to use a pseudonym. Only four participants chose to do so. The other 21 participants' clearly indicated that they did not mind their real name being used. However, because it is difficult to provide contextual information about each participant living in a small city without threatening confidentiality, I decided to use a fictitious name of my choosing for each participant.

Participants were offered a choice for the interview setting between a private room at the Needle Exchange set aside and furnished specifically for interviewing purposes or at a venue of their choosing. Of the 25 participants, 21 chose the Needle Exchange and 4 their own homes. The interviews were prearranged at a time convenient for the participant, and all participants except one, who telephoned to arrange an alternate day for interview, attended or were at home for interviewing.

On arrival at the homes of the four participants I was offered refreshments, and either before or after interviewing was shown around three of the gardens and homes, introduced to pets, shown photographs/artwork, and made to feel comfortable. Two of the participant's homes were in rural areas and two were within the city boundaries. All participants who were interviewed at the Needle Exchange were offered tea or coffee with biscuits, and often taken home or delivered elsewhere after the interview.

Over the course of data gathering, I had regular contact with many of the participants. As most were regular clients at the Needle Exchange, contact was sometimes weekly or fortnightly, in that they would often stay for a chat or coffee after purchasing injecting equipment. For other participants, contact was occasional, and for six participants, there was only the one contact after recruitment, that being at the interview.

Six participants were interviewed a second time, at their request, after the initial interview. Each of these participants either wanted to expand or clarify earlier responses, partly because they had not allowed themselves enough time at the initial interview through not knowing for sure what it would be like for them or because they felt they had not been as open as they would have liked through their own assumptions of me as a researcher. Participants also, over the period of data gathering, brought in photographs, an autobiography, and a diary for my perusal.

The interviews varied in length from 1-½ hours to 6 hours, during which participants were surprisingly candid and talked explicitly about their lifestyles and their experience of drug dependency. No time limits were placed on the interviews, each continued long enough to explore the phenomenon in as much depth as was comfortable for the participant. However, time spent before and after each interview for informal dialogue and closure usually added another hour or more to each session. Two participants requested the tape recorder to be turned off and then continued talking for several hours. All interviews were audiotaped, and in total, I gathered over 87 hours of taped interviews.

Conducted in an informal manner, the interviews were open-ended and unstructured. Although having some guidelines for questions covering such domains as demographics, lifestyle and drug dependence, behaviour change, feelings and knowledge, to allow me to focus on issues as necessary, the dialogue was largely directed by the participants. Each interview began with the same open-ended questions. These questions were: What does having a dependence on psychoactive drugs mean to you? Can you describe your personal experience of it as you live it in your everyday life? All questions were directed at learning more about the participants' experiences. Every effort was made to avoid asking "why" questions, to refrain leading the participant in a direction that they might choose not to venture, and to stay at the level of the participant's experience.

The rapport that had developed between many of the participants and myself as a consequence of working at the Needle Exchange led to easy empathic interactions that facilitated rich disclosure of data. Through the process of dialogue, I also opened myself to new and different descriptions of the participants' experiences and the meaning these experiences held for them. During the interview process, the participant was at all times acknowledged as the expert on the phenomenon, and throughout was allowed the freedom and flexibility to address experiences they may not have had the opportunity to describe, or clarify the meaning of, previously.

As in any interview research, some participants were more articulate and responsive than others. Some were very candid and open about their experiences, even criminal activities and offences, many of which they had not previously disclosed to a "straight person".

Following each interview, the tape was listened to and notes made about any content areas needing clarification, emerging themes and ideas, and my subjective impressions and emotional responses. These background notes were revisited each time data was examined for analysis. In this way data analysis proceeded simultaneously with the data gathering. After the last interview was completed the data gathering process ended. All audiotapes were transcribed verbatim to provide the foundation for the pre-reflective analysis of the data.

Data analysis

Data analysis, in phenomenological research, comprises of three significant activities as identified by Van Manen (1990): identifying and reflecting on essential themes, writing and rewriting, and balancing the research parts by considering parts and whole. Through these actions the researcher aims “to grasp the essential meaning” (Van Manen, 1990, p.77) of the experience under investigation, and through the work of writing, make visible, to those standing outside of the experience, what kind of knowing occurs when one is involved in a situation (Benner & Wrubel, 1989).

In phenomenological research the process of data analysis does not happen in an orderly sequence. Rather, it is a dynamic process of moving between part and whole of the text, in which there is both repetition and overlap, as more data is gathered and further insights realised in the search for phenomenological themes - the experiential structures that make up experience, in order to grasp a thematic understanding of the experience or phenomenon under investigation. Accordingly, the search for themes in this study followed the process of hermeneutic phenomenological data analysis as described by Van Manen (1990) using both the principal source of data, the transcribed conversational interviews, and the secondary source of data, the audiotapes and my field notes, as the texts upon which the analysis was made, the aim being to reach a deeper understanding of the lived experience of drug dependence by way of interpretation.

In this study, the process of analysis started with immersion, an intense involvement in the data. This immersion in the data began early on in the study, in that as each interview was completed, the audiotapes were listened to prior to the next interview, and any emerging themes, or content areas needing clarification, or variables (for example, preconceptions, judgements, etc.) influencing the data were noted. The notes made acted as a form of feedback which was then ploughed back into the interview process, in that as the breadth and depth of the questions grew, other relevant issues were identified and incorporated into the data collection process. Subsequent

interviews were then used to refine and articulate emerging concepts. The notes were added to after each interview and were revisited in the immersion period.

On completion of all interviews, the field notes and the audiotapes were transcribed verbatim into text, both by myself (15 transcripts) and a paid typist (10 transcripts). Although a time consuming activity, the transcribing of the recorded interviews allowed me to engage in imaginative listening and to reflect actively on the narratives as I transcribed. For the audiotapes I did not transcribe, this reflection took place whilst reading the texts and listening to the audiotapes.

I then immersed myself totally in the text by both listening and relistening to the audiotapes and by reading and rereading the text. Through listening to each audiotape I gained a feeling of familiarity for each participant's whole story in its totality, and sensitised myself to the way in which each participant spoke- what was said, how it was said, and what had been unsaid. Each individual transcript was then reread and reflected upon independently to grasp the essential basis of the participants' experience of being in the world with drug dependence before returning to the 25 transcripts as a whole.

Encompassed in this immersion period of listening to the audiotapes and reading the text was also exploration of relevant literature and ongoing contact with many of the participants through my voluntary work at the Needle Exchange. This ongoing contact enabled me to explore with the participants any issues that I felt needed clarification or interpretation, which were then added to my field notes. After this period of intense involvement in the data, a decision was made to set the work aside for a short period of time and occupy myself with different activities. Whilst my conscious mind was thus occupied with other things, subconsciously I was working on the data within, allowing meaning and understanding to come to light, uncovering that what is being said from that which is talked about.

Following this passive phase was again a period of immersion in which I reread the transcripts and reflected on the text endeavouring to further amplify or clarify aspects of the lived experience of drug dependence and address any misconceptions,

misunderstood realities, or missed truths. I then undertook a detailed line by line analysis of all transcripts from which significant statements relevant to the phenomenon of drug dependence were identified. These significant statements were then compared and contrasted with one another for similarities and differences, and for aspects of the experience, which were common to each account. This interpretative (hermeneutic) approach to the data resulted in the emergence and identification of themes and patterns within categories (themes within themes) as they related to the participants' experience of drug dependence. As each theme and pattern was identified, thematic statements were isolated, which in turn were interpreted further through ongoing reflection. This reflective process necessitated such questions as how were the themes related to the participants' lived experience of drug dependence, did my interpretation of the identified theme fit both the context of this part of the text as well as the text as a whole, should they be included or excluded and why or why not, and can I tell the interpretation in a way that the meaning is conveyed faithfully?

At this stage, Van Manen's (1990) four existential "lifeworlds": lived body (our corporeal and mental experiences); lived human relation (our interaction with others); lived space (our physical environment); and lived time (temporality -our situatedness in and sense of passing time) came to mind as guides for reflecting on the emerging themes and categories, as each lifeworld permeates the experience of all human beings. Using Van Manen's lifeworlds as a guide I then tried to identify the essential structure of the phenomenon for each transcribed dialogue. Once identified, I then wrote an account of the essential structure in summary form in my notebook along with any ideas, interpretative comments and thematic patterns that presented themselves to me and which might have been of relevance in the final synthesised interpretation. The essential themes were then segregated from the non essential themes as I brought together all interpreted accounts in order to create a final synthesised interpretation which captured the essential nature of the participants' lived experience of drug dependence.

Throughout the data analysis, writing was the process through which I was able to sort and search for thematic patterns. As a process, writing forced me to continuously reflect on relationships between themes whilst focusing on what the experience meant

for each participant and the overall essence of the lived experience of drug dependence for all the participants. Writing allowed me to both describe things as they appeared and to interpret that which was seen. When no new themes arose, were uncovered or brought to light, the analysis came to an end.

In hermeneutic phenomenology, there is no correct interpretation of the participants' lived experience, nor does any interpretation remain absolute or true for all time. Instead, interpretations change with interpreters depending on both their theoretical and historical perspectives (Leonard, 1989) and the contribution of their own experiences in the interpretation process. As stated by Leonard (1989), interpretations change with interpreters and whilst another researcher embracing a different viewpoint may come to a different interpretation of the phenomenon under study, it is my assertion that the findings presented in this study comprise an adequate and trustworthy interpretation of the lived experience of drug dependence as it is lived by the study participants.

Presentation of findings

In presenting the findings of a phenomenological study, the researcher rewrites each participant's story through an interpretative process, keeping the final description as close as possible to the participant's own language and story whilst working to maintain the inner meaning contained within the stories. Likening phenomenological research to a poetising activity, Van Manen (1990, 1997) points out that the inner meaning appears when it is read with thoughtful reflection as compared to the outer meaning when it is read for information. Like poetry, any presentation of a phenomenological nature is as it presents itself. It is the thing, the result. As such, "it is inappropriate to ask for a conclusion or a summary of a phenomenological study" (Van Manen, 1990, p.13). In presenting the phenomenological research, Van Manen (1990, p.168) states that there is no compelling reason why it needs to be structured in any one particular way. However, as there are certain traditional forms in presenting data and keeping with the standards required by academic practice, this thesis follows a conventional format embodying both summaries and conclusions whilst keeping the characteristics of phenomenological writing.

For organising one's writing in a phenomenological study, Van Manen (1990, p.173) suggests five different approaches - thematic, exemplificative, analytical, exegetical, and existential. These approaches are neither exhaustive nor mutually exclusive and a combination of these approaches may be used. In presenting the phenomenological account of the lived experience of drug dependence I chose to organise my writing using a combination of approaches - thematic, exegetical, and existential (Van Manen, 1990). The main approach used for the presentation of the findings in the following chapters is both exegetical and thematic whereby the phenomenological account of the lived experience of drug dependence is presented alongside aspects of Heidegger's (1927/1996) writings on the phenomenology of Being. The account, based around concepts basic to Heidegger's philosophical writings, comprises three chapters: Becoming and being drug dependent, Being-with-others and Being-with-care. Within each chapter the data and my interpretations are oriented and discussed alongside some of Heidegger's more notable concepts in relation to the emergent themes. Through merging a thematic approach into the presentation of the findings, the meanings of the lived experience of drug dependence are captured and used to describe aspects of the structures that make up the lived experience. According to Van Manen (1990) themes are a means of getting at the meaning and essence of the experience, and of giving shape to the experience.

Interwoven into the description of the lived experience of drug dependence are also features of Van Manen's (1990) lifeworld existentials: lived space, lived body, lived time, and lived human relation. These lifeworld existentials are a means of further exploring the context of the participants' experience, their situatedness in the world and the way in which they experience the world through their embodied selves. In the findings, the lifeworlds are drawn upon in order to further emphasise that the origin of the participants' experience of drug dependence is grounded in their everyday lifeworld.

In keeping with the hermeneutic approach, exemplars are used extensively throughout the data chapters to illustrate aspects of the lived experience of drug dependence as described by the participants, to support the interpretations that were made, and to

keep the account close to the original data. The use of exemplars also allows the reader to be an active participant both in the analysis and process of consensual validation through reading the exemplars given and then the interpretation. Given the data, each reader, as co-analyst, must ask him or herself whether the interpretations that follow are valid and adequate (Rather, 1992; Benner, 1985; Packer, 1985).

The three data chapters which follow address different aspects of the experience of drug dependence. In Chapter V, the context of the experience of drug dependence is described. For the participants that context related to the processes in becoming and being drug dependent, particularly with regard to their embodied selves, and the way in which drug dependence impacted upon their experience of Being-in-the-world. Two main themes, becoming drug dependent and being drug dependent, depict the drug dependence journey, beginning with how the participants became involved in drug use, how they came to know that they were drug dependent, on through to the impact of drug dependence on their embodied selves, and to the activities related to maintaining the lifestyle.

Chapter VI deals with aspects of the participants' relationships to others, their relating to and being related with, their involvement with others in both an individual way and as members of the larger straight society. Chapter VII involves a discussion of concern, or caring - the significance with which being in the world has for those with a drug dependence - all those things that matter, which are of concern, the participants' capacity to anticipate and respond to their needs and protect and care for their self, a self concern in terms of the past, present, and future. The discussion also focuses on the way the participants act and behave, the choices they make in their everyday lives and the meaning they derive from their place in the world, their openness to possibilities, future aspirations, where they can be what they are and what life will show itself to have been in the end. The thesis concludes with Chapter VIII in which the phenomenon and the experience of drug dependence are discussed, and their implications for professional practice and for future research are considered.

Review and Summary

This chapter described the use of Heideggerian hermeneutical phenomenology as an appropriate method to this study by which to gain a better understanding of what it means to live with a drug dependence. This method is asserted as appropriate because of the exploratory nature of the research question and because it uniquely contacts the individual's experience of a given phenomena from a researcher and a health professional's perspective. The specific methods of data collection and analysis were then discussed along with an introduction to the 25 people who participated in the study.

In phenomenological research, emphasis is placed on establishing trustworthiness. Trustworthiness is established in a research study when the interpretations or descriptions accurately reflect the meanings of the participants and the interested reader, when given the interpretations, can see the same things the researcher saw, or given any differences, the reader can follow the decision trail used in the study (Guba & Lincoln, 1985; Sandalowski, 1986). Although there is no one correct way of interpreting the participants' lived experience, nor is any one interpretation true or absolute for all time, there is a need to reduce the number of interpretations to obtain a unified picture and to allow the reader to participate in the validation process (Polkinghorne, 1989; Sandelowski, 1986).

In inviting the readers to be a part of the validation process, I have provided a description of the methods used to organise and interpret the data from the initial turning to the phenomenon of the experience of drug dependence through to a description of the participants' experience in the study findings. Through recording the procedures used in the study the reader can follow my decision trail and recognise that the findings are firmly grounded in the uniqueness of each participant's lived experience of the phenomenon being studied (Sandalowski, 1986), in order to make their own judgement about the validity of the descriptions and interpretations presented in the findings.

Chapter V

BECOMING AND BEING DRUG DEPENDENT: THE JOURNEY

In this chapter discussion is focused on the way in which the study participants found themselves thrown into being-in-the-world with a drug dependence, in other words, who and what they are and had become and the ways in which drug dependence impacted upon their experience of being in the world. In communicating their stories the participants described their existence in terms of historicity, that their existence, the situation in which they now find themselves, had grown out of their past, present, and future. These entities, past, present, and future are inseparable, none can be understood apart from the other, thus each element of the participants' experiences are dependent on the other. What they do and who they are now can only be understood if what they have been and done in the past can be seen, a preunderstanding of what has been. Similarly, what they want to be or do in the future can be understood only as that which has grown out of the past and present of a single *Dasien*. Essentially, drug dependence is a part of the participants' present lives, part of their history, and part of the future they project for themselves. Who and what they are is determined by the decisions or the choices they made, are making, and will make.

For Heidegger, an analysis of being-in-the-world is realised through ordinary everyday existence, *Dasien*. *Dasien*, or *being-there* emphasises the situatedness of the person in the world, of being thrown into a situation already created, an a priori world in which the person participates. Each person has a world, a world that comes from their culture, history and language, a world which they are born into and in which they co-constitute. The world in which the person lives is already there and at the same time the person constructs their world from their own experience and background, their historicity. Background is what a person's culture gives them from birth. By virtue of being born into a culture, a person has a meaningful set of relationships, practices, and language (Leonard, 1989) which are already in the world, a preunderstanding handed down which offers a person a way of understanding the world, of what counts as "real" for the person. For each situation or experience the person comes to they have a

preunderstanding, a preunderstanding which is already in their common background understanding. In order to understand the situation or the experience, the preunderstanding is brought into focus through a framework of interpretation. Essentially, nothing can be experienced without reference to the person's background understanding and every experience or situation requires an interpretation based on the person's background. To understand drug dependence, therefore, it is necessary to understand the context in which the experience is situated and which helps to give rise to meanings that come to exemplify the experience.

In the process of reflecting on the participants' stories I became aware that changes to their embodied selves constituted the context of their being-in-the-world with drug dependence. The way in which the participants came to be drug dependent and the aftermath of being drug dependent have substantial effects on their embodied selves and their being-in-the-world. For the participants their experiences of drug dependence and all that it encompasses are synthesised into their sense of self: what they are is what they have created, what they are creating, and what they will create. Their experiences, described in terms of their embodied selves, both on and within their bodies and their consciousness, are an integral part of their existence, of their being-in-the-world, of *Dasien*.

For the participants, the lived experience of drug dependence is a powerful experience that can be compared to a journey upon which they have been thrown. Thus, in this chapter, the metaphor of a journey was chosen to symbolise the lived experience of drug dependence - of being-in-the-world in this way, and to bring to the foreground the participants' experiences of changes to their embodied selves. In an effort to understand this lived experience from the perspectives of the participants who have drug dependence, three main phases emerged: becoming drug dependent, being drug dependent, and taking care of business (the name of this phase taken from Preble & Casey's [1969] study on heroin use in New York). Hence, these three main phases are used thematically to situate the participants' experiences of drug dependence in the world, to give shape to their experience, and to describe aspects of the structure of their lived experience of drug dependence. The first theme, becoming drug dependent, describes the routes through which the participants became drug dependent and

encompasses the sub themes of starting off with drugs, continuing on, and the realisation that one is drug dependent. The second theme, being drug dependent, deals with the impact of drug dependence on the embodied self and the everyday demands of being drug dependent. Included are the sub themes of feeling different and being different, both bodily and psychically. The last theme, taking care of business, incorporates the essence of the participants' daily routine, the scoring of drugs and getting the money.

Becoming drug dependent

The drug dependence journey, like all other journeys, has a starting point. For the participants in this study, their journey began either when they were introduced to drugs by others, or when they were seduced by the mystique and excitement of drugs long before they used them. Part of their readiness to commence their journey was brought about by their circumstances in life, their background situation that put them at the right place at the right time ready to embark on their journey. In their recall of the reasons for, and the circumstances of, their first drug use, the participants described a variety of influences and factors that set them on their way.

The way most of the participants came into contact with drugs was intimately related to the drug use of their friends, acquaintances, and/or family members. When describing their first use of drugs, most of the participants reported these others as being instrumental in their initial drug use, both by supplying the drugs and the necessary paraphernalia, and by instructing them in how to use the drugs and equipment.

For these participants, first use of drugs occurred mainly in social situations. Most of them did not set out to take drugs or to become drug dependent. Drug use for many was incidental in that they were thrown into situations which led to drug use. These situations were generally related to peer pressure or the need for social acceptance - wanting to belong, to be part of the "in crowd". Wanting to be somebody or to gain status amongst the others were sentiments commonly expressed especially by those participants who began their drug use at an early age. Mostly though, they were

within reach of drugs and drug users, and as such, were vulnerable to the ideologies of the drug culture devotees, or they had a frame of mind and a set of circumstances that lay them wide open for the experience.

Many of these participants had had previous opportunities to use drugs but had chosen not to do so at those times. When they did first use, many could not recall anything particularly meaningful about the situation that led to their initial use other than wanting to be one of the crowd or not wanting to say no. Contrary to the popular image in the public's mind, largely created by the media hyperbole that drug dealers initiate, facilitate, and promote drug use, none of the participants were introduced to drugs by strangers. Rather, as the following exemplars show, social networks created some of the participants' initial drug use.

*My best friend, he used to use misties [morphine sulphate tablets] and I used to go around to his home and always see him cooking up and what have you. And that's how I came to use the needle. He wanted me to try it and just gave it to me. **Angus***

*Just before I finished my apprenticeship I started smoking a bit of pot [cannabis]. One of the salesmen at [father's store], we started mucking around together and seeing a little bit of each other and I smoked a bit of pot with him. He offered me some and I didn't want to say no. **Gerard***

*I was not quite 13. It was way back in the end of 1968 and I was flatting with two women who were using heroin, and at that time, heroin wasn't, the police didn't know anything about it. They hardly knew about marijuana, and they didn't know anything about heroin, and it was relatively easy to get... and a lot cheaper.... I'd moved into their flat. They didn't give it to me straight away. I hassled them for months to have a try. I want some. **Eliza***

*Mum's boyfriend, he was into his smoking and that. He would always have a bit [cannabis] lying around the house. I'd pinch a bit every now and again and then roll myself up a little doobie [cannabis smoke]. **Wayne***

*The first drugs I used were this sort of cocktail of pills that someone handed to me. I don't know what they were but, yeah, I just swallowed them with alcohol. Everyone did it. All my friends. **Lilian***

*My bro's, eh, and then mates used to sniff the petrol and glue all the time, and smoke the dak [cannabis] and I didn't want to be left out. I was one of them and besides, they kept telling me that I had to do it so I couldn't nark on them. **Willie***

Some of the participants felt curiosity was the main reason for their initial drug use. In their search for kicks, their longing for new and more intense experiences, they were led to drugs. For these participants, drugs were perceived to be glamorous. The aura of excitement, mysticism, and status surrounding drug use, the publicity, the media hyperbole, the drug using accounts of peers and friends, and music, all provided the impetus for their embarking upon the drugs bandwagon.

I remember the Stones' song - Mother's little helpers. When I heard it I'd think of my mother, how her little helpers [Ativan] got her through the day, couldn't do without them. I'd listen to Grateful Dead, Joplin, Hendrix, Moody Blues, Jefferson Airplane, Velvet Underground, you know, searching for the kingdom, yeah, you know, from the song "Heroin", you know it don't you? You know, the Velvet Underground, yeah... I knew there was something I was missing out on. I wanted to know, I wanted to get on the bandwagon too. Those songs got me dead curious. After I got stoned on pot with [friend] I went looking in the library. You wouldn't believe what I found there....

Alistair

I had a friend that was working for a chemist, doing the push bike delivery thing after school, so I got a whole list of drug names off another guy that I knew that knew a bit about drugs and then just got my mate that did the delivery, worked for the pharmacy, just to sort of when he was in there after school, just to have a look around the shelves and find the names and grab bottles of those ones and then I'd experiment at school with them. I just wanted to see what it was all about, if the stories I'd heard were true.

Simon

I started on fly spray. You just stick the bag, the can goes in the bag and you just hold it shut. And you shake your hand and you just hold it shut and press the nozzle down and it just fills up the bag and you just sniff it. I saw it on the Tele and wanted to know what it was like. It looked a hoot so I thought I'd give it a go. **Steven**

I smoked grass way back. I guess I started smoking it 'cos it seemed the appropriate thing to do. I used to hear everyone talking about it, used to read about it in the papers and that and I guess I had an eagerness to try it.... So I got hold of some [cannabis] and tried it at home. It was perfect for me really because I used to get pretty low at that time and it helped. **Jimbob**

Unlike the participants whose first rendezvous with drugs was not planned, a few of the participants actually aspired to become "junkies" and actively sought out the objects of their desire. Seduced by the drug lifestyle, these participants' ticket on the drug bandwagon had been reserved long before they ever used drugs. All they had to do was find the bandwagon.

*Like I said, I wanted to get on the bandwagon. I wanted what Grace Slick was singing about in "White Rabbit", you know, feed your head, do you know it? It's all about drugs. I wanted to know what it was like. [Starts singing] I'm going to try for the kingdom if I can. **Alistair***

*Before I used drugs I read up everything I could about them sort of thing, and yeah, I just wanted to learn as much as I could about them. Like, I was just attracted to them. Don't know why, can't explain it. Just knew that was what I wanted. Like I haven't got anything else I'm interested in. Couldn't really see myself being any other way. Sort of weird really when I think about it. I just knew that's how it was going to be. I was going to be a junkie and that's what I am. **Herman***

*All my whanau smoke weed. Right from the cradle I wanted it. The old man [father] bashed me when I nicked his. "Wait 'til yah 10, boy. Fucks the brain up when yah growing". Didn't wanna wait that long, eh. I was a smart cunt, eh. When I wanted something I got it. I knew where the old man grew it and used to rip him off. I started when I was about 8 on the weed. Always wanted it. Right from when I used to smell it way back. **Dan***

For a few participants, initial involvement with drugs was connected with their experiences of coping with their feelings and of facing the world. Drugs, for these participants, represented a refuge, or form of relief from the pain of past and present abuse or personal disturbance. To them, using drugs was a means of satisfying some inner need, whether it was a loss of self esteem, a reaction to the loss of a relationship, a sense of hopelessness, depression, or of dealing with the emotional pain experienced after a traumatic event, as reflected in the following exemplars.

*I was real good at athletics at school but then hurt my knee and had to stop after they operated. It had a huge impact on me 'cos one day I was somebody then the next I was nobody. I felt like a real failure. I'd let the team down. They needed me to help win the cup but I couldn't, not after the operation. When I looked in the mirror all I saw was someone who let them down. I thought it [heroin] would make things better, make me feel better. **Rosemary***

*When he offered me some mushies [psilocybin mushrooms] I was ready to try them. I'd been pretty unhappy at home with [stepfather] always on at me and I knew that after what [friend] said about them that they'd make me feel real good, make it all fun again, so I wanted them. It was cool. **Lauren***

*After he [brother] raped me when I was eleven, I freaked out. He said he'd bash me if I told anyone. I kept crying so he made me smoke some dak, that it'd stop me hurting. So I did. I stopped crying, and I kept on smoking it. **Tui***

I tried grass [cannabis] way back when I was flatting but didn't really like it. Didn't do a thing for me. It wasn't 'til I was really down after [wife] left with that motherfucker that I tried it [heroin]. Wow! Did that ever get rid of the greebies!
Jared

As illustrated by the exemplars, there is a myriad of factors that together brought into being the participants' first drug use situation. Availability of drugs, opportunity and the desire to use at a particular time and the environment in which the drug use took place were all catalysts in launching the participants on their journey.

Continuing on with drugs

Whatever the circumstances or the reasons for the participants' initial drug use, they then continued on using drugs and, over time, increased their drug use until it was no longer only experimental or occasional use but more regular. For most of the participants, their first drug using experience was enjoyable. In recognising that the drug used affected their functioning, made them feel relaxed, anaesthetised, more able to enjoy life, these participants wanted to recapture the feeling. In order to recapture the same feelings these participants' next use of drugs was, in the main, anything from a few hours after their initial use to days later depending on availability and circumstances. In the following two exemplars, the participants describe how, in their keenness to repeat the experience, went looking for drugs the next day.

I got stoned at work. They [work mates] were always stoned. They turned me on. I loved it [cannabis]. It made me feel relaxed, on top of the world. Work just changed. It actually became enjoyable. I didn't want to wait 'til they gave me more so I went and scored off one of them the next day. There was no going back. **Gerard**

I didn't know much about it [using drugs]. It was relatively, I suppose it, and it was relatively unknown in [town]. One of the guys at work was, you know, getting into this and that, and the next thing I got into a bit, you know, Tuinal, sodium pentobarbital, you know, the barbiturates. And yeah, it was great. You know. Marvellous. I liked the feeling that, I'd been waiting to feel it all my life, that numbness.....it [using barbiturates] was the best thing that happened since sliced bread. I just had to have more. I just needed more so I got some off him the next day. **Tony**

Not all of the participants used drugs again within such a short period of time. For some, the time lapse between their first encounter with drugs and their second use

ranged from a few months to a year later. Other than lack of opportunity, these participants' decision to steer clear of drugs until a later time was based on their experiences with their initial use. For them, their first drug using experiences were either not enjoyable or the effects felt were not meaningful enough to want to repeat the experience straight away. Despite experiencing feelings of being out of control, feelings of discomfort, feelings of unfamiliarity, or feeling as if nothing had happened after their first use of a drug, the experience was not so pernicious as to discourage them from wanting to try again as depicted in the following exemplars.

I failed to get into the hostels so I ended up in a guest house and there were about 5 other students there and they all smoked pot and I watched it, I watched them smoke it a few times, just to see what happened to them and talked to them about it. Then I tried it. It didn't do anything for me. About 6 weeks into the first term I got into the hostels, and basically, out of that environment, I didn't smoke pot again 'til about a year. Nearly a year it was, towards the end of my second year when I tried pot again.

Hugh

I don't think I really enjoyed it [first time smoking cannabis] or I didn't just enjoy it. I didn't really. It's just something I did. It wasn't quite like what I thought it would be. I really didn't like it. I didn't like the feeling. I didn't feel quite right. It sort of was like floating but I wasn't. I wasn't sure. It was a while before I tried it again. Some months later. **Jared**

I had my first taste when I was about 16, something like that. Meant to be heroin. I hit it up. Yeah. It was terrible. Terrible. Fucking horrible. You get this massive rush. Like real massive and, um, as soon as it goes in after a few seconds, it just goes through your body. It goes right down to the palms of your hands and your feet, the top of your head and stuff like that. It's like prickles. Real bad prickles and it's just whoa! It's just really painful. It's just so raw. A real raw taste. Like pins and needles. Real bad. Right throughout. Right throughout, specially your feet, your back, your head, all your extremities. Right through your body, right up to there [indicates to head]. And after that, it's just, phew, man, a wicked headache. You know, baddest headache I've had in my life. You're lying on the ground thinking, "I wish it would go away". It's thumping. That was my introduction to the needle. It wasn't even a very nice thing. It was an ugly taste. Not dirty ugly but just a horrible feeling.. . I can't remember when I used next after that. I think it was a couple of months I suppose before I did it again. **Rosemary**

Many of the other participants also perceived their early drug use in sickness terms, with vomiting, nausea, and any other unpleasant effects accepted as being a part of the drug using experience, an initiation rite that had to be got through if they were to continue on with their drug use. For these participants, any unpleasant effects

experienced were generally downplayed by the positive effects of the drugs, for example, the “high”, or because they had been forewarned to expect some form of sickness by others, and that if they pressed on through their first few encounters with drugs, the sickness would depart as demonstrated in the following exemplar.

*Being sick after hitting up heroin didn't last more than 4 or 5 times. It wasn't quite like spewing up when you're ill, sort of different. Like, the first few times I was kinda giddy, felt pretty woozy, then suddenly felt like spewing. I'd rush off to the loo and spew my ring out. Didn't really mind though. It was just one huge spew about 5 minutes after hitting up. After about the 5th time it didn't happen, bit like getting sea legs I suppose. Got used to it [heroin]. It was never enough to put me off. [Friend] hated that sick feeling. I told him it would pass, like if you ride it out long enough, it doesn't happen again. **Rosemary***

No matter what the length of time between the participants' first use of drugs and their next and subsequent encounters, and not withstanding the unpleasant effects experienced by some with their early use, the driving force behind the participants' continuing on with drug use was the personal and social rewards that they experienced. For many of the participants, getting high was the most reinforcing personal reward experienced. Whether the participants regarded it as getting high, getting stoned, getting buzzed, or out of it, it was a very personal experience for each of the participants, all of whom found difficulty in describing what the high, the buzz, or the stone was, and what it meant. For each participant it was a sought after experience, one that they were prepared to give to themselves over to drugs for, an experience that had different meanings depending on the situation in which they found themselves in their everyday life.

For some of the participants, getting high meant feeling relaxed. Often preoccupied with everyday problems, getting high enabled these participants to feel free from worry and a feeling of total relaxation. For them, their experience of getting high was generally one of overwhelming happiness, calmness, a state of being that each one of them sought again and again. In the following exemplar a participant describes the euphoria he experienced when first injecting liquid morphine and how difficult it was to put it into words. What this exemplar also captures is the participant's awareness that such happiness and relaxation is unbelievable, that if it had not happened to him, he would have found it difficult to believe that getting high could be so pleasurable.

*It's a bit hard to explain what it [first use of liquid morphine] was like...you really have to try it yourself to know what it was like, like it was, like my whole body was warm from the inside out. Um, it was almost like it warmed your whole body up and it's like all of a sudden it just, it just bangs into you, you get a big rush through the head and you, then you're instantly stoned. It's unreal. It's unbelievable. You're just instantly feeling really relaxed and you just sit there and quite easily go to sleep no trouble and nothing is a problem. You're just really happy. Yeah. You just get a big rush and all of a sudden your whole body is warm. Feeling warm stays in you the whole day but the rush only stays with you for about 30 seconds and you're really happy. Unbelievably happy. I just couldn't believe how great it was. I wanted to feel like that all the time. Didn't want it to stop. **Steven***

In the following exemplar, another participant describes her experience of getting stoned, again emphasising the freedom from worry. Getting stoned led her to experience a feeling of calmness to the extent she was able to compare it to a feeling of what she thought was normalcy. In knowing the difference, she wanted to maintain the feeling and the only way she could do that was to keep on using.

*It's just; it's just an amazing feeling of well being when I'm stoned. Yeah. It's like a really calming feeling as well. Anything you're worried about, or, it's kind of like, it's like, say, you're abnormal and you take it and find out you're normal, it's sort of, yeah, like becoming normal.... You feel totally calm, yeah, totally calm. A total sense of calmness, really confident. I never felt like that before. I knew the difference. It's like there's a knot in your stomach or something that sort of goes away after you have it. You know [laughs], that's why I get stoned. **Jenny***

For some of the other participants, getting high was a way of escaping reality, of blocking out pain, or to feel nothing. For these participants, everyday Being was a profoundly disturbing experience that they had found difficult to deal with. It was as if they were on the edge of an abyss with nothing to hang onto. Feeling overwhelmed by the pain in their lives placed them in a situation of despair from which they wanted to escape. For these participants, drugs and getting high provided the route by which they were able to escape or at least the means by which they were able to either forget what had been or come to terms with it. These participants found it difficult to talk about their past experiences, experiences they wanted to block out, not think about, especially the traumatic aspects of the experiences. Having tried drugs, they knew that continuing on with them and getting high was a way they could regain a sense of control over their lives, of not letting past events invade their everyday Being, of

dulling out that which overwhelmed them in the following three exemplars, the overwhelming feeling of despair that led the participants to continue on with drugs is captured. For the participant in the first exemplar, her experience of being repetitively raped was so painful that the only way she could escape severe trauma to her Being was to continue to get high, to mash out.

Every time the fucking bastard did it to me [brother raping her] I couldn't stop crying. Every time I cried he'd give me some to shut me up. "Take this slut or I'll kick your fucking head in" he'd say as he stuck the bag in front of my face. So I did. I sniffed glue like he said and if it wasn't glue he'd give me petrol on a rag. I could feel it. My heart would go thump, thump, thump but it calmed me down. It made me feel better. Sometimes I got real sick, real sick and dizzy but it made me not think about that cunt. I didn't like doing it but I did it. I took any thing he gave me and then he'd get his mates to fuck me. "Do it bitch or I'll cut you". So I took more, anything he had, just to mash out. Not to think. Tui

In the next extract, the participant feeling overwhelmed by the pain of past hurts, describes how getting high helped wipe away, block out his feelings of despair and loneliness.

*Getting high's not a way of trying to block out things. It is **the way** to block them out. It does block them out... I can talk about what happened [physical, verbal, emotional and sexual abuse] but, um, thankfully, all that I... thanks, thanks to the drugs, I don't feel too much. I don't give a damn about myself. I rarely give a damn about other people. I wouldn't deliberately go out and kill myself. No. If I had of had the bullets when I was 10 I would have done it. Yeah. I guess I'll just keep on with it [using drugs] until my times up. That's me. The down clown. It's a big front. I sort of put on this big humorous front, you know, and, oh, inside, I'm as soft as shit like everybody else, hurting just as much, and you know, I feel, you know, all those drugs help me wipe that away, those feelings. I keep on using them. I don't know what you'd put it down to, what I put it down to is a broken heart. If you don't think you can die of a broken heart, believe me, you can, because I'm dying. My parents, you know, my sisters, you know, wherever they are. I haven't seen them since 1981. I am alone, totally alone. That's how I know alone is the most horriblest word in the English language. I take them [drugs] to make me feel **nothing**. I take drugs to make me feel nothing. Tony*

In the last exemplar, getting high for the participant involved very strong feelings of being encased in a comfortable void where nothing existed other than Being.

It was the IV drugs I liked, I'd have to say. The high. The void, just the numbness. It's what I liked. The nothing. Not a care in the world. Nothing. It was just the switch off. Nothing exists, just me. I know women that are IV users, they've gone to parties or something and they've been raped by just about the whole party, and once they've got home and got away from that situation, they're all mentally fucked right over by the situation but as soon as they've had a taste, phew, who gives a fuck. It doesn't matter,

*doesn't exist, that situation doesn't exist, may as well not happened. They're certainly not sore any more. The pain's gone, the memory of it's dulled right out, it's just nothing. It's just a void. It dulled every thing out. There was nothing any more. It dulled out everything. Every body. You're free and stuff. The past. The abuse [from stepfather]. Your crimes, the fact that you're even using, where you get the next taste, you don't worry about that while you're actually on it, worry about that as you're coming down, you know, every thing, like pay the rent, where's my next thousand dollars coming from, I've got a hot bike in the shed, all of that, it's just gone, just nothing, all that exists is just this little bubble around you, that's it. You're enclosed in it. Just so comfortable. It's just so comfortable. I mean, if you could take away every pressure in your life, every pressure being even the minutest little things, arghh, I nearly got caught stealing that bike, I nearly punched my mate over there 'cos he's a dick head, I wonder if I'll get laid, shit, I'm down to \$30, why she's [mother] a psychotic fanatically religious fucking egg, should I go to the pub tonight, every little thought, every little detail, every little iota of life that occupies your mind at any time, of any day, gone, and all there is, is just this numbness, just total and complete, prolific euphoria. It's gone, every thing's gone, nothing exists. Fuck, drugs, man, make it all go away, so, fuck, you just keep on with it, wanting more, just to dull it all out. **Toby***

A sense of belonging and social acceptance were among the social rewards that propelled some of the participants to continue using drugs. Just as a desire to be part of the in-crowd and social acceptance were two of the reasons some of the participants initially used drugs, so too were they motivating factors in continuing on, even though a few of these participants experienced initial unpleasant effects. For these participants, being part of the in-crowd through using drugs provided many advantages. Membership of the in-crowd meant a sense of belonging, of having shared interests and aims, of having something in common to talk about and do together, of elevated status and identity, of increased confidence, and a feeling of us against them. The following extract captures the experience of becoming one of the in-crowd and the sense of belonging the participant felt.

Like I say, I was a shy and reserved person. I'd be shy and reserved and have all of this shit built up inside of me and no way to get it out. Like I had all these sort of little problems with myself and life, like lack of confidence to the fullest, to the extent I couldn't deal with things, little problems I had. I couldn't speak up. I wanted to be just like them [the in-crowd of drug users at the time]. Always looked like they knew what they were doing, just being themselves, full of confidence, always doing things together, like they were this thick [demonstrates]. When [one of the in-crowd], like I already knew this person, said did I want to hang with them, I couldn't believe it. Like I'd smoked cannabis by myself but I'd just have it by myself and I'd be even more shy and reserved, I'd sorta climb back into this hole. I don't know. I'd hardly talk. It's sorta obscene my sort of shyness, but when I started hanging with them it was like I got confidence. I was one of them. We started doing things together, like there was a

group of us and there's, you know, there's always something going on. We were good mates. I felt good about everything. It's like I say, because of me being a shy reserved person, you couldn't get a word outta me edgewise for hours then suddenly I was haha blah, you know, you couldn't shut me up. I changed from this shy reserved person to like, boom, I'm this, I was like this most confident, boom, I can conquer the world, on top of the world type of person, like someone others wanted to be with. All of a sudden it was like I got a life, a social scene. You know, cruise around to a mate's place sessioning [talking about drugs], there'd be coffee and a joint, and that's the way the day consisted. Like, I could go to and party and be coherent and be the person I wanted to be, you know, this confident rah loud person just the same as all the others. It was good. I was one of them. Simon

As illustrated by these accounts, each of the participants found that continuing on with their drug use fulfilled some needs. Drugs were all-purpose. They gave to the participants whatever they wanted or needed. For some of those participants, these needs were social or recreational, with drugs being used for relaxation, to party and have fun, to get along with others or to feel part of the group. For others, these needs were personal, whereby drug use was continued to help cope with the worries and problems of everyday living, to relieve boredom, to escape reality, to feel numb, or to feel nothing. Sometimes the participants' needs differed day by day, or depending on the situation in which they found themselves. Drug use at one time could be to help deal with specific problems and at another time be social or recreational. For most of the participants, this stage of their journey into drug dependence was experienced as a time of experimentation and of adventure, of finding the drug which worked best for them, the one that would lead them to the kingdom. This was a time in which the participants trusted their being to whatever drugs came their way. They would smoke them, swallow them, snort them, or inject them in varying quantities. They would take tablets, capsules, liquids, powders, resins, plants. Some drugs they used separately, some they used interchangeably, and others they used simultaneously. For the participants, a whole range of drugs were available for the trying. As one participant expressed it:

From there, from there I went to the library and I got the Whole Earth Catalog, you know what that is? Somebody told me about it. I got the drug page out of it, so I thought I'd try out all the drugs on the drug page, you know, like mushrooms, cactus, nutmeg, morning glory seeds. Yeah. From there I'd go out and steal cactus, you know the cactus plants, and try them. I didn't like them. I didn't like cactus. It didn't jibe with me. Then datura. Man, that would be the wickedest drug I've ever had. It's totally hallucinogenic. It's just berserk. Yeah. You're in another world completely.... Then I tried nutmeg, ground it up into a powder, mixed it with milk

*and drunk it. It's hard to explain what sort of stone it was really. It wasn't very good really. And morning glory seeds. They, um, have an equivalent of a microgram of sort of LSD, you soak them in water, crush them up and eat them. It just feels like a trip. Then, then it was, I ripped off this doctor's bag. It had some morphine, palfium, and there were some methadone pills. They were in cans, you know, cans of morphine, cans of pethidine and that so I tried some of them. That was good. I made a morphine pethidine cocktail. Little ampoules. You snap them open so I sucked them up. It was 15 mgs of morphine in the morphine ampoule. I can't remember the milligrams of pethidine, but I sucked them both up so that they mixed and that was my taste, and, oh man, that was just amazing, you know, just the rush and everything was so smooth. There was no pins and needles. It was just sort of, it was just nearly like an orgasm I suppose. It just felt so good. It was just so, phewww, all through the body, then after it's gone, once the rush was gone I was feeling out of it, really stoned. It felt really good. You know, I was there, it was the kingdom. Once you had a taste, you get on with every one. You talk to every one. You can't stop talking. It was so good. I wanted to do it again. It was the feeling, the feeling. What it did to me. It was all on after that, from then on. Regular. As much as I could get. **Alistair***

Like Alistair, many of the other participants played around with different drugs, experiencing their effects, discarding the ones that did not jibe with them, adding new ones as they came across them, trying different ways of using. Although a few of the participants injected drugs the first time they used, the main route of administration of a drug for most of the participants at this stage of their journey was either orally or by smoking. For many of the participants there was a gradual move over to injecting drugs intravenously, however, not all of these participants continued with the injecting method as a way of using drugs after having tried it.

Through this period of experimentation, the participants not only found the drug of their choice - the one which kept them on their journey, but also the method of using which best suited them. Availability of drugs, the opportunity and propensity of the participant to use at a particular time, and the social ambience in which the participant was situated, all contributed to their continuing on with their drug journey. Also, during the early stages of their experimentation, depending on the above elements, there would sometimes be long periods of time between the use of drugs and yet at other times a much shorter period. However, for all the participants, as time went on, the time span between each use lessened until drug use was every day.

The realisation of drug dependence

In his book *Junkie*, Burroughs (1969) describes the lengthy process needed to arrive at dependence. *"It takes at least three months shooting twice a day to get any habit at all. And you don't really know what junk sickness is until you have had several habits. It took me almost six months to get my first habit, and then the withdrawal symptoms were mild. I think it no exaggeration to say it takes about a year and several hundred injections to make an addict"* (p. 11).

Equally, the participants in this study did not become dependent on drugs overnight either. For the participants, the period between first use and realisation of dependence was a time in which they became aware that drugs gave them a feeling of well being and a feeling that their problems had faded away, consequently, they came to use more drugs with greater regularity in order to keep on experiencing these effects. For each of the participants, this stretch of the journey varied considerably. The length of time spent on it depended upon a variety of factors: the drug used and its inherent characteristics, the method of using, the availability of drugs, social and environmental situations, and intrapersonal and interpersonal factors. Generally though, the length of time spent on this stretch of journey for the participants was around three to twelve months, with the female participants, on average, arriving earlier than their male counterparts. Moderating the length of time at which some of the participants arrived at drug dependence were stages of no drug use or the ability to control use. For others, progression was more rapid; particularly if the initial drug used was by an intravenous route with the effects being more reinforcing.

In most cases, the period up until realisation that one was drug dependent was thought of in positive terms. Although negative aspects were experienced during this stage they were not so salient as to impact in any meaningful way on the participants' drug use. The overwhelming euphoria experienced, the sense of belonging - being part of the drug crowd, the excitement of the lifestyle, the relief from physiological and/or psychological pain, the feeling of relaxation, and the pleasure were all aspects that were conducive to the participants' continuing on with their drug use that eventually

led to drug dependence. Over time, repeated exposure to the various drugs used by the participants, particularly the opioids and the benzodiazepines, led to greater tolerance, consequently higher doses were needed to produce the effects originally produced by lower doses of the drug. When drug use ceased, the participants experienced psychological and/or physiological withdrawal symptoms, or indications that something was wrong. Indications that something was wrong were not always physically experienced. Often something wrong meant a changed behaviour, an act that was atypical of the participant as illustrated in the following exemplar.

*I guess one day it just hit me and it really scared me. It was [boyfriend at the time]. He, he didn't know that I was tasting on my own. I was cooking up some [morphine sulphate tablets] and heard him come into the house. I heard him and it was like, oh fuck..., I just freaked out. I didn't want him to know. I didn't want to give him any. I wanted it all for myself. Fuck. Something was wrong. I was hiding it [using] from him, getting real greedy, and that's when I realised that, fuck, I've got a habit. I've got a fucking drug habit. I'm a fucking junkie. **Lauren***

For other participants, something wrong meant an inability to find a vein, becoming aware of track marks, a pre-occupation with drugs, mood changes, or uncontrolled and compulsive drug use. As indicators, they usually led the participant to the realisation that they were drug dependent. In the following exemplar one of the participants describes how seeing his track marks led him to an awareness of his dependence.

*Because he [friend] had so much of it [Ritalin, methylphenidate hydrochloride, a stimulant] I started shooting that up too. He had so much of it I was getting my hands on it all the time. I was using it all the time. I was using it everyday and it got to the stage where my track marks were just bloody hideous. Like they really scared me, fucking scared me, you know, every time I looked at them. I was just really stressing myself out and I realised, hey man, this needle thing has become, it's just become too much, because in the past I'd only been doing it once in a while and now it's come to the stage where I'm doing it everyday, more than once a day, and, um, I really freaked out. Fuck, I was an addict. It's a funny thing. You'd have thought after freaking out looking at my arms that it would've put me off. It should've but it didn't [laughs]. Because the need to get out of it seems to overpower the need to look after your body. I just kept blasting 'cos, well, I wanted to get out of it. **Wayne***

Generally, realisation of drug dependence did not happen automatically. Often it was gradual and was only recognised when other users pointed it out after a participant had

experienced physical and/or psychological withdrawal symptoms that were not previously associated with the cessation of a particular drug. For these participants, the moment of recognition that they not only wanted drugs but they also needed them was often distressing. In the words of one participant:

*I stopped taking it [morphine]. I hadn't realised how dependent I was on it. I didn't know that I'd gone so low. After a couple of days I had what I thought was a cold, felt chilled, runny nose, few aches and pain. I mentioned it to [friend] that I was coming down with a cold and he said, "Fuck off. That's no cold. Try some morphine and see how fast it disappears. You're a friggin junkie, mate, doped up to the eyeballs". Well, I'm telling you, the morphine stopped that cold straight away and I gradually realised that I needed more and more to keep that cold away. **Timothy***

In the participants, the severity and duration of withdrawal symptoms experienced varied considerably depending on the particular drug used, the dose, and the length of time it had been used. Consequently, these factors played an important part in either making it harder or easier for the participants to associate the symptoms with being drug dependent, of believing that they needed drugs. Because of the varied nature of the withdrawal symptoms experienced after cessation of a drug and the fact that many symptoms such as sleepiness, restlessness, nervousness and depression were all attributable to many other possible causes at the time, a few of the participants were ambivalent about actually being drug dependent. For these participants, being dependent on drugs had not been a consideration and often, a period of time was required before they came to terms with thinking of themselves as drug dependent. In the following exemplar, one of the participants describes how she slowly slipped into drug dependence without awareness that it was happening. Her journey into drug dependence had passed unnoticed. She had travelled on thinking it a long way off.

*I felt like an old lady in a young body. Um, I was crook a lot of the time, not eating properly, not staying healthy. I was pretty run down. I'd lost a lot of weight, very skinny. Couldn't sleep and always felt really nervy. Basically I thought the world was fucked. Then I ODed [overdosed on drugs]. I just got really down and I took some bad shit. It was a massive dose but it was bad shit. I don't know. I just woke up in the hospital. It was hell in hospital. I didn't get out of bed for ten days. I was too weak. I had cramps and I kept shaking. They [drug counsellor] came to talk to me. We talked about me being a drug addict. I said that I wasn't, that I was a long way off it, but they said I was. I can't remember how long it was but finally I said I was. That I did have a problem. I didn't realise how it crept up on me. I just didn't want to be an addict but I can't help myself. I guess I was. I just didn't know it. **Trish***

This was the point in time at which many of the participants were confronted by the reality and meaning of their drug use, the *addict* role identity which they were taking on, and the *addict* lifestyle in which they were becoming thrown or projected into. The participants' way of being-in-the-world was no longer as it had been. Being had become inauthentic. The participants' had become caught up in a way of being in which drugs had taken precedence over being ahead of oneself. Instead of them controlling their drugs, their drugs had taken control of them. It was a way of being that for many of them was uncertain, ominous, and beyond comprehension. Up until this point in time, the participants' way of being-in-the-world was non-reflective of what was to come, of being non-aware of dependence as the destination of their drug use. The participants acted without consciously examining or considering the effects. It was only when something was wrong that they reflected on their situation consciously.

After realisation that they were drug dependent, of finding themselves in this situation, most of the participants acknowledged the experience of drug dependence as a major event - an event that for some was a complete resignation, yet for others was not easily accepted. Once resigned to the fact that they were dependent, the participants were able to surrender themselves to it, knowing that they were making a conscious choice of being-in-the-world in this way. For those who found it hard to accept, their delusions of being in control continued until they could no longer fight against them. Drugs had taken precedence over being. They could no longer go without drugs. Because their need was too great, they finally came to accept that drugs had become their life. The following extract from one of the participant's interview illustrates the feeling of resignation he initially experienced on realisation of his drug dependence, followed by his feeling of acceptance of his drug dependence by making it a choice, something he chose over not being drug dependent.

Like I didn't want a habit. I didn't want to spend money on it every day. I didn't want to be like a junkie. I thought I could handle it. A little bit more, you know. I'd started during poppy season. I wasn't using great amounts, two, maybe three times a day. I suppose it was about three or four months of use, poppies, some misties, bit of opium. Like I'd been using for three, maybe four months then I actually realised that I'd got myself a habit on just using for a short time. It got me [laughs]. It wasn't as bad as I thought it would be. Basically, it becomes a way of life and not, not a drug thing. I

don't think that having a habit has actually got that much to do with the physical part of using. A lot of it's like cigarette smoking and that. It's mostly headspace. Yeah, it's headspace. Yeah, you choose what you do. Paul

As previously mentioned, drug dependence did not just happen. For the participants in this study, drug dependence developed over a variable period of time. Slowly, through their continued use of drugs, the participants slipped into dependence, only for it to be identified through feeling and being different, both in body and in mind – signs that something had changed. Among the signs experienced by the participants were tolerance and withdrawal symptoms, relief or avoidance of withdrawal symptoms by the use of a drug, obsessiveness with drugs, continued use of and craving of drugs despite adverse physical or psychological reactions, and a feeling of being out of control with regard to their drug use. Usually, the first step on the way to the participants' realising they were drug dependent was the changed sense of embodiment, their feeling and being different in both body and in mind. For most of the participants, this change occurred when their familiar taken-for-granted body experienced symptoms of tolerance and withdrawal. Although the majority of the participants were in no doubt about the facticity of their drug use, a few of the participants were unaware that the source of their physical and/or mental stress was related to their drug use, however, they were subsequently informed by others as to the nature of the symptoms they were experiencing.

Once named or recognised for what it was, whatever the route into it, or the time spent travelling it, drug dependence impacted upon the whole of their Being, on their bodies and on their minds, for it is in the intimacy of their embodied selves that drug dependence is experienced and it is through the lived body that they perceive and relate to the world - an inseparable connectedness. Through their drug use the participants had been thrown into a new way of Being. Being addicted or being a junkie was no longer something that happened to other people, it had happened to them, and with it came a sense of loss of their former selves, of their previous way of Being-in-the-world, and of feeling and being different. From this point on, drug dependence was enmeshed into the very fabric of their Being, a Being determined by the decisions and choices the participants had made, were making, and would make, a Being dominated

by drugs. Drugs were no longer a part of life. They had become life itself around which the participants' Being now revolved.

Although each of the participants' individual lived experience of their drug dependence - the nature of their drug use, the duration of using, and the impact of drug using on their lives - were different, the underlying experiences of Being-in-the-world with a changed sense of embodiment, of feeling and being different in one's body, were shared. Accordingly, the remainder of this chapter describes the impact of drug dependence, and the demands of maintaining the life, on the embodied self under the theme of Being drug dependent.

Being drug dependent

For the participants in this study, being drug dependent affected the whole of their Being. For them, being drug dependent was to feel different and to experience oneself as being different in body and in mind - the embodied self - from whom and what they had been before they found themselves in the world in this way. Being drug dependent also meant being involved in, and maintaining an all-consuming lifestyle which each of the participants, upon realisation, made a conscious decision to commit to.

Feeling different and being different

For the participants, feeling different and experiencing oneself as different began with their wanting to create a better reality - a more pleasant state of Being, or to change a painful or unpleasant reality - to obliterate or make Being tolerable. To achieve these states, the participants used a variety of psychoactive drugs, each of which has got quite different chemical features and, which through their action on the body's biological functioning not only affect emotions, feelings, sensibility, moods, consciousness, and thinking, but also lead to their own characteristic type of dependence. Through the continued and compulsive use of these drugs over time, each of the participants developed a physiological and/or psychological dependence, the effects of which, through their impact upon the embodied self of the participants, led the participants to feeling and being different, both in body and in mind.

Feeling different - bodily

As a consequence of their continuous drug use many of the participants experienced certain physiological changes in their embodied selves, the two most important being the development of tolerance and of physical dependence, both of which went hand in hand in that, as with most drugs, tolerance precedes dependency. In their journey of drug use, of progressing from occasional use through to more regular and compulsive use, many of the participants found that their bodies gained tolerance relatively quickly to the drug(s) used. In gaining a tolerance, these participants found that their bodies no longer responded to the drugs in expected ways and that they needed increasingly larger and more frequent doses to produce the effects previously experienced with the original dose. For this reason, becoming tolerant to many of the effects of the drug(s) meant a catch-22 situation to the participants. They were caught in a situation in which they needed to balance the body's increased tolerance of the drug(s) with a spiralling increase in dosage and, therefore, increased search for and cost of the drug(s). Being tolerant brought its own complications and problems. Often the participants felt trapped in a situation with only two choices: to give up or cut down on drugs to reduce the tolerance and endure the discomfort, or to continue using at a rate in excess of their tolerance and face the economic burden and ongoing search for drugs. The following interview extract captures the sense of being caught in a situation and feeling both conflict and entrapment.

*I had to made a decision to give it [opiate use] up, for awhile, to get my tolerance way down. It was costing too much and I was aware that it had become a problem, that it would be an effort to give it up, or at least a traumatic thing. I didn't want to give it up but I couldn't keep up with the money side of it. I'd done it before. I knew it was going to be rough going, like it doesn't take that long before you've got a habit. Now I've got such a habit I have a taste and don't even get stoned off it. It just stops me feeling sick. And that pisses me off... ..yeah, when your tolerance goes up it's time to cut down. It's really a two-sided sword. You're trapped both ways, like, keep on with it and you've gotta find the dough or give it up to get the tolerance down and it's like getting sick. I don't like feeling straight. I just don't like it. **Brian***

At the same time as a participant's growing level of tolerance and build-up in the amount of drug(s) needed to produce the desired effects were taking place so too were

changes in their body's response to the drugs such as that when the drugs were not taken, the participant began to experience physical withdrawal - the arrival of a number of distressing and unpleasant symptoms. Withdrawal, for many of the participants, meant submitting to such symptoms as nausea, vomiting, cramps, depression, restlessness, diarrhoea, insomnia, and bodily aches and pains. Experiencing such symptoms made the participants feel overwhelmed, of having a changed sense of embodiment, and of losing their familiar taken-for-granted way of being-in-the-world. In the first exemplar the participant describes the extreme distress she experienced when she first encountered withdrawal.

*Fuck, I hated it [withdrawing from drugs]. It was so fucking scary. I felt so scared of what's happening to my body, so frightened that it won't stop, or that I won't be me again, that I can't bear it. It just comes on so fucking quick. Hot and cold. I can't sit down. I can't lie down and I can't fucking move around. I just kept on crying. When it happened, when I couldn't get any [drugs] it just went on for such a fucking long time. My whole body was just someone else's. It wasn't me. I couldn't control it. I don't ever want that to happen to me again. I hated it. **Rosemary***

This participant's lived experience of withdrawal was of her whole body aching and of not being able to control the symptoms. To suffer such anguish was to lose a sense of her familiar taken-for-granted way of Being-in-the-world and of being overwhelmed. As a consequence she used an increased quantity of drugs more frequently to avoid experiencing withdrawal again. In the second exemplar the participant expresses his feelings of apprehension and of disembodiment, and of his determination not to be in a position where he would have to experience such feelings again.

*Then one of them died [friend who overdosed] and it all came to a crashing end. I'd decided to, you know, what happened, what had happened, so I just stopped and I got, I felt sick, wiped out. My kidneys packed up. I was doing three or four 30-mg blasts every day. It was like, fucking being sick and wiped out, you know, feeling wiped out, and sore kidneys. It was like, fuck, someone else's fucking body, not mine. I wasn't going to let myself get to that stage again. I wouldn't. I've got nothing against having a minor habit but not that again, you know, fucking being sick. **Hugh***

Some of the participants underwent voluntary withdrawals, either through treatment centres or alone. This was usually when they felt they had acquired a tolerance for higher and higher doses of a drug(s). These withdrawals were not for the purpose of

stopping drug use but to reduce their tolerance and to once again experience the euphoric effects initially experienced and before tolerance developed. For these participants, voluntary withdrawal meant accepting and enduring the symptoms experienced. Because of the nature of the symptoms experienced, voluntary withdrawal inspired both dread and relief. As one participant expressed it:

*The first time I went through withdrawing I didn't know what was happening or what it was, couldn't work out why I couldn't sleep or, you know, I just felt awful and I didn't really relate it to that but... ..when I decided to do it because I was using too much on my own I sort of was dreading it, like I knew what I would have to go through but in some ways it was a relief knowing that it wouldn't be costing so much afterwards. Yeah, I was well and truly hooked then and needed to do something about it. **Jenny***

Regardless of whatever reason a participant had for ceasing their drug use, whether it was to reduce their tolerance, the hassles of having to find more money for buying increased quantities, or personal reasons, the withdrawal symptoms experienced meant discomfort in one way or another. In all the participants withdrawal symptoms were relieved by continued or renewed use of the drug. As their drug use once again escalated the participants who had experienced distressing withdrawals started to regain a sense of their previous bodies. Putting an end to withdrawals for them meant the alleviation of discomfort, of regaining control, of once again feeling normal in their body as shown in the following exemplar.

*It [opiates] had me in it's clutches. I tried to do without it, my tolerance kept on growing, growing so much that I couldn't afford to buy enough to get off on. My prescriptions didn't give me enough so at one point after I got caught doing a house over I thought I'd do without. I steeled myself for it but, man, I couldn't stomach it. My body shuddered and twitched. I was drenched in sweat. It just wasn't me. It created havoc. I wanted to do the full cold turkey but, hey, fuck, it was the running shits that did it. I couldn't hack all that shitting. All I needed was another blast to get back to normal, to feel like I was normal again. **Jimbob***

In experiencing withdrawal symptoms when drug use ceased and having the same symptoms relieved by renewed use of the drug(s) these participants became aware of being physically dependent on drugs. Drugs had taken over their bodies. Their bodies, having adapted to the drugs, no longer functioned normally without them. Continued drug use by this stage for many of the participants no longer meant getting stoned,

getting high, or getting out of it. Continued drug use was to regain a sense of bodily self, to feel normal, and to be able to function in a bodily way. Not all of the participants experienced their continued drug use in a bodily way. Because of the non-physical dependence producing nature of some drugs, a few of the participants did not experience physical tolerance or withdrawal symptoms after prolonged drug use and abrupt discontinuation. However, these participants, along with those who experienced withdrawal symptoms all developed a psychological dependence on drugs, reflecting both the individual participants' attitude to and the intensity of their need for a particular drug(s). For the participants, dependence was not only in the body, it was also in the mind.

Feeling different - psychically

Taking drugs that gave pleasure and enjoyment did not always lead to tolerance and physical dependence in the participants but it did lead to a strong desire, a yearning, to repeat the experience, and in doing so, to go to a great deal of trouble. As the desire or yearning to experience the effects of drugs became so central to their thoughts and emotions and activities that the need to continue to use them became a compulsion or a craving, the participants had reached a state of psychological dependence. They had become caught up in a way of being in which drugs had become the reason for their Being.

An integral part of each participants' psychological dependence was the belief that the effect of the drug(s) was needed in order to feel well, to feel normal, to feel in the right frame of mind. Feeling well in the mind, to the participants, was of much greater importance in their continuing drug use than either tolerance or physical dependence. As one participant expressed it:

I just don't have a habit in my body. I have it in my mind. I have this kind of dialogue in my mind. "I can give up. I hope to hell I can give up", but I can't. I'm an addict. My life is planned around my habit. I need it to feel well. I've tried giving up and can do it in my body but it's in my mind that I can't. My money goes on it [opiates] over my food, over my health. I can't get rid of that voice in my head. It's always telling me, "I want it. I want it. I need it" Timothy

Accordingly, some participants had encountered various periods of time in their lives when they had abstained from using drugs for one reason or another, for example, whilst incarcerated or in a treatment centre. Even though the participants had got through the experience of physical withdrawal they had continued to experience powerful cravings that kept on persisting until, overwhelmed by the intense cravings, they surrendered to their addiction. For these participants abstaining from drugs was a disturbing experience. Feeling overwhelmed by an irresistible craving which appeared to be driven by some magical inner force reinforced their feelings of not being in control. Of having an ‘addiction in my head’. In the words of one participant:

*Like, I've got the willpower to get over the physicals. You know, you get over that like you get over the flu but it's the head space I'm in. I can't get over it in my head. There's been a few times when I've had to stop. You know. I told you about them, it was a piece of piss, nothing more than like the flu, you know, a few aches and pains, a bit of sweating - all the physical stuff. But my head! I just couldn't stop thinking about using. It's like a voice in your head, never ending, always on at you. The devil for all I know! Like, I think I'm okay. Over the physicals, doing okay then this voice starts up. You know. I'd go all day. No thought given to it [injecting drugs] then I'd see [another drug user] and the voice'd start. I'd break out in a sweat. I'd be thinking 'only a blast'll stop it'. Can't stop thinking about it. **Paul***

For the participants at this stage, the persistent craving for and emotional and mental preoccupation with drugs and their effects was because of their need to achieve a state of psychic well-being, to be at home in their bodies, to feel normal, to keep straight, to function in their everydayness more so than for the buzzes, the enjoyable and pleasurable effects they experienced in the early days of their drug use. The following exemplar captures vividly the participant's awareness of his growing psychological dependence and of his need to use drugs to feel in the right frame of mind, to function. Getting a buzz was no longer the driving force behind his drug using.

I've tried to stop. When I have, all I think about is using again. Stopping doesn't work for me so it's just not worth me giving up at the moment. I'm finding life a lot easier on it [opiates]. I find facing the day a lot easier. I find facing people a lot easier. If I don't have it, I'll do nothing. I'll stay at home. If I have it, I get out and about. I'm doing things like, I achieve things. Just simple things like going to see Social Welfare or go to appointments. If I'm not using I'll just sit at home and say, "stuff it!" So yeah, it definitely gets me motivated, gets me out. When I'm hanging, if I haven't got it in me, I don't seem to think as quickly and as clearly as I do when I'm on it. That's what I find anyway. I sort of get tied up in things and when I'm not stoned I get tied

*up in things so much. It's sort of like I need it to make me feel normal like every body else. Like when I'm stoned I'm happy all the time. If I was to be straight I'd be sad, I'd be angry, I'd be depressed, I'd be every thing, you know.... Like I'm not experiencing any of that at all. Like, when I'm not stoned life's flat. Like, I find myself thinking about getting angry, getting depressed, getting bored. I suppose in a way I'd say about 80% of what I'm doing is self medicating so I don't have to think about things I think about when I'm straight. Like people that've pissed me off or people that've done things to me, I'll think about them. I'd feel angry. I'd feel ripped off. I'd feel depressed. I'd feel hurt, but if I'm using, I won't act on it. I don't dwell on those things. Like I keep on using becous it helps me get through those things. I feel a lot better. **Steven***

Unlike physical dependence which was fundamentally an all-or-nothing matter for the participants, psychological dependence continuously developed and was the driving force behind their drug dependence. The degree of psychological dependence not only varied significantly between the participants but also dictated the quantity of drugs each participant needed to feel normal, to function in their everydayness, to alleviate their discomfort. As the following exemplar shows, different drugs lead to different degrees of psychic dependence.

*It's crazy trying to explain it. It's sorta like when I use the opes [opiates] it's the real me. I think it's 'cos of.... I've been using for so long and I'm just not used to being straight but when I am straight I don't feel normal. Like, you know, if I stopped taking drugs I don't think I'd have any serious withdrawals physically 'cos I'm not really physically addicted to anything. It's all in my head. Um, sort of psychological I suppose you'd say. I think it would be, it would be just really hard to get used to not having them. Like when I smoked dope I could go without it and not think about it at all, like I wouldn't want to go without a taste 'cos I wouldn't be able to think about, you know, other things. I'd be thinking about the next one. **Wayne***

To Wayne, the desire to keep on using opiates was so powerful that not to have any would consume his whole Being. In going without he would be unable to think about anything other than where his next lot of drugs were coming from. For Wayne and for the other participants, drugs had become such an obsession to the extent that they took over their Being, their overall lifestyle, more so than their moral beliefs and values. In taking precedence over all else, drugs had led the participants to give up possessions, values, and relationships formerly held in high regard. The following exemplar captures the sense of being taken over by drugs, of giving up things of value and of resigning oneself to the overwhelming need for drugs.

*I gave up every thing for them [drugs]. My furniture, my CD's, my video, my fucking body, my whole fucking being. Every thing, every nerve, every bone in my body, every thought is about getting more, getting enough. I haven't really got any other needs. I don't need any thing else. People let you down, families let you down. If I thought I couldn't get any [drugs] I'd die. Life's just not worth living without it. Morph [morphine] just shuts it all out. It keeps me safe but it's a fucking bastard at the same time because every thing I do, I do for it. **Tui***

Drugs had become the means through which the participants lived their lives, relying upon them for gratification, for fulfilment, or to avoid feeling at all. Many had lost total interest in, and had no reason for, living drug free. Even if they had stopped using drugs they would find it hard to adjust to life without them. Drugs had come to represent their very existence. Drugs had become their driving force, their *raison d'être*. In the stark words of one participant:

*It's [drug use] like a jealous lover. It doesn't let you do or think about anything else. It's just a total obsession. Once I started [injecting drugs] I just didn't want to stop. I was in love for the first time, not with a man but with drugs. You know, I'll spend hours preparing it, it's like a lover's ritual. Caressing the syringe like a lover, waiting for the rush, the giant orgasm. I can't think of anything else. Everything I do is for it. It just swallows your whole existence. **Lauren***

As their psychological dependence, their desire, on drugs increased and the participants further submitted to their powers, they experienced a wide range of feelings. For the participants, being psychologically dependent on drugs meant feeling anxious, feeling fearful of being without drugs, feeling uncertain, feeling different and needing drugs to feel normal, in the right frame of mind, and of feeling obsessive and compulsive, thinking of nothing else but drugs, how to get them, and of having to do whatever it was they felt they had to do to stay normal. In the following exemplar one of the participants describes the overpowering psychic need he has for drugs and the feelings of anxiety he experiences not knowing where the next taste will come from.

I mean after you've got a habit, it's a vicious little cycle. You know, like you come full circle. You take the shit, you've come down, you've gotta have more, you take the shit, you come full circle. You've gotta have more then it all just starts to blur and all you're living for is the taste, when you start to come down, see, it gets closer and closer, like to start with you have your taste and you get a habit and before it's worn off, you're thinking about where you're getting the next taste. Once your habit starts

increasing it's coming back here, you've had your taste, you're starting to come down, you're not anywhere near coming down, all you're thinking about is where the fuck you're getting the next one, or who do I rip off to get the next one. Um, you know, and you come up with some pretty bizarre plans. Like, it's all you do, think about where the next one's coming from. Toby

These feelings, as described by the participants, are closely related to Heidegger's (1927/1962) concept of uncanniness. As described by Heidegger, uncanniness is a state of feeling different, of being different, of feeling anxious in a world of one's own making, a world which is determined by one's own choices. In Being-in-the-world as such, one finds oneself alongside of things, objects, or tools, which are used toward some end, these things being ready-to-hand when one is engaged in smooth everyday action. When things are ready-to-hand, one is able to concentrate on practical activity, everyday functioning rather than the things, or objects, which are taken-for-granted. When smooth functioning goes wrong or breaks down, when there is nothing ready-to-hand, then one becomes aware of the things or objects as being separate from oneself and with this realisation, one experiences anxiety. For Heidegger, addiction (Hang) is a condition that brings one closer to anxiety. It is a condition in which being-already-alongside of the things or objects of one's desire or drive takes precedence over being ahead of oneself, particularly when the thing or object is unready-to-hand.

In being psychologically dependent on drugs the participants in this study experienced feelings of anxiety, of uncanniness both when drugs, and equipment for using drugs (things, objects, or tools) were unready-to-hand and because of their awareness of being-as-such in a world of their own making. When drugs (things), which were used toward feeling normal and feeling different, were ready-to-hand they were taken-for-granted, used in an unassumed way. In the unready-to-hand state when drugs were unavailable, or when things went wrong, the participants became aware of being and feeling different, of feeling anxious, of being absorbed in their longing and need for drugs, and of the accompanying physiological effects of being separated from drugs rather than simply being engaged in authentic being. As one participant expressed it:

I'm in a good mood when I use drugs but, um, I can be a bit snotty, sort of, you know, when I don't get out of it for the day. A bit pissed off, you know, a bit snappy at people and stuff... ..Yeah, like I feel normal when I've used and I feel sort of, I don't

feel right when I haven't used. I sort of feel weird, hanging out. I just don't feel, don't feel good, just that sort of feeling things aren't right. I've always got the urge to get out of it especially when I haven't used for awhile. When I'm out of it, when I've used, I'm definitely more, yeah, more social. Things sort of go better. I sort of go better when I'm not hanging out. When I've got something to use. Herman

Like Herman, all of the other participants were psychologically dependent upon drugs to the extent that drugs were used continuously as a tool in adjusting to life, alleviating discomfort, in dulling emotional pain, and as a means of feeling normal. Because of their deep psychological involvement with drugs the participants had little interest, motivation, or drive for living without them. When drugs were ready-to-hand the participants were able to function smoothly in their everyday living but when drugs were unready-to-hand their thoughts were on nothing else other than the object of their desire. The participants' need for the effects of their chosen drugs was strong enough to influence them to be involved in a variety of behaviours and activities, these being sometimes deviant, risky, criminal, desperate, and even violent, that they would not have previously considered or engaged in prior to their drug dependence. What the participants did, or went through, for example, destroying relationships, prostitution, committing crimes, selling possessions, taking health risks, to continue taking their chosen drugs reflected the degree to which drugs had taken precedence over all else. As one participant expressed it:

I thought I was a long way off being a junkie but I wasn't. I thought I had control over my use...it came as a shock when I found that I needed it as well as wanted it [opiates]. I never thought I'd find myself in so deep. I found myself stealing from friends, dealing drugs to pay for mine, asking everyone for theirs, if they had any. I sold my body, all my things, everything. I didn't care any more. I just didn't care. The more I had the more I took the more I wanted the more I needed. My day to day life is scoring and getting money. I've learned to steal, to cheat, to lie. If I didn't use I wouldn't have had the nerve to do it all. I just don't have a conscience any more. Drugs come first and have for a long time. Rosemary

In their journey of becoming and being drug dependent, the participants had been caught up in a way of being in which drugs took precedence over all else. In being-in-the-world in such a way the participants needed to continue to take drugs on a regular basis to engage in smooth everyday action, to feel normal, to achieve a state of well-being, or to avoid withdrawals. Consequently, to obtain a steady supply of drugs to

maintain dependence, a major part of the participants' everyday life was consumed by two important activities: the search for a supply of drugs and getting the money to acquire the drugs

Taking care of business: the daily routine

Once the participants had become immersed in the drug culture lifestyle the search for drugs and finding the means to purchase them became a significant part of their everyday routine. Although the participants were involved in a myriad of other activities in their day to day routine, such as socialising, child minding, and avoiding risks, the search for a supply of drugs and finding the means to purchase them took precedence over all other activities. Once the participants had a supply of drugs they could carry on with their normal everyday lives. In their accounts of being drug dependent the participants described how their everyday Being was dominated by scoring - obtaining a supply of drugs and getting the money to finance their drug use as well as to provide for their everyday Being.

Scoring - getting the drugs

In being drug dependent the participants were in need of a regular supply of drugs. Without drugs the participants became sick, depressed, and unable to carry on with their ordinary everyday routine and activities. Consequently, a large part of the participants' day was spent obtaining a supply of drugs that they needed to keep them feeling well enough to lead their normal lives. In the words of one participant:

*Sometimes I spend all day scoring. I might start at 10 in the morning and I'm still looking 10 at night. I might drive all over town. Sometimes I've been up to Auckland, down to Wellington, hanging out. Then I'll grab whatever's going out of sheer frustration. I'll just take whatever comes my way, you name it, I've tried it. I'll knock on every cunt's door whether they've got something or not. I'll even go into gardens and steal poppies if I have to. Once I've had a hit I can think about other things, get on with things... ..until I have to score again. **Jimbo***

Just as it was for Jimbob, so too did scoring drugs for the other participants mean a never-ending search that consumed much time and energy. For many of the

participants, the main source of supply of drugs was through a dealer. In committing to a drug dependent lifestyle knowing and becoming known to a drug dealer, or several dealers, generally meant being able to score successfully and to avoid being ripped off - being sold inferior or adulterated drugs or being given a short changed quantity. Having a reliable dealer, one that could be trusted, gave the participants a sense of safety and security, of being cared for, as illustrated in the following exemplar.

My dealer is pretty cool. I don't see anyone except him. It's not often he hasn't got what I want, but if he hasn't, he hooks me on to someone who has. He hasn't let me down yet. We've got quite a good business relationship going. He doesn't rip me off and he doesn't sell me shit and if he gets something he knows I like he'll let me know. I need to have a dealer I can trust, one who'll be there and take care of me. I don't think I could stand it if I had to look further all the time. Tui

Establishing a relationship or building up rapport with a dealer not only meant there was less risk of being ripped off but also that the participant was able to buy on tick (credit) or receive a good deal (extra drugs or better quality drugs). Usually tick was only available if the participant was a regular client of the dealer. For the participant, buying on tick meant less hassle, less stress, of not having to hang out if the required amount of money to purchase the drugs was not forthcoming, or of having to go elsewhere to get the necessary drugs. In being a regular client the participant expected that they would be treated right, looked after. Not being treated right often led the participants to experience anger, particularly if they felt they were being cheated as illustrated in the next interview extract.

There's a lot of fuckers [dealers] out there, you know. All trying to fuck with you. It's hard to track down a fucking good dealer. I mean there the fuck aren't any, you know what I mean. You get those fucking idiots that are always trying to burn you, think you're fucking hanging out, that you're a junkie and try and sell you crap. Those fuckers make me angry. They used to mess with me but nobody does now. They know I mean business. I pay the fuckers for what I get and I want good stuff. I spend a fucking lot of my time chasing it up and I want good stuff. I spend a lot of my fucking time chasing it and I want no bastard burning me. If I can't pay on the spot I'll pay extra next time round for the credit. He knows I'm good for it. He doesn't rip me off and I don't rip him off. That's when you get a fucking good dealer, you keep the cunt. Like you respect one another. No fucking hassles. Willie

Occasionally a dealer could not be contacted, had left town, or been apprehended by the police. The participants then had to spend time finding another source of supply. For these reasons, most of the participants had other contacts that could supply the required drugs or knew of someone else who knew someone else who could supply them. In being drug dependent it was important for the participants to be part of a drug distribution network in the community in which they lived to ensure a steady supply of drugs. The more users and dealers the participant knew or made contact with, the greater the chances of always having drugs ready-to-hand. For some participants with no regular dealer, or other contacts through whom drugs could be purchased, scoring meant having to hang out in likely places, in particular, pubs, until a contact was made. Making contact with other users meant opening themselves up and taking a risk disclosing who and what they were, as well as leaving themselves vulnerable to being ripped off or given a bad deal. It also meant having the skills to determine which people were likely to be able to meet the participants' needs. In the following exemplar the participant elucidates his experience of making contact with a potential source of drugs and his feelings of vulnerability on being ripped off.

*When I came here I didn't know anyone. But then I actually met a guy here [needle exchange]. I came in here to get a syringe and I met this guy and, um, he was looking through the New Ethicals, and I asked him for a cigarette and I noticed he was looking up Rivotril and I said, "oh, have you got some rivvies, mate", and um, he said, "Yeah", so I ended up buying them, then I said I'd be into getting some valium off you and he, um, ended up coming around to my place, but he talked me into getting footballs instead of valium. 'Cos he said the footballs were quite good to ping up, you know, but the valium's not so good becos it's too chalky so I ended up scoring some of those off him on a weekly basis, um, yeah, and that lasted about I don't know, then I found out he was ripping me off so I stopped scoring from him, then I met this old, old guy who lives in town here, he's quite a well known junkie in town [Tony], and he's one of the master's of seeking, as it's called, you know, for going to the doctor's and spinning a yarn and coming out with an awesome script. He sort of looked out for me and I talked to him about it and took his advice. **Wayne***

Having the ability to seek out likely contacts for a supply of drugs was essential if one was to maintain their drug dependence in a new town. For one of the participants, scoring drugs in a new town was easy. Through his knowledge of drug users and awareness of their unitedness, he knew who and what to look for. Having self-confidence, for him, meant he did not have to go without, that he could readily build

up a network of users who might be able to provide him with the object of his desire as illustrated in the next exemplar.

It doesn't matter where I'm living. Auckland, Wellington, whatever. When I need something and I'm new in town I go to the pubs. That's where you meet people really quickly, instantly. Yeah. All the druggies stick together and know each other, so yeah; it's easy to score. I just go to the pub and, oh, you just pick people out. I asked one guy if he wanted a joint and you just, sort of, you just ask people and you progress from there. You can look at people and tell what's what and who's who. You know by the language they use, the way they, who they are..., the way they look. I mean, you can often tell who you should go up to and ask if they smoke dope. Yeah, so I just go to the pubs and meet people. I still haven't met a lot of users in [town]. Hard users. I only know one, two, three, and myself. Four hard users in [town]. Steven

If a particular sought after drug was not available, the participants would have to settle for an alternative one that might or might not provide the desired effects. If the effects were not what were desired, the participant was often left feeling unsatisfied and frustrated, hanging on the edge. If prices were too high, the participant would have to go elsewhere or buy on tick. Again, in such situations the participant experienced feelings of frustration and even anger in being beholden to a deadly dealer who held court over them, either choosing to favour or choosing to withhold. Similarly, if the demand for a drug was high, prices would increase and a shortage might occur leading to the participant once again experiencing frustration at not having their needs met. Alternatively, if a drug was readily available in abundance, a participant was likely to go on a binge increasing their dependence to a point where they were not able to control it or afford the drugs. As such, greater availability often led to greater chaos, more overdoses, less care, and more troubles. Unavailability or shortage of drugs, high demand and high prices, no contacts, or the disappearance of one's dealer all led to the participants experiencing feelings of anxiety, overwroughtness, of being strung out, of being unable to concentrate on everyday Being. As the following exemplar shows, the experience of not being able to score, or of having trouble scoring, of drugs being-unready-to-hand could be quite distressing.

It takes time. It takes a lot of time to keep a regular supply going. You're always off and running, looking for more, looking for the best, checking this out, checking that out, rah, rah, rah. When your dealer shoots through or hits a bad patch you're fucked, utterly fucked 'til you find someone else. You always worry about where you're gonna get your next blast. Once you've had your blast you can keep on. Things

go okay for awhile then fuck me dead your next dealer's shot through and you're in the same boat shitting about where the next blast's coming from. You know, it can be a struggle. It really is sometimes. You're always strung out, worried about being ripped off, worried about getting your next blast, then worried about getting the money. It's a crazy life. It really is. Timothy

To keep themselves supplied with drugs a few of the participants turned to dealing. By selling enough drugs they were able to pay for the next lot and use whatever was left over themselves. Like other participants, they were subjected to the same conditions in getting their drugs, all of which contributed to them experiencing feelings of anxiety, overwroughtness and distress. Furthermore, the added risks of dealing, such as the police, the public and their vigilante view of dealers, being at the receiving end of users desperate for drugs, the possibility of being ripped off, of not having tick bills paid, and of being narked on, often led to these participant experiencing greater levels of stress, fear, and mistrust. In the following exemplar one participant is commenting on his experience of how he promoted himself to dealing in order to support his drug use and the stressful effect it had on him.

I started cooking up some deals with him [friend who was growing cannabis] and started selling pot and sort of, um, I started selling drugs and was making a bit of money on that. Then I started to deal in a bit of acid. The acid was good 'cos I was getting it quite cheap and not using it myself so used the money for pot. I sort of built up my own clients and I ended up, um, selling quite a lot. Selling about fifty to a hundred caps and silver foils a week, um, which opened me up to other drugs. um, having that much money I started mucking around with pills, Ritalin, Rohypnol, rollies, um, and other pills and then I got introduced to misties and um, I was still selling the pot and buying pills for my own use out of the money. Then I started buying opium and when I got the chance I'd go out and grab poppies for myself, yeah, do poppy raids....then after I got a habit I was still selling pot, most of it covered my drug use but occasionally I'd have to do a few burglaries to keep up with my habit....but yeah, selling drugs sorta pays for it but it's all the other crap I have to watch out for, like the police, you know. They've turned up at my place and I get followed by them which gives me the shits. Yeah. When people find out you're dealing, all of a sudden you're a dodgy junkie. Sometimes my customers, my clientele owe me big time, like I'm their best mate and I never see them again after they've scored and owe me. I get real pissed about it. Like I started selling just to keep myself in drugs but it sorta got out of hand. There's always someone turning up on the doorstep, um, I'd normally have about 8 or 9 people go through by lunchtime but yeah, I need to score about 60 or 70 mgs a day so I guess I'll have to keep on with it.

Paul

Because of the illegal and often risky nature of buying and selling drugs all of the participants experienced feelings of vulnerability and threats to their freedom when scoring drugs. Generally, the participants were very careful of where a transaction took place and who was present, but there were times when drugs were unready-to-hand that they took added risks in their desperation to score, all of which further exposed them to the possibility of being caught which added to their feelings of vulnerability. For the participants, both the possibility of being caught and the reality of being caught were daunting. Having the drugs they needed to feel normal, to function in their everydayness, taken off them and being left to suffer withdrawals was both fearful and humiliating. In the words of one participant:

It's [the possibility of being arrested] an occupational hazard I guess. I try and keep my using a secret from most people, you know, straights and that way hopefully you don't get into too much shit. Like, if the cops are on your back, it's fucking full on stress. Like I got busted in Oz buying smack, would you believe it, from an undercover cop pretending to be a junkie. Talk about a nightmare. By that time I had a real habit. They took what I had and I was shitting myself. I ended up in the cop station for three days, like I started going through cold turkey and they wouldn't give me anything, not even call someone. It was so degrading. I was begging them told them I'd do anything. They treated me like shit, called me filthy names. It was like I was nothing, just shit to them. That's why I'm careful now. You know, who I buy from. It's always a danger that you'll get busted. Lauren

Another risk the participants faced when scoring their drugs was that of being ripped off by the dealer. Being ripped off involved being sold drugs of an inferior quality, drugs that had been adulterated heavily with another substance, a lesser quantity of drugs than what was paid for, or of having the dealer take one's money with no intention of supplying the drugs. Precautions taken by the participants to avoid being ripped off ranged from tasting the drug before purchasing, talking to other users as to which dealer could be trusted to give a good deal, and not letting the dealer know how desperate they were for the drugs. If ripped off, there was often no way the participants could get their money back, have the inferior drugs replaced or be supplied with the correct quantity of drugs. Also, because of the illegal nature of buying and selling drugs, they were unable to approach the police if they had been ripped off. There was, however, other ways that they could seek retribution. These included narking on the dealer - informing the police, spreading the word about being given a bad deal by the dealer, or even ripping off the dealer. Like the omnipresent risk of

being arrested, being ripped off was a never-ending possibility that added to the participants' feelings of vulnerability and stress. Although often shrugged off when it happened because of the participant's inability to demand redress, being ripped off hurt, was upsetting, frustrating, and sometimes traumatic. In the following interview excerpt, a participant who endured being ripped off with much outward matter of factness and calmness nevertheless summed up her experience as:

*.....really horrible. It fucked me off no end. I felt shitted on. I don't ever want it to happen to me again. I'd heard of other people being ripped off but didn't think it would be me. If [boyfriend] had of gone to get them [the drugs] it wouldn't have happened to him. But he made me go 'cos he said someone was coming around and he wanted me out of the house. So I went to [dealer's house] and when I got there, there were all these fuckwits sitting around and he told me to sit there too and he would hit me up for free so I said okay. After he did, two of them raped me and after that they told me to fuck off and tell [boyfriend] to get fucked, he wasn't getting anything and they were keeping his money. I got real upset 'cos I didn't know what [boyfriend] would do when I turned up with out the drugs. When I told him I got beaten up by him for being so stupid. But I said I wouldn't go and get them again. He'd have to. **Veronica***

Although the participants were aware of the risks attached to both buying and selling drugs they were not a deterrent. Rather, the risks were generally viewed as an intrinsic part of the lifestyle and as such were often discussed in a nonchalant way. However, if a participant was in fact arrested or ripped off, as Lauren and Veronica had been, the event was generally devastating in one way or another. Even though scoring from a dealer was the most common way of getting drugs for most of the participants, some of them had other ways of scoring drugs. These other ways depended largely on the participant's need to obtain drugs and their abilities in doing so. In some cases the participants cultivated or manufactured drugs themselves, such as cannabis, opium poppies, or homebake. Just as scoring drugs from a dealer was rife with risks, so too was growing or manufacturing drugs. For the participants who scored their drugs by these means, arrest or being ripped off were omnipresent probabilities. Because of the risks involved many of these participants also experienced feelings of vulnerability, stressfulness, and fearfulness. In the following exemplar, a participant is describing his experience of what it is like taking the risk of growing opium poppies.

It was wild man. I had, like, this whole paddock filled with poppies and when they flowered it was so cool. Just a mass of pink flowers. I was freaking the whole time though 'cos I thought if they were spotted from the air the cops'd show on the doorstep. Every time there was a plane or heli in the air I felt like crawling under the

floor and hiding 'specially after I started bleeding them. Yeah, it was cool. My whole day I spent going round bleeding them and collecting the resin. I'd dry it on sheets of glass and then scrape it into a jar. I had heaps at the end of the season and I'd have a blast three, four times a day. Having a blast laxed me out a bit but it was a huge adrenaline rush from start to end. You know. Thump, thump, thump with the old heart. Sometimes I'd break out in the sweats thinking some cunt was gonna rip me off or I'd get nabbed. Like, sweet fuck all people knew about my operation...yeah, it was wild. I'd do it again but, hey, I'd probably get nabbed, but yeah, it was worth it. I had enough to keep me going like about six months. Didn't have to go out and score at all. Jimbob

Although growing or manufacturing drugs sometimes allowed a participant to have a ready supply, only a few participants were prepared to take the added risks of being done for cultivation and manufacture. Cultivating and manufacturing, for these participants who were prepared to risk being done were often rewarding, in that they not only reaped the benefits of a ready supply and had the potential to generate extra money, they also induced feelings of autonomy and resourcefulness, of beating the system. Generally these activities increased the possibility of a heavier prison sentence if the participant was caught, particularly if large quantities were involved. Consequently, most of the participants had other means of acquiring drugs besides scoring from a dealer, and cultivating or manufacturing. As a commonly used alternative to the above methods of acquiring drugs, many drugs were obtained from medical practitioners by false pretences. Most of the participants had visited one or more doctors and obtained prescriptions for drugs after purposefully describing symptoms that were consistent with a specific type of drug treatment. For these participants, obtaining a supply of drugs from a doctor was less fraught with risk as they could always argue the drugs were obtained legitimately if found with a quantity of them. Often the scam was detected and the participants were unable to score any drugs, or arrests were made, however, this was regarded as part and parcel of the ruse. The Ministry of Health Drug Abuse Containment Newsletter published names of known drug users who sought drugs of abuse by this method, consequently, some of the participants presented to doctors using an assumed name in order to score drugs.

For many of the participants persuading a doctor to prescribe some drugs for a non-existent condition was a challenge which required much time, ingenuity, and gall. Often the participants would experience feelings of satisfaction, excitement, and pride in

deceiving a doctor. One participant, described by another as “*the master of seeking - of going to the doctor’s and spinning a yarn and coming out with an awesome script*” ((Wayne) provides a vivid description of having a pretty good nose for which doctors he could score drugs from.

I’d just go to a doctor, you know, give him a pack of lies. You know, can’t sleep. If I’m going into a doctors to score drugs, as soon as I walk in the door, before I even sit down, just by the doctor’s manner, his body language, his mannerisms, I will know whether I will get drugs out of him or not. Yeah, pretty much right, you know. Not all the time, of course, but pretty much. I’ve been surprised by what I can get, you know. 30 mg morphine sulphate. How much do you want? It was just a matter of going in and deciding what I wanted. As I said, more often than not it was even before I sat down. Just the way they carried themselves, the body language, the mannerisms, and, um, the first few questions they want to ask you. Um, and my mind would be just racing flat out, through all the variables, which drug, which drug, you know, benzos, barbs or what. I was an extremely manipulative person. I became damn good at it, unfortunately. I had a pretty good nose for which doctors I could get anything I wanted. I had a book for my ideas on each different doctor I went to, date of birth, everything, in this book, and, but most of the time I could commit it all to memory. Like in [town], I used to visit over twenty different doctors, and I’d have it all in my memory. I didn’t write it down but after awhile I started writing it down because I got more than twenty doctors. So I had to start writing it down. It’s all I fucking did. Every day I’d go to a different doctor. Most of the drugs I got I’d sell, like, you know, the benzos, the barbiturates. I was still taking the benzos, of course, but I was selling the Rohynol, morphine, pethidine, doloxene, selling whatever to buy what I wanted. That’s when I wasn’t knocking off chemist shops. Tony

The feeling of satisfaction gleaned from persuading a doctor to prescribe some drugs on one pretext or another encouraged the participants to further use this as a means of scoring drugs. To many of the participants, scoring drugs through doctors was regarded as one of the highlights of their day. Often the quantities prescribed were in excess of their immediate needs. Consequently, they would sell the remainder, only to have to go through the process the following day, not having had the foresight to look ahead to tomorrow. In many ways this was indicative of drugs having taken over their Being. Another ploy used by some of the participants after visiting a doctor was to add items onto the prescription particularly if the doctor had not drawn a line through the remainder of the script. Prescription pads were also stolen from doctor’s surgeries, bags, and hospitals by some participants who then filled them out, forged the doctor’s signature and then presented them at pharmacies, usually remote from the doctor’s surgery. These activities were sometimes detected but more often than not, the

participant got away with the act and was able to secure a supply of drugs for themselves.

Forged and stolen prescription pads, and writing in extra drugs on a script all contributed to the risks each participant took in acquiring drugs. Success in these methods, however, contributed to some participants experiencing feelings of exhilaration and of satisfaction at outfoxing pharmacists and doctors, and yet at the same time, feelings of fear and anxiety over whether they would be caught or not. As the following excerpt illustrates, forging prescriptions, stealing prescription pads and altering prescriptions was part and parcel of the participants' lifestyle, of making choices and acting on them.

*I guess having chronic back pain made it easy to outfox them. I was always in doctors' surgeries and often they'd pop out of the room. Quick as a flash I'd rip a few pages off the prescription pad, look around to see what else I could get then wait for them to come back. I'd ask for morphine or pethidine then add something like digesic, even diazepam to the script. I always get a real buzz collecting the stuff from the chemist especially when I knew I got away with it. It's always a bit of a gamble though, you know, the risk of getting caught out. Sometimes I'd shit myself if the chemist picked up the phone while he was filling it in case he was phoning and checking on the script. I'd keep my cool though. We all do it. Part of being an addict I suppose. **Timothy***

Stealing or buying medication off relatives or other known people who are legally prescribed it was another common means of scoring drugs. Most of the drugs acquired by these methods were opportunistic. If a participant knew or heard of someone, in particular, a cancer victim who was being prescribed copious quantities of painkillers; they were often approached and asked if they would consider selling any drugs surplus to their requirements. Sometimes, in their greed and need for drugs, the participant encouraged the cancer victim to have their prescription increased on the pretext of experiencing greater pain and then brought the drugs the person did not need. Sometimes the person was intimidated into handing over their drugs, and other times, their drugs were just stolen. Either way, using these methods to score drugs meant being unscrupulous, manipulative, and relentless. In their need for drugs the participants would stoop to anything as illustrated in the next exemplar.

*He [wife's father], he had bottles, big bottles of morphine linctus, cancer patient morphine which is just liquid, you know, and they put, um, like 30, 40 milligrams in a bottle and they also put cocaine in it to stop the cancer patients falling asleep all the time, to keep them awake, and I was getting that off [wife's father] who was pretty sick up in [town], so yeah, I'd whip up there and um, and shaft his medication. She [wife] got the doctor to double the dose so we could get his, and yeah, you know, it was pretty low down 'cos we'd shaft just about all of it and leave the poor bastard in pain... but what the hell, he was just about dead so we figured it wouldn't matter too much. You know, the drugs always came first... **Gerard***

Keeping up their drug use without having to pay for them was the driving force behind some of the participants scoring drugs from friends or family members. Like Gerard, many of the participants grabbed whatever opportunity came their way to sustain their drug use and to secure a supply of drugs. Mostly there was no consideration for anyone other than the participant and their need, no thought that the friend or family member might need the drugs themselves, and if there was, it was only a fleeting one. Occasionally, a participant might experience feelings of guilt and a sense of disturbance and wickedness when stealing drugs off known people. However, these feelings soon dissipated when the drugs were ready-to-hand. With the knowledge that the participant had their next fix, any remorse felt vanished and the participant then experienced feelings of relief and gratitude at having scored some drugs. As the following exemplar shows, scoring drugs from known people becomes acceptable if the need is there, but repeated attempts could be quite disturbing.

*Always when I visit rellies [relatives], even straight friends, I'd look in their drawers and bathroom cabinet and see if there was anything worth scoring. If I wasn't addicted I wouldn't do it. I never used to do it but sometimes there'd be Valium, might be Serapax, Rivotril, even Codeine or Digesic. I'd take a few of whatever right then and put the rest in my bag. I always get the guilts, you know, ripping off the rellies, that sort of thing, I've got a conscience, catholic upbringing and all that. It's wicked. I know it's a sin but so what, I need them I always say to myself 'I'm not going to do it' but I do. I'm driven to it. **Rosemary***

Other ways the participants kept up their drug use without having to pay for drugs included scoring from pharmacies, hospitals, doctors' surgeries and bags, and in one case, a drug supply warehouse. Scoring drugs through these means often led to the participant experiencing a whole range of feelings from excitement and exhilaration through to fear and remorse depending on the element of risk involved, whether they

were alone or with others, and their need for drugs. For the participant in the following exemplar, the experience of scoring drugs through breaking into pharmacies and doctors' surgeries was simultaneously both exhilarating and worrisome. While experiencing the excitement of scoring drugs by these means the participant also feared for his very freedom.

*Anywhere there was drugs, you know, we were getting them. Um, grabbing doctors' bags, surgeries, chemists, anywhere. We just went through the North Island. We'd check the town out and we would do the hospital, go to the chemist. We spent months going through the country. I enjoyed it 'cos, you know, drugs were, drugs were expensive.....it was exciting, you know, you were breaking the law but getting drugs at the same time. If we did a chemist, there's quite a bit of gear in a chemist that would keep us going for quite awhile...I loved it, ay, I really did, it was good. You didn't have to go to work in the morning. You had heaps of drugs. The only thing you had to worry about was the police, and if you got home that night, then that was it, you know. Like one night I remember in some surgery where the police turned up and we took off out the back door [laughs] and started jumping fences over the way and we shit ourselves. Like we were crashing through the fences bashing ourselves something really bad. Yeah, it was exciting, never knowing if we'd get caught or not. Yeah. We did it for years. Years and years. We needed the drugs. **Gerard***

For Gerard, the need for drugs far outweighed the risks encountered in scoring his drugs in this way. To be overcome by such a need was to have given himself over to drugs, to do what he would not have previously done prior to his drug dependence. Other widespread means among the participants for scoring drugs without having to raise money were the exchange of sex for drugs, being given drugs by other persons, in particular, one's partner, or buying large quantities of poppy seeds from bulk bin shops for a few dollars. For the participants, having drugs ready-to-hand by these means meant feeling less anxious, of having a load taken off one's mind, and of being lucky. In the first exemplar the participant describes her feelings on scoring drugs from her boyfriend.

*I suppose I'm lucky I don't have to go out and score my own drugs. [Boyfriend] gets me anything I want. I used to turn a few tricks once but he doesn't like any other dude touching me. I hated those jerks any way so it's great not having to do it. He's got to keep me happy and if I've got some speed I'm okay. He gets it. **Veronica***

Like Veronica, the participant in the second exemplar experiences less anxiety knowing he can score drugs and stay out of it for a small amount of money each day. For this participant, knowing that drugs are ready-to-hand means having a load off his mind.

*I couldn't afford to buy opiates from [dealer] any more and I'm not going out robbing houses so, you know, you can get out of it on opium for five bucks if you know this trick. Like for five bucks I can get high on opium so I'm going to do it every fucking day [laughs] basically because I can. Yay! [laughs]. You know, like if you get poppy seeds, the correct brand of poppy seeds in the bulk shops, and wash them, they're covered in a, you know, anyway, I'll go and buy half a KG which is more than enough for me and wash it. Like you don't wash it for too long because you'll wash the stuff out with the seed and, yeah, you don't want to not wash it for long enough because you're not going to get out of it. For a half KG I'll end up with about 600 mg of water, so yeah, just drink it straight down and yeah, it stops you from hanging out until you get some money. Like for five bucks I can stay out of it pretty much. **Brian***

Although these means of scoring drugs were less anxiety producing for the participants, a large portion of their day went toward taking care of business, ensuring a supply of drugs were available. In Being-in-the-world as drug dependent the participants needed to keep up their supply of drugs. As described by the participants much of their day to day life was taken up by scoring. When drugs were ready-to-hand the participants were able to engage in smooth everyday functioning. When drugs were unready-to-hand, the participants experienced anxiety and were absorbed in their longing and need for drugs. Scoring drugs took precedence over all else.

On occasion, a participant had a stockpile of drugs that meant smooth functioning took place while the drugs were unused. For these participants, a stockpile of drugs meant they were able to relax, take things easy, and forget about business for awhile. Although relatively uncommon, some participants did have foresight and were able to exercise control when drugs were plentiful, when their supply was secure. However, in exercising control to stretch their drugs out further, these participants were confronted daily by temptation, a powerful feeling hard to overcome as shown in the following exemplar.

*We'd done a burglary down in [town] and um, we had thousands of dollars worth of drugs, over a hundred thousand dollars worth of drugs. We had morphine, we had everything. You know, everything. I was using morphine, liquid morphine, misties, Valium, Halcion, um, rollies, bennies, um, what else did we have? Oh God. Heaps of things. Oh jeez, they lasted us a long time. It was something like four or five months and that's with selling a lot as well. Yeah. It was good before we ran out, didn't have to go out and score for the next day. We stashed lots away, made it last longer, spread it out. Oh jeez, it was hard stretching them out thinking about them stashed away when we could've been using them but we did it. We made them last yonks. **Steven***

Mostly though, the majority of the participants needed to do business daily, not only because of their inability to finance a quantity of drugs which would last them for a period of time, but because the more drugs they have ready-to-hand, the more likely they are to use them without any fore thought for tomorrow. For these participants, a supply of drugs ready-to-hand meant not having to be self controlled, of living day to day, of having no foresight, of making the most of today, and of bingeing as illustrated in the next extract.

*After I'd done a job [burglary] I'd score some drugs, eh. It's easy to score when you're in the know eh. Only prob is all the bro's wanting my drugs eh. With bro's around, drugs don't fucking last long eh. Gotta use it while it's hot. Anyways, couldn't keep any back for a rainy day knowing there's some stashed away. Gotta use it while it's there eh. Use it all today is my motto. Might be doing a lag 'morrow. Go hard out eh. Hard out's the way to go. **Dan***

Price also influenced the quantity of drugs the participants were able to score. Most days it was a struggle for the participants to find the money to score even enough drugs to feel normal let alone for other living expenses. For the participants, not having money to score was an obstacle to smooth everyday functioning and this in turn contributed to the anxiety they experienced. It is no wonder that many of the participants turned to crime to support their drug use when other legal methods of raising money failed.

Getting the money - financing drug use

Unlike a few of the participants who were able to score drugs without paying much or any money for them, the majority of the participants needed more money than they had to maintain their drug use. For these participants, the quest for money to buy drugs filled a large part of their day and involved both legal and illegal activities, all part of taking care of business. In the early stages of their drug dependence journey most of the participants were able to finance their drug use without resorting to illegal revenue raising activities. Any savings, spare cash left after everyday living expenses and money borrowed, all contributed toward financing their drug use at this stage. As the participants became more dependent on drugs extra money was required. For many of the participants, this money came from cutting back on daily essentials, for example, food, not buying clothing, socialising less, and giving up both luxury items and

sporting activities. Depriving themselves of such items and activities to finance their drug use was to feel compromised, pulled one way and then another, to go without in order to have. In the words of one participant:

Some days it comes down to "should I buy some food or should I buy some drugs?" I always end up buying the drugs 'cos when I'm not hanging out I'm not hungry so why waste the money. I'd rather spend it on drugs and fill up on popcorn. Like I've lived off popcorn for zonks. But sometimes I'll stock up on food if business has been good.

Tui

When economising on both luxury and essential items no longer provided sufficient money for drugs, the participants sold off their belongings. Among these belongings were such items as stereos, furniture, clothing, jewellery, and cars. Only bare essentials were kept. For many of the participants, selling off belongings they would like to have kept was painful, especially when the belongings were let go for a fraction of their value. Paradoxically, the participants also experienced a sense of relief. Getting money by selling belongings brought breathing space, some respite before the quest for money once again took over their lives. In the following interview extract a participant describes the painful decision of having to sell the car he would dearly liked to have kept. This participant had come to the point where his car was viewed in terms of how many drugs he could get by selling it. Using drugs had taken precedence over owning it.

My car stereo, it was just another thing I had to sell. Sell it and there's a pill for me. Um, but as I got older, well, I ended up with more of a drug habit and I needed to get, um, more money and, um, I'd sold just about everything but my car. I'd held off selling my car. I wanted to keep my car, but yeah, it got to the stage where I was using about three hundred dollars worth [daily] and um, it's all I had left and um, I had to have money. I'd got about eight grand for everything else, and um, I spent that in, I don't know how long, but it wasn't long, only a few weeks and it was all gone and that was all on drugs. Yeah. Only a few weeks. Then I had to sell my car. I sold my car. I sold my Fairmont and that went up my arm too. I got seven, just over seven, seven two for it. Seven thousand two hundred bucks for the car. I spent two grand to pay off a few debts and things like that, and um, I spent the other five on drugs, and um, yeah, that was gone in a few weeks too. **Angus**

Whilst the participants had belongings which could be sold they had short periods of respite from having to get money, especially through illegal means. Having drugs ready-to-hand for them meant being able to sit back and not worry. When the drugs

were all used and unready-to-hand the participants were back thinking of other ways of getting money, of how to take care of business.

For those who owned assets prior to selling them, some money could be acquired through bank loans or by using credit facilities. Again, money acquired by these means meant a period of respite and freedom from anxiety. Like all good things, the relief from worry ended when the money ran out. Once the loans, overdrafts and credit facilities were depleted, and debt collectors appeared, the participants again experienced feelings of desperation and anxiety. As one participant described it:

I actually regret having the tolerance like I have because of how much I use, you know. I ended up getting loans from the bank and running up credit and things like that.... Um, I went and got a loan of eight grand and that was gone in a few weeks. I was using a helluva lot then, and um, I thought I'd end up, I don't know, maybe like going to jail 'cos it was getting harder to get money. Something drastic will happen 'cos there's no way that I could, um, good things come to an end and with the drug habit I've got, all those, um, you know, easy earned loans and things like that, that's when I got into crime. Angus

As Angus found, raising money through legal means was limited. A participant could only borrow a certain amount of money or have access to a limited amount of credit from friends, family members, or financial institutions. Once a participant had exhausted these means and money could not be derived from legal sources, they resorted to crime to get money to support their drug dependence. Although a few of the participants engaged in criminal behaviour prior to being drug dependent, the majority of them had not carried out criminal activities before using drugs and becoming drug dependent. When the participants reached the point at which they found it necessary to engage in illegal behaviour to obtain money for drugs, many of them were at odds with themselves and experienced feelings of guilt and remorse. It was at this stage that many of them realised that things were starting to get out of control, that having drugs ready-to-hand took precedence over previously held values and their sense of righteousness as illustrated in the following exemplar.

I didn't really have to go out to look for money really 'til this year, but like the whole time I was just drinking and smoking dope I never actually had to go out thieving to support my habit. It wasn't 'til this year that I started getting into the more expensive

drugs that I had to start ripping people off and doing, you know, selling things and stealing things to get money to buy my drugs. I didn't want to have to do things like that but I really needed the money. It's not something I was brought up to do but once I got into the expensive drugs I had to. When the body wants them you sort of get desperate and do things you shouldn't. I sort of feel guilty about it sometimes but, yeah, it's like there's an old me and a new me, and the new one does that. When it comes down to it, I do it 'cos I need the drugs. Wayne

Like Wayne, many of the participants felt as if they were driven to engage in criminal activities to get money because of their need for the effects of the drugs - a need that apparently justified their actions. In their criminal behaviour, most of the participants focused on particular activities and areas of crime depending on their desperation and need for money, their skills, their confidence in carrying out the crime, and their values. Such activities included dealing in drugs, prostitution, shop lifting, motor bike/vehicle theft, theft from vehicles, buying/selling/receiving stolen goods, fraud, burglary, theft and robbery. Of all the criminal activities, shoplifting was the most commonly reported. Shoplifting was a lucrative occupation and provided relatively large amounts of money for the participants who did it. Although some shoplifting was opportunistic, most of it was planned or to order - whereby the participants stole specific commodities for resale to particular people at their request. Shoplifting was a skill that was developed over time. Of the participants who shoplifted, many spent much time casing shops out, eyeing up merchandise that would raise the most money, establishing busy shop periods, checking out sales people, and working out the best escape routes. Many of the participants viewed shoplifting as a career, a way of earning money which required confidence, gall, daring, and the ability to plan. Shoplifting to them was also a challenge, an ability in which the participants felt much pride especially when they were successful at it as illustrated in the following exemplar.

Shoplifting was just another challenge I had. Another addiction that I had, like I'd always been good at it and it fitted in with my new lifestyle, drug using and that. It was like, if I said in my mind "I want that. I'm getting that", and I'd get it. So, it was like whether I went out on a mission to get that \$200 to buy it or whether I just shoplifted it straight out, or whatever, because like I'd made a mission that I was going to get it and that came in handy with drug using. You know. When I came an opiate user, it's like, you know, I want that morphine. I'm going to get it and I knew ways of how to get it and it was skills I'd learned and what not. It's like sure, I don't have any trades or qualified, qualified in any, you know, sort of job, but it's like I've got all these skills, at least I know how to shoplift. Shit. I've made a lot more money shoplifting through the years than my parents have combined but of course the money's gone up my arm, you know. But, you know my enterprising skills and what

not. I'm quite intelligent to an extent, but they've all gone into being a good shoplifter, the motivation and drive isn't there for anything else. It's [shoplifting] a challenge. It was a fucking.....I always see it as a challenge. Fuck. It's the shopkeepers fault if I can get out of that store with it in my pocket and I still to this day have a feeling like that, where it's like, well, fuck, that's why I'd like to have a job as a shop detective, 'cos I know all about it, you know, things of shoplifting. Simon

Just as some of the participants felt pride in their ability to shoplift so too did a few feel guilt and a deep sense of wrongdoing. In particular, one of the participants, through feeling guilty over shoplifting, experienced a sense of alienation from himself when actively shoplifting. Although feeling as if he was not himself when actually shoplifting, he still carried out his shoplifting in a rational way justifying it by his need to have a blast.

Mostly it's [shoplifting], it's sort of more spur of the moment sort of thing. Sometimes I do plan to go out and shoplift, yeah, like if I get up and need to have a blast and I've got no money I'll mission out to go shoplifting, see what I can get. I don't like doing it. I've got some values but if I get something I can change it for money. When I go to the shop to do it, it's sort of like not me doing it. I stand and watch it but I know it's me. Something usually tells me what to get to sell. There's always someone to sell it to. Not really to the crowd of people I hang around with. I usually sell it to people that are sort of more middle class, that sort of crowd. I sell it to them, most people I know are pretty poor and don't buy that sort of stuff anyway. Herman

Like shoplifting, burglary was a rewarding crime often netting the participants a good return for the risk. Both private houses and business/commercial premises were burgled and the goods stolen often sold for a fraction of their value. Some were exchanged straight out for drugs. Similarly, many of the participants who carried out burglaries also regarded burglarising as a skill that developed over time, and which required much courage, determination, and even desperation. Driven by their need for money to procure drugs, many of the participants started off with small time burglaries and moved to more grandiose large scale burglaries as they became more successful at them. For a few of the participants, successfully raising money for drugs through burglaries led to feelings of powerfulness, of overcoming fear, of being vigilant, and of being sharp. In the stark words of one participant:

One thing leads to another, like getting into the drug side of life was, it was, fuck, you know, you gotta get money eh.... Yeah...I suppose it led me into my criminal side of life, like I say, I started off, like these fucking stupid little pill popping, druggie, deviant little crimes and all that led to, sort of jumped to burglary types of crimes, like sort of a new set of bros, and like, it was we needed money for drugs, so like we'd

do a few burglaries, you know, gloves and balaclava and stuff like that, like man, you gotta be a braveheart to get what you want, eh. You get into a rut of burglaries and fuck man, you gotta stay sharp as a razor or you do a lag eh. Like I've got expensive habits and shit like that so gotta get a couple hundred denominations a day. You can't fuck around too much eh. You gotta watch your arse 'cos no other cunts gonna do it, and it's like I say eh, it's when I needed money that I turned to these sort of crimes.

Dan

Unlike Dan, who described himself as a full time junkie and a full time burglar who enjoyed what he did, and who had gained powerful status among his “bro’s” because of his ability to raise money through being a burglar, some of the other participants experienced feelings of anxiety, nervousness, incompetence, and being out of control when carrying out burglaries to get money for drugs. This was especially so if they had used drugs prior to committing the burglary. As one participant expressed it:

I didn't sort of make it as a burglar. I mean, even when I, if I did need some one to do a job with or something and I couldn't do it myself, there were people willing to come with me. I needed people to do it with me 'cos I wasn't confident doing places my own. Like, when we did [commercial premise] I was too nervous, like I'm one of those people that should not be doing it that sort of thing. We did {commercial premise} and I opened up the safe and it was empty. This was after we'd taken out the alarms and all the rest of it, and I was peaking [experiencing a drug high], I was a nervous wreck [laughs]. And I found this briefcase and picked it up, gave it a shake and opened it and there was a lot of money in it so I said let's go. We went out to the car, we were driving and saw the police going the other way and we just about get home and [friend] says where's the briefcase, and I'd left it back there. You know, I had left it sitting back there on top of a shelf [laughs] and I couldn't believe it. I wanted to go back. I just shouldn't have been there. There's people that just shouldn't be doing that stuff. Gerard

Like shoplifting, burglaries were both planned and opportunistic. Many of the participants specialised in both these criminal activities mainly because they were both relatively easy to do and because the financial gain was generally high. Although a few of the participants experienced qualms when about to commit a crime, their need for money for drugs took precedence over their conscience. They, however, justified their actions through adherence to “the junkie code of ethics”, by which they refused to steal from private homes if the home dweller appeared to be visibly poor or perhaps a beneficiary. Very few experienced remorse when stealing from shops, businesses, or well to do people. It was as if these deserved to be ripped off because they had more than the participants did. Other forms of theft comprised of stealing from vehicles, motorbike/vehicle theft, and theft from offices, the university and the hospital. Theft

from vehicles was more opportunistic but some participants did set out specifically to do cars over. For these participants, doing cars over was in many ways a precursor to more serious forms of crime. It was as if it was part of becoming a more skilled thief, of developing skills and gaining confidence in the quest for money. As one participant described it:

*Like I say, I got more involved in drugs. I sort of bumped into a new set of friends. I made a lot of friends as such and then we jumped into different forms of crime where I just tagged along with them, and at first it was just sort of cars for, you know, going into cars for car stereos and stuff in cars and that and leading from that, it just sort of went up into, you know, the car in the driveway, and then we moved into the house, and then it was, you know, to have money to live, you know, and do the drugs and I'd do whatever to have money for drugs. So yeah, it sort of started there and moved on to different crimes. **Simon***

Motorbike/vehicle theft also provided good dividends to some participants. One participant in particular regularly stole motorbikes or cars as a means of generating large amounts of cash. Thieving, for this participant, was an acceptable way of getting money to support his habit as illustrated in the following exemplar.

*Once I started using IV at I got a raging habit pretty quick.... Yeah, I'd average out about, you know, about 500 bucks every couple of days. So yeah, I needed money. Like I supported my habit quite easily. At first I used to steal motor bikes to order. Like there was this guy, he owned a motorcycle repair and motorcycle shop...he'd ring me up. I need this, so I'd go out looking for it. I'd get the best price for those bikes, a couple of pounds of pot, a couple of sachets of smack, you know... **Toby***

This same participant also favoured armed robbery as a means of getting money or drugs. Generally, most of the other participants stayed away from violent crimes. For them, armed or aggravated robbery was an uncool activity, a last resort for the desperate user. Dissimilarly, for the three participants who engaged in armed or aggravated robberies, they were a mindblowing way of getting both money and drugs. In most cases when carrying out an armed robbery, these three participants were out of it, but not so much that they were incompetent in carrying out the task. For them, carrying out an armed robbery successfully meant being clued on, shrewd, determined, and greedy. Again, their need for drugs was the impetus behind these crimes as illustrated in the following exemplar.

I'd committed four armed robberies on pharmacies by the time I was 20, and I've never even been looked at for them. Old people were getting busted and I was sitting back laughing 'cos I was always a greedy little prick. I wouldn't tell them what, that's

*why they get caught, they all do a chemist's hit, run round this junkie's house and all blast up. Nah, I'd do it becos, I'd go bush. Didn't need to take food. Next three days I'm just phew, phew, phew [demonstrates injecting himself in the arm three times], then I'd get together some of the powders, like diacetyl morphine, pure smack practically, um, all misties I'd sell, not where ever I'd done the hit, most junkies make errors like that, but further away. Like nine times out of ten I would be out of it when I did a crime. Not too excessively though. Like when I did a rolling. I don't really call it an armo but I suppose it was. Like it was a drug dealer. I got 36 pounds of bud, four hand guns, a shit load of ammo, um, I can't think how much money I got out of him but it was a lot... like I was pretty clued on, just clued on to do crime, how to hurt people, how to avoid detection. Um, where to get your next score, how to make money. I've always had a thing about money. Like I've got a wicked drug habit and yet I've still got money. That's because I'm not slow. You know, you need money, money makes the world go around. Like you have to pay for your own habit and you have to make money. **Toby***

As described by Toby, the need for drugs was strong enough to impel these participants to commit crimes that put other people at risk. Essentially, drugs had taken control of their Being and they would do anything to get money to buy them or acquire them. For those who did not resort to such uncool criminal activity there were many other crimes that could more easily be employed to get money for drugs without the dire consequences that came with being charged with armed robbery if caught.

Fraud, particularly of the benefit type was commonly practised by some of the participants. Using false names and bogus bank accounts, these participants were each receiving several unemployment and sickness benefits. Again, the participants who gained money by these means felt enormous pride in their ability to cheat the system. Cheating the system required much sophistication and switched onness as demonstrated in the next exemplar.

*I've got quite a sophisticated system going with the benefits. Two sickness benefits and three unemployment benefits. If you know the system it's real easy setting them up. I've got four different addresses which I use. It's really quite easy. Work and income is a fucking joke, every time you go there's a different caseworker who doesn't know you from a bar of shit. I keep a notebook with details and conversations and all that stuff so I know exactly what to say to who and where 'cos they are through different offices and you've got to be really switched on the whole time. It's really amazing all the ways you can get money. I'd never have thought of it by myself but it was [friend] who put me onto it. Said it was a real easy way to get money and it is, especially 'cos I need it. **Lauren***

Because many of the participants were successful at getting money through fraudulent means they continued to do so despite the risk of getting caught and the possibility of doing time and going without drugs. Generally, being successful at fraud was related to the participants' ability to deceive and to know how the system works. Again, this need for drugs over rode their sense of wrongdoing or of doing something that they would not have previously contemplated.

Prostitution was also another common way for several of the participants to get money. Among the participants who prostituted all but one were female. For them prostitution was a consistent way to get a regular supply of money. Interestingly, none of the participants prostituted prior to drug using, rather, they all engaged in it after becoming drug dependent as a way of getting money to pay for their drugs. What stands out from these participants' experiences of prostituting is their perception of being limited in their choice of other ways to get money easily. To them, prostitution seemed the most logical choice as they had a saleable commodity that carried with it very few risks in comparison with other illegal criminal activities. Although a good way to get money, not many of the participants liked what they had to do. For some, being a prostitute meant nothing more than a means to an end. It was just something that had to be done, did not take too much time, and provided a ready source of money at any time. Paradoxically, being a prostitute also lead to an increase in drug use as the participants generally had to be in a euphoric state to cope with their feelings whilst prostituting as illustrated in the following interview extract.

Every night I'm out working [prostituting]. I've got some regular clients. It would probably be six to eight a night, paying sixty to a hundred bucks depending on what they wanted, um, and I found the only way I, like I have to be in that euphoric state to cope with it. I really don't give a damn about myself. I'm more interested in staying in that state of Utopia. You know, I don't think I would of experienced being a working girl if I hadn't been a druggie. It's become a huge part of my life. It's really a means to an end. You get into a habit, and get a habit. Hey, that's clever, but seriously, you get into a habit, a daily pattern of having to earn money, big money, to pay for drugs.

Trish

Like Trish, the participant in the second exemplar also had feelings of low self worth and self-condemnation at having to prostitute herself to pay for her drugs. For her, being addicted was a vicious circle in which she was caught and to make it go around

she needed to sell herself. Encased within the circle were feelings of shame and repulsion.

*When you're addicted you'll do anything, even shameful and repulsive things. It's really a vicious circle, like I'll let strangers fuck me to get it [morphine]. The more I fuck, then more I can buy, the more I use, the more I want it so if I get lots of money then I can buy heaps and then I won't have to do it for awhile. It's like I do it 'cos I have to stay on top of it, always have something to use then I use more because I don't like doing it. I say to myself each time 'another fuck, another blast'. That's how I have to look at it. **Lauren***

For all of the participants who prostituted, the high cost of their drug use was the driving force behind their entry into what they generally considered a shameful activity. However, it was an activity that supported their drug use with little risk of conviction.

Another significant way of getting money to support their drug use was by drug dealing. Of those who reported it, drug dealing was engaged in as a way to secure a regular supply of drugs for their own use as previously mentioned at no monetary cost to themselves as well as get some money for extra drugs. None of the participants had made a conscious decision to be a dealer. They had more or less just fallen into dealing and established themselves as dealers in an informal way mostly selling drugs to a small group of known drug users. In the words of one participant:

*I started selling it [opiates] because I needed the money, just needed extra money because it [opiates] was costing too much. It started when I began throwing up, threw up each morning and, um, my friend would come in, come around and I would give him 60 bucks, 120 bucks to get me something. That's when I knew I didn't want to be without. So yeah, that's when it became regular, like, quite a few people started buying off me and that. Sort of fell into it I suppose. Most of the time what I do sell, what I do have covers most of my own drug use. **Paul***

All of these participants were just small time dealers making only enough money to support their own drug use and perhaps a little extra. In being a drug dealer as well as drug dependent, the participants generally did not have an easy time. For most of them the fear of being ripped off added extra stress to their daily lives. There was also the fear of being marked on, the fear of not being able to score drugs to sell, hence, no drugs to use, the fear of having their homes broken into and the fear of losing their freedom. Feeling fear as a result of their drug dealing was particularly disturbing for one of the participants as vividly captured in the next exemplar.

They [drug buyers] not only stole all of it [100 morphine sulphate tablets] but they ripped off my money as well. I had over fifteen hundred dollars and the fuckers stole the lot. It was so unreal. They pushed me around, like it, like I was so frightened but didn't know what to do. Couldn't call the cops and say 'those fuckers stole my money and my drugs'. Who do you think would've ended up in prison? Not them. I'd be the one done for it. And then the fuckers had the cheek to tell me that they'd call the cops and report me as a drug dealer if I didn't hand over what I had. Shit. Talk about scary. They were real heavies and that's when I started selling only to people I knew.

Lauren

Although these fears were very real for the participants they were often offset by the excitement they experienced at getting away with being a dealer, the benevolence felt occasionally at helping those hanging out that had neither money nor goods to trade for their drugs. They also experienced feelings of importance and respectfulness, both gained from having the status of dealer - one who risks their freedom. In the following interview excerpt one of the participants describes how he felt when dealing.

*It's [dealing] a really one-to-it way of getting money as well as getting drugs. It's like I don't try and rip people off. I give them a good deal compared to some other dealers and sometimes if they're really hanging out I'll give them something to carry them over 'til they get some money together. It's like I've built up a bit of respect as a fair dealer and that's a real psychological buzz for me. If you're fair and don't fuck them around too much no one messes up on you. If I take care of them they'll take care of me. As I said, it's really a one-to-it way of keeping yourself in drugs and making some money. Sort of a junkie shopkeeper, that's me. **Wayne***

As far as Wayne was concerned, he was providing an important service to the people he sold drugs to. Through dealing in drugs he had not only an opportunity to practise his entrepreneurial skills but was also provided with some status in the drug using community, especially as he had a reputation for being fair. On the whole, dealing was an activity that was embarked upon to sustain the participant's own drug use rather than for financial gain though it was also a good way to get extra money for living expenses. If the participants were able to cover the costs of their own drug use without having to resort to other criminal activities they felt they were doing okay. With a good supplier who did not rip them off or whom they did not rip off, they had a steady supply of drugs for their own use without having to experience the anxieties and frustrations commonly associated with having to get money for drugs or of having to buy their drugs from others. As one participant articulated it:

*After he [husband] stopped bringing stuff home [drugs from the wholesale warehouse] I had to get them from somewhere else. It became really quite stressful and frustrating trying to find the money for them, like I have real problems finding it sometimes. Then I met a dealer, a heroin dealer through my doctor's receptionist, his receptionist called in one day and came to visit and yeah, she'd left working with him and was nursing at [town] hospital and had nursed this guy who had broken his leg and he was a, a heroin importer, and she brought him to my place. I don't know how she made the connection to come to my place with him, um, but that's what she did. My doctor knew about my using and she might have read my notes or something. I don't know, but yeah, so I met him and then I started getting heroin from this guy, he was selling it to me really cheaply, and um, he would give me two grams a week for \$1000 a gram. I would use perhaps half a gram and sell the rest to cover my own using so that my own using never cost me anything. I never had any problems getting rid of the drugs but I'd have problems getting the money for it, getting people to pay for it, that was the thing. I set the prices. If the other guy, he knew what prices were in Australia and he knew that it was valuable but he didn't know what prices were here, and I never ripped him off. I was quite fair with it. I didn't want to rip him off because he was my supplier basically and you know, yeah, you don't rip them off. And I did that for a couple of years and um, and I wasn't dealing in heroin all the time. In between times, he [husband] would bring stuff home, he would bring stuff home again, and um, I would sell that. I preferred that rather than selling the heroin because I knew the heroin was good quality and clean. Yeah. I kept it up for quite a few years 'til I got arrested. **Eliza***

Just as Eliza took to dealing to sustain her own drug use or to get money to buy the drugs of her choice, so too did most of the other participants take to some form of illegal cash generating activity in response to their need for drugs. Very few of the participants were able to support their drug use through legal means alone, consequently most of the participants needed to engage in some form of criminal activity to find the means to continue their drug using, stave off withdrawals, and keep cravings at bay. Rather than be without drugs the participants were willing to take risks and commit crimes to generate income for drugs that prior to drug dependence they would not have contemplated. By whatever means the participants came to acquire the money for purchasing drugs or how and where they scored their drugs, it was noticeable from their accounts that a large part of their everyday Being was consumed in doing so, in taking care of business.

In Being-in-the-world as drug dependent the participants were caught up in a continual cycle of using drugs, getting money for drugs, scoring drugs, and using drugs. Drugs had taken precedence over all else. Ensuring that they had a supply of drugs and the

means to acquire them, both of which were necessary to keep mind and body together, impacted upon the whole of their Being.

In becoming and being drug dependent the participants had journeyed into a different way of Being-in-the-world, a way in which they experienced profound changes in their embodied selves, both through their use of drugs and being without drugs. Being drug dependent meant the participants had lost their taken-for-granted way of being-in-the-world. Not only did they feel different in their bodies but also in their minds. To feel normal and to function in the everyday world without experiencing physiological and psychological withdrawal, the participants had to take drugs on a regular basis. Obtaining a supply of drugs and finding the means to do so consumed a major part of each participant's day. The participants had been caught up in a way of being to which they had become committed, either consciously or unconsciously.

Rather than face their world without drugs the participants were prepared to continue with their way of Being despite both the physiological and psychological effects of being drug dependent. When asked to sum up what it was like for them to live with drug dependence, the participants reflected on how drugs had altered not only their minds but also their bodies. Some reported that they felt controlled physically and mentally by their need for drugs as illustrated in the following exemplar.

*Drugs take over your life. They take over your life to the extent that you can't think about anything except them. If you try not to think about them your body soon lets you know it's time to think about them again. Yeah. They take over your life. Living the life of a junkie is all consuming; it eats away at you. I didn't start out to be one and if I hadn't had the accident I probably wouldn't be one now. It's always a bloody mission to get hold of them [drugs] all the time. Like, I don't know anyone who I can just go there, give the money, get the drugs and go away. It's always at least 4 hours or something, when, if I'm trying to score. I set aside a day for it, for waiting around and, you know, running around and all that sort of crap. It just gets too much, too time consuming and you just don't have the time to get on with your life and it all seems such a waste. It's a waste of your life because that's all you're doing. It's like life revolves around drugs. You take them, you have to get them, you have to find the money for them, you get them, you take them. It's not a life, it's a fucking merry go round, it's a whole career and it has been for awhile. It's not much of an existence, being like this. **Timothy***

Some spoke of experiencing changes in emotion, of the drugs affecting their moods, of their addiction being a phenomenon located in their heads, of the overwhelmingness

of being addicted, and of being in a living hell and of having no future, no possibilities other than the way they now were. In the words of one participant:

*Like I never thought it would be like this. No. Hell. No. Never. When you take hard drugs it's your whole life, your whole life is involved in it. It ends up in a lifestyle. It's not something you can do just now and again. It is your whole life. There is no room for anything else. Especially if you are trying to score because your whole, man, everything, your whole life is, just, yeah, consumed by the whole thing of **getting it, doing it, finding it, and...** Like I didn't know. I didn't have a picture of what it would be like now. You don't when you're younger. You just worry about what you're doing now. Like I never really thought what it would be like later. Like I was just having fun at the time. Just having fun. Yeah, and you don't, you don't think about the future when you're young. Just worry about what you're doing now. I just wish that I hadn't had that first taste, really. Or that second one. The first one didn't exactly get me. After that first one I didn't really want another one. It wasn't 'til that other one; it wasn't 'til the morphine, from that time on. You didn't really think about getting addicted. Addiction. It never crossed my mind. You think back on it now and you think, **fucking bummer**, you're pissed off with yourself. It creeps up on you without you knowing. Yeah, before you know it, you're addicted. That's right. Yeah. You do. Just one day you, you know you are, you just think, **FUCK**. You can't go without. Look at me. I've gone 35 now, and it's been 15 years. If you gave someone the Valium for 15 years, every day, they'd say, whoah... yeah, fuck. They'd be in a helluva mess. Yeah. Yeah. Yeah. A way of life, it is..... It's actually seeing a light at the end of the tunnel, that's the hard bit. You know, when you try, when you haven't got any drugs, there's no light there. You can't see a light at the end of the tunnel when you haven't got your drugs. It's hard to see one there. It's hard to imagine one so you can keep going and give up, you know. You can't actually see a light to go for; there's nothing there. It's like, the end. When you have the drugs and you don't think like that any more, your whole thought, your whole way of thinking is changed. So you don't think, you know. But I know when, you ask any druggie, they'll tell you once, soon as he has his taste, like all of us, all we do now, we think, "**Right, that's it. No more, last one**". As soon as you've got that feeling, you feel good, you say stuff like that. "**No more drugs. I'm going to give up now**". And it's not 'til you wake up that morning, you know, phew, you know, you're just shitting yourself. I know when I always think, "oh, I'll give up" but I say to myself, "hey, you're fucking joking", you know, 'cos I know when the drug wears out of my system, I won't feel like that anymore. What I mean is, when the drugs are gone, I'm not going to feel like I can give up. You know as soon as the drugs run out that you're not going to be able to give up. You just wish you could. It's like, it's just a momentary thought. Just a thought in your head. You don't dwell on it or anything. When you've had your drugs you don't dwell on any thing. You don't even think about getting them. You just get off. You watch a program on TV and they tell a joke and you think it's funny whereas before, fucking no one would make you laugh, you know. Yeah. When you're stoned, to me, it's like feeling normal. It's just like you [meaning being like me - a normal straight person getting on with their every day life]. I mean, it's just like you are now, right now. You just, you've got things to do, you go and do them, whereas when you're not stoned, you can't do that. You can't do that, you know. You just, there's not, there doesn't seem to be a point to doing anything. What's the point in doing this? What's the point in doing that? You know what I mean. No motivation at all. Yeah. No energy. Fuck no. Yeah. But you've*

*got to motivate yourself to go out and get some drugs. But you couldn't motivate yourself to do anything else. The only reason you're doing that is 'cos you know you have to do that to get the drugs so you can feel all right, so it's just something you have to do. Fuck. It's horrible. Terrible. I should never have got into it. It's just, it's strange how that little pill did it all, from having every thing to nothing. It's amazing the amount of power it has over you. I think back now, I sit in the van thinking, no, it just seems like last night I'd be lying in bed with the wife, you know, every thing happening. Now you look around, you think, fuck, here I am now. It doesn't seem real. Yeah, fuck, it's terrible. **Alistair***

Others spoke of the feelings of enjoyment and pleasure they derived from drugs, of their passion and intense longing for drugs, and the release from pain they experienced after using drugs. As two participants summed up:

*Drugs are a big part of my life. I just let the drugs take me to fantasy land. I guess it's like living out of my body in my head sort of thing. Just lying there and, um, just like dreaming, fantasy, it's not being with my body. Um, just floating. It's more like day dreaming. I don't ever want to go back to the way I was before when everything's all hard and horrible. I suppose it's like it takes the hardness out of living. Makes it nice and soft, blunt sort of. It's how I want to be. **Trish***

*Now I take drugs because, originally one of the reasons I started taking drugs was as an escape, as a refuge from others. Now I take it because I want to enjoy the effects. Yeah, I like drugs. I like this way of living. I think drugs should be compulsory to be honest. There's no better way to find out about what someone's actually like than get stoned with them a few times. **Hugh***

And for some, there were feelings of friendliness. Drugs were their friends. Drugs helped them feel okay when the going got tough.

*I'd be waiting and I'd be hanging out, like I'd be getting withdrawals, my legs would start cramping up, and then my hands would cramp, real wicked, man. My fingers and that, and I'd start withdrawals. Withdrawals start kicking in then I'd score about lunch time, one o'clock sort of thing and have a taste, sit back and everything it'd be all right. You know, drugs are my friend. They give me more confidence, they comfort me, they're there but when they're not it's a real cunt. Yeah, they're my friend. **Paul***

It is obvious from these accounts that living with drug dependence is a different way of Being, that the participants have chosen their existence through their physical and psychological needs and in choosing, have let drugs dominate their every day lives. They had become totally immersed in a journey that had led them to drug dependence. A journey that not only impacted upon their lifeworld profoundly but also upon the lifeworld of others, for Being-in-the-world means Being-with-others.

Review and summary

In this chapter, the focus has been on the way in which people who have a drug dependence experience their own Being-in-the-world. For the participants, becoming and being drug dependent means to have embarked upon a journey which began with their first drug use, their increasing involvement with drugs, their coming to the realisation that they are physiologically and psychologically dependent upon the drugs, and their having to maintain their dependence through taking care of business, obtaining a supply of drugs and finding the means to do so. As such, each of the participants had found themselves thrown into a particular world, a world both constituted by and constitutive of their selves, a world that through their decisions and choices led to drug dependence.

For the participants, the realisation of being-in-the-world as drug dependent meant a reconceptualisation of themselves as being-in-the-world in a new way, a process of incorporating into themselves an image of themselves as being-in-the world as “addicted”, as “a junkie”. Normal every day Being had become a thing of the past for the participants. In terms of their lived experience, not only did drug dependence impact upon their bodies, it also impacted upon their minds. They felt different and were different. With their physiological dependence their bodies were altered. Smooth functioning had broken down and drugs were needed to function again. With their psychological dependence, they found themselves emotionally and mentally preoccupied with thoughts of drugs to the extent that their every day Being revolved around them and large portions of their every day life was filled with taking care of business, of obtaining drugs and finding the means to do so in order to function in the world.

For the participants, living with drug dependence was a life changing experience into which they had been thrown. Finding themselves thrown into the world in this way not only impacted upon themselves but upon others, for to be in the world means to be with others. In being thrown into the world, one is not alone. Rather, self and others are alongside of one another and interact with one another in an every day manner

within a background of social, historical, and cultural practices that are always present in the world.

In being-in-the-world as drug dependent, the participants encountered and lived alongside of others, and were involved in activities in which others were engaged. The way in which the participants found themselves Being-in-the-world alongside-of-others is the focus of the next chapter.

Chapter VI

BEING WITH OTHERS

In the preceding chapter the context of the participants' lived experience and the nature of becoming and being drug dependent was presented. In being in the world as drug dependent, the participants' lived experience of drug dependence inherently involves encounters and relationships with others. Because the relationships and the interactions the participants have with others significantly impact upon their lived experience the focus of this chapter is on the lived relation the participants maintain with others in the interpersonal space that they share.

In the Heideggerian view, one's everyday Being-in-the-world is a Being-with-others. "The world of Dasein is a with-world. Being-in is a Being-with-others" (Heidegger, 1927/1996, p.112). For Heidegger, to be-in-the-world is to encounter other human beings, to be alongside others as participants in a world of one's own concern whether or not others are present physically in one's everyday existence. Even Being-alone is Being-with in the world, for others do not need to be present for one to be aware of them. It is through sharing the same world that their existence is part of one's existence. The world into which the participants are thrown is a world into which none of them go into alone. It is a world which is already there, a world handed down through their culture and shared by others. It is a world in which the existence of others is an essential and integral part of their Being.

Heidegger's notion of thrownness is of relevance here, for the particular world in which one finds oneself located is a world which has others in it and is such that the existence of others is essential to its being there at all. Not only is one part of the world of others, one also experiences the effect of others in one's world. As such, a Being-with-others is an interdependent state. It is with and through these others amongst whom one lives that determines the way in which one is in the world, for one can know nothing of one's own existence except through other people. One does not recognise one's self first and then come to term with others; the others are already in one. It is

through them that one is defined. It is through others that one is told who one is. It is through others, through one's place in a family, through friends, through work, through living in a community that one learns who one is. Essentially, others are those who are there with one, in one's lifeworld. It is amongst the others with whom one lives that one finds forms and chooses one's relationships, encounters help, hindrance, or indifference, and becomes whom one is and what one does.

Accordingly, my aim in this chapter is to explore the ways in which the participants found themselves alongside others, their lived relations, both in a personal way and as part of the wider community within which they live. By the very nature of their drug dependence the participants found themselves in a different situation in the world. Not only did their drug dependence impact upon their personal relationships with others, it also influenced the reactions which others had toward each of the participants, reactions coloured by both the negative and ill informed beliefs and attitudes about drugs and drug users and the myths and misconceptions that abound in the public mind. In being drug dependent, the participants encountered or were alongside many others, from the beginning of their journey into drug dependence through to the present time.

The ways in which they came into Being with drugs were related to the drug use of significant others in their lives. The ways in which they maintained their drug dependence were dependent upon their relationships with others. As a consequence of their drug dependence existing relationships with others changed and new relationships were formed. For the participants, Being-with-others during their becoming and being drug dependent have both been and continue to be a significant part of their lived experience. In these ways, Being-with-others for the participants is intimately tied to their Being, the worldly existence into which they were thrown. The world into which the participants found themselves thrown is one where societal and cultural bias, stereotypes, and negativity were evident to each one of them. Although four of the participants identified as Maori and the remainder as New Zealanders or Europeans, their cultural legacies were not acknowledged within the mainstream community. In their community, the participants were seen as belonging only to the "addict" culture, a deviant culture which made possible the participants continued existence as dependent

drug users through societal definitions and reactions. In being thrown into the drug culture each of the participants was being shaped by the taking up of the language, the meanings, the norms, and the practices of others in the culture. Through these means they came to identify themselves as *junkies* and *addicts*, learned ways to take care of business, how to cope with periods of no drug use, how to identify themselves to others, how to interact with outsiders (non drug users), and how to maintain a sense of being together, of community with others in the shared world in which they found themselves. Despite the different lifeworlds inhabited by the participants and others, the participants spoke of reciprocity in their discussions of their Being-with-others. By projecting a world of significance for themselves, the participants found their own way to be alongside others in a shared world. Just as the participants experienced the impact of others in their world so too did they impact upon the world of others. Just as each participant was characterised by his or her individuality, each with their own set of possibilities and individual relationships, so too was each participant one of the many, the 'they', *das Man*, people in general, amongst whom we all find ourselves. Just as the participants' Being was a being with others, so too was it a being-with-one's-self, a choice of self through which relationships with others were experienced, a self dependent upon the mode of being each participant adopted. In Being-with-others in a shared world, the participants and others were inextricably bound to one another, each forming an integral and essential component of the other. For the participants, the lived relations with others, those who are there with them in their world of concerns, have been, are, and continue to be meaningful part of their everyday experience of being drug dependent.

Through the process of data analysis interpretation and ongoing reflection four themes emerged from the participants accounts which are considered to best capture the ways in which they found themselves alongside others: Being in a We/Them World, *Junkie* Friends, Lovers and Families, and Being One's Self. For the participants, being alongside others in the world is an integral part of their Being-in-the-world and as such, these four themes reflect different ways of being-with-others. Encompassed within Being in a We/Them world is the way in which the participants, as drug dependent people, found themselves alongside others as part of the wider society within which they live. Junkie Friends comprise of the way in which the participants

choose their friends and experience friendship. Embraced within the theme Lovers and Families is the way in which the participants relate to others with whom they are most intimate – their lovers, and those whom the participants were thrown into existence with, those with whom there was no choice over – their families. The last theme, Being One's Self embodies one's understanding of one's self. Although each of the participants exist as an *I am*, they also exist as *I am with the others*, for their understanding of themselves is dependent on the understanding of themselves as Being-in-the-world with others.

Being in a We/Them world

In their accounts of being drug dependent each of the participants spoke of the social world in which they found themselves situated and the ways in which they, as drug users, are perceived by others in society, the non-drug users. For the participants, as members of this society themselves, the ways in which they are perceived were viewed as highly defining in their lived experience of drug dependence. As a result of their drug use, their drug using friendships and their drug lifestyle, the participants believed they were perceived by society as outsiders, as part of the *Them* group, those who have deviated too far from the norm concerning the use of psychoactive drugs. In deviating from the norm by choosing to use drugs for purposes other than medical use, the participants marginalised themselves from mainstream society. For the participants, marginalization and inclusion in the *Them* group, as those who are drug users, not only served to shape profoundly the participants perceptions of themselves as *addicts* or *junkies* but also made them susceptible to all the other negative characteristics that arise from not fitting society's normative categories. In being marginalized, part of the *Them* group, the participants experienced intense social stigma and prejudice. Not only did they feel that they were looked upon as not fitting into the community, as being corrupt, deviant, or as violators of the rules and sanctions imposed and respected by society, they also believed they were viewed by many members of society with fear and dislike as illustrated in the following exemplar.

Everyone around you is all fucking anti-drug. You don't get fucking respect if they know you use intravenous drugs. They sit there with their fucking holier than thou smiles on their faces looking down on us. You can see the fucking hate in their faces. Scourge of the earth's gonna get their little darlings and turn them into junkies.

*Fucking eggs. They fucking look at you like they want to kick the shit out of you. You're told to fuck off, you piece of shit, get out of here. No fucking junkies wanted in our town..... So what better way to say, "fuck you mate, stick your rules up your arse" than to have a needle hanging out of your arm. Who the fuck do they think they are to sit there and give an opinion on what the fuck I do in my life. They should get the fuck out of my face. Fucking wankers. Think they're better than me 'cos I use drugs. They don't even fucking know me. **Toby***

Just as Toby felt the injustice of being prejudged and of being set apart from others in society because of his drug use and drug lifestyle, so too did the other participants. For them, being a drug user meant living in a *We/Them* world, a world in which they live outside society incurring society's animosity, a societal division they considered was enforced upon them as a result of the negative societal attitudes, social stigma, and prejudice that they felt much of society holds toward dependent drug users. As one participant expressed it:

*It's like I told you. It's a world of we's and them's, only we're not the we's, we're the them's, you know, social deviants, addicts, thieves, whatever, people with no standing in the community, much different from the we's, the normal straights who don't want to know us, wish we didn't exist, you know, people who'd rather we dropped dead from an overdose. You know, it's like when you start using drugs, you sort of tippy toe away from a normal life into a different life. It's like you're buying a new script for life, only it's not what it's like in the *We* normal world, you know, **WE** don't want junkies in our town, **WE** don't want them giving our kids dope. It's like being connected to a different world where you're looked upon by the **WE's** as shit, you become nothings, non existent in their eyes. You hear them talking about us, "look at them, low lifers, drug addicts, dirty people." You can see the disgust in their faces, hear it in their voices, and, you know, the worst thing about it all is that 'cos we live in the same society as those people we end up thinking their stereotypes about ourselves and feel guilty about what we do. It's really not fair. **Eliza***

Like Eliza, many of the participants expressed strong feelings of anger, unfairness, and sadness at the injustice of being set aside from others in the society in that they live and interact. Despite the intense social stigma and prejudice that worked to not only widen the societal division between the participants and the rest of society but also to further drive the participants into hiding, they still interacted with others in society. For the participants, as parents, partner, friend, child, patient, customer, neighbour, or community member among other roles, there could be no complete severance from the *We* group. In fulfilling many of these roles each of the participants inhabited two worlds, the straight *We* world and the world of *Them*, the drug users. For the

participants, being in both worlds meant having double standards of behaviour, of having to develop a sense of identity to connect into two different groups of people and two different social categories, and of having to pretend to be someone one was not. In the words of one participant:

*Sometimes it's like being in two worlds, a straight one and a drug one. It gets fucking hard pretending to be straight sometimes. Like, I've got this straight as a die identity for my old man, um, the bank, and what have you. Double standards I suppose. Look at the old man. To him I'm straight as. Doing okay at Uni., and what have you. Says he's proud of me. Fuck! His world'd fall apart if he knew that the twenty bucks I scored of him yesterday was spent on poppy seeds to stop me hanging out..... Fuck man, you can't let people in the straight world see you're bent 'cos you know what happens. You've gotta pretend you're one of them if you want to be in the scene, like when I visit the old man, when I'm at Uni., what have you. Like, look at my old man. He thinks all drug users are fucking addicts. Sickos, fucking worthless shits. If he had his way we'd all be shot and strung up by the fucking balls. He'd fucking disown me. Fuck. I just wouldn't want him to know. It'd be the end of it. **Brian***

For Brian, listening to his father talk about the drug dependent person as *persona non grata*, an emaciated unkempt down and out who cares for nothing other than satisfying a craving for drugs and enticing children to try them, led him to experience feelings of incongruence and fearfulness that his father would find out who he really was and disown him. In giving his account, Brian also expressed concern that his father's perception of addicts is not an idiosyncratic one, that there is an everyday public perception of people who are addicts as being unscrupulous, evil, deviant drug pushers who are not fit to live in their society. This concern was not unique to Brian as many of the other participants expressed similar concerns. For these participants, the public perception of dependent drug users as being unscrupulous deviants who would stop at nothing to get drugs or sell drugs was not only worrisome and distressing but also led them to experience feelings of persecution and rejection, which in turn, greatly affected their Being-in-the-world. The following extract from a participant's interview shows the degree to which participants suffer from the societal negativity toward dependent drug users.

*Christ almighty! If you're a drug user you get treated like shit by everyone. You know, if a bird flew past and shit on your windscreen, you'd wipe it off before it dried. That's what they see drug users like -that shit you wipe off your windscreen. You don't count for anything. No one cares about you. They don't want to know you. I'm just Tony the drug user, the loser, the no hoper. It's because of the drugs. that's why. **Jesus Christ**. They're all anti the whole thing. They ostracise you. My drug use has never encroached on their standard of living but they think it has. All of them, the*

whole fucking lot of them treat me like shit. You know, I'll go for a walk when it's night and there's no one around 'cos they don't want to look at a piece of shit like me. I'm just treated like shit by them. I'm just another fucking problem that needs to be get rid of. **Tony**

To Tony and many of the other participants much of the blame for the perception of drug dependent persons as worthless deviants lay with the mass media. During the period of data collection, there were literally hundreds of news reports, editorials, background accounts, and feature stories about the drug problem, addiction, and drug pushers, along with many other variants on the theme of drugs and drug users as the main problems in our society and of costing millions of dollars. To these participants, the sensational media coverage that demonizes both drugs and drug users was of great concern. For them, it was as if they were being targeted by the media as enemies, as deviant criminal villains who posed an active threat to our society. Being portrayed as such led many of these participants to experience feelings of anger, of feeling undermined, and of being ineffective members of society. Such portrayals also led some to feel as if they were losers and of being a corrupting influence on young people as illustrated in the following exemplar.

I get really pissed off with the papers. It's no wonder society's got a fucked up view of us. Those articles I told you about, you know, addict faces robbery charges, drug dealer ensnares school children, drug dealer destroyed my daughter's life, taxpayer subsidises junkie, blah, blah, blah, are just crap. You know, we're all losers to them. Those articles, you know, take away our dignity, make us out to be big time losers so we don't get any respect. They really stigmatise us and that pisses me off 'cos most of the drug users I know are not, I repeat, are not anything like the media stereotype, you know, the drug crazed addict out to get all school children. Man, it really sucks. It's like they've got to have somebody to blame for all the wrong doings in society and I guess we're it. You know, it's like it's not a war on drugs, it's a war on us, the losers in society. Christ, man, I don't know why they can't step out of the ark. Fucking moralistic pricks. They think becous they're not losers they're the only fucking normal people in society. **Timothy**

That society has never approved of drug dependent people and has long perceived them as deviant criminals who are distinctly different from the *We* group, the normal members of society, is alluded to in Timothy's reference, above, to the ark.

Similar beliefs are also reflected in some of the other participants' accounts of the way in which the negative societal attitudes developed over time towards drug dependent

people led them to feel victimised, discriminated against and reproached as valid members of society. These participants also felt that their personal freedom to make choices as to what substances they used was being denied because of societal laws which now condemn the using of substances that once were legal and have been used by humankind throughout recorded history. In the following exemplar one of the participants discusses his feelings of anger at having his freedom to consume drugs limited because of the redefinition of acceptable drug use patterns fuelled by temperance crusaders in society.

*It all changed with the temperate crusade, that bunch of fucking moralists who flounced the Protestant ethic and capitalism to change the laws about drugs so that people would be easier to manage and control. You know as well as I do why society doesn't like us using drugs, why they've illegalised them all. They're symbols of freedom which they can't control. All the illegal drugs provide us with a world which those cunts can't control you in. no boundaries, no limits, no social constraints. They tried to create a new social order by prohibiting them and spreading the word that all drug users are evil, that we're all drug pushers who loiter around school yards waiting to entice small children into decadence. They've portrayed us as scourge, tried to ostracise us. Christ, I get so angry when I think thatwhen you look at archaeological evidence from centuries ago that prove drugs were used back in prehistoric times it's ironic to think that what was legal then is now illegal and what was illegal then is now legal. Visiting a coffee house in 17th century Egypt was a capital offence. Heroin was a legal substitute for opium. They can't control us if we use drugs. That's why they don't like us. I don't know why they don't just leave us the fuck alone to use what we want when we want. **Hugh***

Like Hugh, many of the other participants expressed feelings of rage and anger at the way in which they are labelled and stigmatised by society as addicts, violators of the rules of society, as a bad influence on others, as public menaces and as outsiders, the *them* group. Amongst many of the participants was a consensual feeling that they, as individuals and as a collective group, were shunned, looked down upon, believed not to be in control of their lives, and of being of no value to society.

In perceiving society to not see them as valued members, the participants further withdrew from mainstream society into their own social world. This was particularly evident with several of the female participants who commented on the differing social standards and attitudes toward drug dependent males and females. Reflected in their accounts were the negative and judgmental attitudes and the negative stereotyping of drug dependent women as fallen, as being sexually promiscuous, and as being unfit and

incapable of caring for their children. In their view, society is less accepting of the drug dependent female, it looks down on them more and treats them more punitively than their male counterparts. Confronted with rejection and disdain by society for their drug dependence, these participants further withdrew into their own social circle, minimising their contact with the straight world. Minimising their contact with the straight world had repercussions for two of the participants. Having fallen pregnant whilst drug dependent, these two participants were reluctant to seek prenatal support and assistance because of their experiences of the social prejudice and negative attitudes held by many towards drug dependent pregnant women. For these participants, the fear of being accused of exposing their unborn babies to harmful effects and being told that they could not possibly be good mothers or care for their children adequately was enough to prevent them from seeking prenatal medical attention and postnatal care. The fear that they would be forced to give up their children was also a factor in them not seeking support and help.

Being on the receiving end of the intense social stigma applied to drug dependent women, especially when pregnant and parenting, led these participants to experience feelings of low self-esteem, guilt, ineptness, despair, and irresponsibility. Battling against a general premise that addicted women are bad and inadequate mothers meant these participants felt they not only had to prove to society, but also to themselves that they could be a good parent regardless of being drug dependent. Having their competency and parenting skills doubted and being under the disdainful eye of society because of their drug use also led these participants to experience a sense of failure and inadequacy in caring for their children. To society, they were not normal or proper mothers. This perspective further served to isolate them from society as the following exemplar shows:

When I discovered I was pregnant it was too late to do any thing about it. God knows. I tried every thing to get rid of it. I didn't want the baby. I was worried about it getting addicted too. I kept thinking, 'if it lives, it lives, if it doesn't, it doesn't'. I didn't go to the doctor until he was just about born 'cos I knew what they'd say. "your baby's going to be addicted. You have to stop using." Blah, blah, blah. It was all shit. And that's just what happened. "you can't look after the baby when you're addicted. You have to give it up. Stop this. Stop that. do this. Do that." I told them to stop treating me like a fucking imbecile, that I was a person just like them, that I had feelings too. But they kept on and on and made me feel guilty for falling pregnant that I ended up crying all the time. They told me that I would be a bad mother if I didn't

stop using, that I wouldn't be able to cope with a baby. You know, it was like they were blaming me for falling pregnant and if I didn't give the baby up they would get social workers checking on me all the time because all drug addicts neglect their kids. They don't even want to give us a chance, they just think we can't look after our kids. They tell us we're failures even before we've started. You know, like, I worry about my kids, worry that they'll end up in jail, that they'll become addicts, that I won't be able to cope but at least I'm trying. Sometimes I am a bad mother and it won't matter what my kids will do, I'll be blamed for it 'cos I'm an addict. That's why I don't want any thing to do with them. Rosemary

In talking about their relationship with society, Rosemary and the other participants often used the word *they* referring to the general public. The public *they* to whom the participants referred can be related to Heidegger's (1927/1996) *das Man*, no one in particular, not this one, not that one, not oneself, but the others who are there in everyday Being-with-one-another. The *they* to which the participants refer are the others who impose the kind of Being of everydayness, the standards for the way one is to act, behave, and speak in the public world. In *das Man*, the everyday self of *Dasien* finds stability and the everyday world becomes levelled to the rule of the average in which everyone says what one says, does what one does, and is what one is. Essentially, one's thoughts and behaviours are characterised by conventionality and conformity to the morality and prevalent attitudes of the society in which one lives. To do otherwise is to stand out from *they*, make a show of oneself, be outside the average world. By not conforming to the prevailing attitudes and social morality through choosing to use illicit drugs and being drug dependent, the participants found themselves in an anomalous situation in relation to the *they*, of which they are one, a situation which has consequences in terms of the authenticity of their existence. The following exemplar captures the sense of being a part of society and yet not being a part of it.

The other thing that a lot of drug using people face is that society has this concept of drug using not being okay mostly because it is illegal, um, and society has this thing that all things that are illegal are not okay, and so, therefore, a lot of people who inject drugs or take drugs of any description are looked upon as the scourge of the earth, at the bottom of society, or the dregs of society, or something, and that's a huge thing in terms of people with addictions just surviving in society, is learning to feel like, or getting to feel like they're okay decent human beings in the world, and, um, I mean, what the hell are the dregs of society anyway for God's sake. You know, people live as a part of society even if they're on the fringe. The whole of society affects us. I think using addicts are really smart and switched on, you have to be. And I think that a lot of people in society and that, make the mistake of treating people

*who inject drugs like they're stupid and they don't really know any thing, and that's where society falls down, I think, because people, you soon pick up when you're being treated in that way. When you're being patronised, being treated with contempt or condescended to, or something. You soon pick it up and more often than not, people just clam up when that's happening or they become abusive. People aren't isolated units. The whole of society affects us. We're real people too. **Eliza***

For those participants like Eliza whose drug dependence was known of in the community, being treated with contempt was an everyday happening that had definite effects on their everyday lives. Many of the participants spoke of the difficulties and obstacles in using and getting services, in finding suitable housing, in being harassed by police for no known reason, in not being treated with respect and of not being trusted. Experiencing such difficulties heightened the participants' feelings of worthlessness, of being despised, and of rejection. As one participant expressed it:

*It's bad enough being a fucken' native [Maori] but those cunts [straight people in society] know you ping up [inject drugs] then you're rooted. "Get out of our town you fucken' worthless piece of shit. We don't want your sort here. Get outta my house. Get outta my shop. Get outta my life." Who the fuck do they think they are better than me. Fucken' cunts always fucken' on your back. Fucken' pigs banging on your door. "What're up to Charlie. We're watching you Charlie." Don't the fuck they know it's a cunt trying to make a living to get your drugs without those fucken' turkey's telling you you're a worthless piece of shit all the time. Cunts sure know how to make you feel good about yourself. Just waiting to stab you in the back. It's fucken' troubling, man! It fucken' is. **Dan***

Because society judges drug dependent people harshly, a few of the participants chose to keep their drug use and drug dependence very hidden. For these participants, only a few close friends or some particular person, such as a health professional, knew of their drug dependence. Concealing their drug dependence meant these participants were able to continue living in the community without fear of being stigmatised as a drug addict, of being treated with hostility, of being rejected, or of being regarded as a non-person. However, in keeping their drug dependence hidden, in pretending to be one of the *We*, these participants experienced feelings of loneliness and isolation, a feeling of being in limbo, caught between two worlds, and a feeling of vulnerability - of having their secret exposed. Such feelings, in turn, added to their dilemma, being caught between two worlds. Rather than solve their dilemma, their loneliness, secretiveness and vulnerability made it worse. The following extract from a participant's interview shows the reasoning behind concealing his drug dependence.

*No one I meet knows I take drugs. No one knows. Only a few people from my past, from years ago, from my criminal life. All the people I meet now, I don't let them know that I take drugs. Oh hell no! they've no idea. I worry sometimes they'll find out but I'd never tell them. Like, people's attitudes just change if they knew. You'd never live in this town if they knew. You'd never live in this town again, especially this town if they knew. Everyone talks about everyone. It's terrible. I've hidden it from people for different reasons. One. Because it's none of their business, and two, I don't want them to know about it. Like, their attitude changes towards you and they don't see you as a person. They'd see you as a hard out junkie. They'd treat you so differently, like, every where you go, they'd keep an eye on you. Anything that went missing you'd get the blame. It's just horrible. You feel had enough taking drugs and being on your own, and, like, you're not really one of them but you're trying to be, yeah, it's really important to conceal your drug use because they just treat you so differently if they know. There's no need to let them know because anything you say or do will be used against you sooner or later. Always will be. They all use it against you, everyone of them will if they know. It's just better if they don't know. They leave you alone. You have to hide it or they treat you differently. **Alistair***

Unlike some of the participants who worked hard to conceal their drug dependence, and others who withdrew from social contact with non-drug users, one of the participants was very open about his drug use and drug dependence. To this participant, being open about his drug dependence meant being visible, being counted, having a voice, and exercising his freedom of choice. It was this participant's hope, that through being visible, some of the prejudice and social stigma based on ill informed moralistic beliefs of what drug dependence means would fade away and a more positive and non judgmental attitude toward drug dependent people would develop throughout society. However, being open about his drug dependence as a way of increasing the visibility of drug dependent people and their right to be treated like normal people, and in turn, hopefully reducing some of the prejudice and social stigma, was not without its risks. Taking such risks though for this participant was to have a sense of worth, to be concerned, to be involvement, and to be vigilant. Taking such risks also led him to experience feelings of vulnerability and defensiveness as expressed in the following exemplar.

It was after I got busted that I became open about my drug use. I think society presents stupid reasons for making a drug illegal and I won't buy into them. Because of their laws, society sits in judgement on us, blaming us for all the ills in society and taking away our rights. Once I was aware after being busted that the Misuse of Drugs Act is not legal, it's anachronistic, I decided I'd stand up for what I believe in, my right for freedom of choice about which drugs I use and to have the same rights as normal, members of society. You've got to give up a hell of a lot to do that, always

having to be on guard, risking your freedom to fight for personal freedom. Sometimes I think I'd rather admit to being a criminal than a drug addict because of the stigma in being labelled a drug addict, and the demeaning way they treat drug addicts, but yeah, fuck, it's been worth it. It's ignorance that fucks society up and if I can tell them what it's like, that I'm living amongst them, that I'm not going to steal from them and that I'm not an object of fear, then it's worth laying my freedom on the line. You know, I'll stick up for myself. I don't, I'll not march to anybody else's beat except my own. Hugh

The need to be honest and open about who he is and what he does was important for this participant. Using drugs and being dependent is a part of who he is as a person in society alongside of others. To pretend to be other than who he is would be to cover up his authentic being, not march to his own beat, let societal prejudice drive him into hiding. In sticking up for himself, the participant is acting to recover the self he had lost by living in the world of the other, the conventional *We* world in which everyone is expected to act as *they* act. When living in the conventional world of the other by the others' rules, to act in such a way as to be connected into a different group of people and a different social category is to make a show of oneself, to incur society's animosity, to be labelled and stigmatised, as each of the participants found. As drug dependent people, the participants were not perceived to be part of the conventional world, the *We* world, the non-addicted world, rather, they were perceived as part of the *Them* world, outsiders, people distinctly different from the majority of society, people who have deviated too far from mainstream society concerning the use of psychoactive drugs. Because of their inclusion in such a group, the participants were denied legitimacy and treated as non persons in the wider social world, yet, for them, being drug dependent had become a part of who they are and how they related to others, not only on a societal level but also on a personal level. Whatever difficulties or rejection the participants encountered in being alongside of and relating to others in the wider public world of the *We*, all the participants viewed their relationships with others on a personal level as defining in their experiences of their drug dependence. Among the others to whom the participants related on a personal level were friends, lovers, family members, and self, all of whom were guiding forces in the participants' lives. The significance of these relationships in the participants' everyday lives is discussed under the following themes: junkie friends, lovers and families, and Being-with-oneself, one's relation with self.

Junkie friends

Although the study participants maintained relationships with many non-drug using people in society, most of them found that as they became more deeply involved in a drug lifestyle, their relationships with straight people, in particular, their old friends, floundered. As drugs and drug using took precedence over all else, many of the participants felt uncomfortable being with old friends, especially if their drug use and their drug dependence were concealed. No longer linked by mutual interests, many of the participants found old friends not only made demands on them but also confronted them with reminders of their former selves. Unable to meet such demands, or face being confronted with who they were before being drug dependent, these participants sought out straight friends less and less. For some of the participants, being with old friends who were unknowing of their drug dependence led to feelings of guilt and discomfort. Fear of being found out added to their discomfort to the extent that they found it more comfortable not to have contact, as illustrated in the following exemplar.

You can't tell them 'cos they'd think you're a loser. You'd lose them through their narrow-mindedness. They've got a preconceived idea of what a drug addict is and you'd fit the bill whether you're like that or not. You don't want them to know 'cos you'd lose them, but you lose them anyway 'cos you worry about them finding out so you stay away from them. Then you lose them anyway 'cos you don't do anything with them. Angus

For many of the participants, old friends who knew of their drug dependence but did not share an interest in obtaining or using drugs became threatening with their disapproval and dislike. In the eyes of their friends, these participants had lost credibility and respect. The participants were no longer taken seriously or viewed as trustworthy. Thus, their relationship with old friends floundered with the friends drifting out of the participants' lives. In the words of one participant:

I felt pretty uncomfortable being with her [friend] after I started using. It was like a dark secret I had to hide. She was always on her moral high ground about drugs and I sort of felt the gap widening between us. It was starting to get really uncomfortable being with her so I told her. I told her I was a junkie. She said she sort of sensed something was different about me, that I was getting sort of boring and unreliable. You could tell she was horrified. I saw the trust she had in me just go out of her face and it was like, there was nothing left to talk about. I was somebody different. She

didn't want to hear about it so we sort of drifted apart, broke away from each other so to speak. Sort of cut each other out. I sort of missed her but didn't really if I was honest about it but we didn't really have anything in common any more. That's when I made new friends, friends I had something in common with. Lauren

Because of the discomfort the participants experienced in being with straight friends, it was to others who shared similar experiences, a similar outlook, and a similar lifestyle that the participants looked to for a feeling of connectedness and understanding. In seeking out and being with these others, the participants felt more comfortable, more united, and more able to be themselves as reported in the following exemplar:

I found that I couldn't relate to my straight friends. They didn't understand what I was going through. They were so judgmental and narrow-minded. You know, their idea of a drug user was you don't trust them, you don't leave your money lying around, don't let them in your house. It was bloody hard work being with them. That's what did it. I couldn't be myself with them anymore. Soon as I stopped seeing them and spending more time with some other users I was able to relax, be myself. They weren't always judging me. We all had the same understanding. It didn't matter that I used drugs, that I didn't always turn up when I said I would. They were in the same boat. We all had to go out and score. That came first. Jenny

For the participants, seeking out and establishing relationships with others that used drugs and were drug dependent also provided them an extensive social network of associates. Such a network for the participants meant that they were able to exchange information and aid with others who shared a similar world view, others who were familiar with what they were talking about and who knew how to act if help was needed. Being within such a network also meant that resources could be pooled to purchase drugs, information about the availability, cost and quality of drugs could be exchanged, favours could be extended, ideas about getting money for drugs could be discussed, and new or alternative sources of drug supplies could become known. For the participants, such associations provided not only a source of mutual support, both emotional and physical, but also others to share in the drug experience. Essentially, being a part of a network composed of others who shared in similar experiences enabled the participants to experience feelings of security, of belonging, of acceptance, and of being-in-the-world together as illustrated in the following exemplar.

You know, we're all in it together, like birds of feather, we're all out there doing the same stuff. It's like we're all one big family, hooked together by our addiction. Anything you do or say is okay. You're accepted the way you are..... No one tells

you you're wrong and no one criticises you. If you want someone with you when you're shooting they're there, no questions. If you want someone to get high with, that's no problem either. If you want someone to do a job [burglary] with, there's always someone. Everything or anything goes. If you keep in with the same crowd you're safer, you're all in the same boat together. You've gotta feel safe 'cos it's pretty risky being a junkie. Paul

Although a wide drug world friendship network provided the participants with contacts, information, pooled resources, support, and a sense of belonging, most of the participants, when discussing the nature of their relationships within drug world networks, did not consider any of their associations to be friendships in the true sense. Generally, to the participants, the word *friend*, although used often when talking about their relationships with other drug users, signified a pre drug use relationship, one in which the fundamental element of trust was present. Post drug use relationships, in comparison to those formed pre drug use, were mostly considered to be devoid of trust. Such friendships, lacking in trust, were accepted by the participants as being the only type of friendships possible once drugs took precedence over all else. Consequently, the word *friend* often meant nothing more than someone to get drugs from, someone to hustle money with or from, or someone to do drugs with, even though the participant might spend a great deal of time with that person in their everyday life. Although sharing a lot of time with their drug world friends, most of the participants felt that their friendships with other drug users were disappointing and second rate to former friendships. For them, trust could never be a part of their friendships, not while drugs came first. In the following exemplar, a participant expresses strong feelings of disappointment in the relationships she has with others after becoming and being drug dependent.

I don't really have any friends, not true friends anyway. You don't have friends when you're a drug addict. You like to think they're friends but, you know, they're not really, they're just other addicts, all worried about getting their next hit. They're not like the old friends you used to have, like, old friends don't rip you off but I've been ripped off by [two other drug users]. I thought they were my friends but now I can't trust anyone. You're always waiting for them to rip you off. It's a joke really. They're only drug friends. Second rate friends. If they can't get something out of you they don't want to know you. Sometimes I wish I had a true friend, someone I was close to like before but once they know you use they don't want you as a friend. They just think that you'll rip them off. Funny eh! That's just the way it is now, it's pretty sad but that's how it is. Jenny

Amongst the participants it was generally agreed that although they had many associates, very few of them were looked upon as friends. Even though the participants felt a sense of connectedness, felt at ease with them, and were accepted by them as being part of the same social world, they also felt a sense of loneliness, of being alone in a world of others. In the words of one participant:

*Once you start taking drugs they come first before anything else. They're what's important. Without them you're lonely. Totally alone. If you score you're not lonely. You don't even think about being lonely. You don't even think about not having any friends. You've always got mates though, always got mates, either wanting something from you or got something for you. You're really just all alone though. That's how I know **alone** is the most horriblist word in the English language. I know 'cos I'm the loneliest person you'll ever meet. **Tony***

Notwithstanding the lack of trust among drug users, the feeling of discomfort around straight friends, and the feeling of loneliness experienced by many of the participants, it was apparent that bonds of togetherness and camaraderie did develop between the participants and the others with whom they related in the drug world. To the participants, these bonds not only united them against the *We* group, the straights in society, but also connected them into a social world in which they found a degree of acceptance and support not matched in the straight world. In their social world, the participants found others who shared a common way of Being and so understand each other in a way that those who do not use drugs cannot do. To them, only other drug dependent people could know what it is to be in the world in such a way, to experience the arduousness and difficulties associated with drug use. In the following interview extract a participant describes how only another who has shared an experience in common can understand what he is experiencing.

*Anyone who hasn't experienced a little turkey [withdrawals] won't be able to understand exactly what is happening to you. Only junkies understand junkies. When the body cries out for more, only another junkie knows what it feels like, what you're going through. An outsider just can't understand the extreme lengths a junkie'd go to, to get that drug back into their bodies. They just don't know. They just don't have any idea what it is like, how desperate you actually get. **Jared***

Having a common base of understanding through sharing similar drug experiences and a drug lifestyle enabled the participants to develop a sense of identity with other drug users. To the participants, being a junkie or an addict gave them the identity that they

had been searching for. The inner sense of sameness they felt with other drug dependent people was important. To them, it provided a feeling of being accepted, of being in, of being someone, and of belonging. As one participant remarked:

We're all druggies or junkies, addicts, or whatever they [society] call us. I suppose I don't mind being called a junkie. It's what I am. I'm in with that crowd. Feel like I belong. Have something in common with them, share the same ideas, you know, do the same drugs, speak the same language. I suppose I sort of know who I am now through being with them [other drug users]. They accept me just as I am. Yeah, I'm one of them, like I am a junkie. That's what I am. Steven

Together, the participants and the others with whom they share an identity, participated in a social world characterised by the getting and using of drugs, furtive illegal and criminal activities, a set of special rules, roles, norms and values which serve to join them together within their social world and separate from straight society. Through this social world, composed mainly of drug dependent people, the participants took on the attitudes, image, and ways of their drug world associates and came to view themselves through their eyes. Together as addicts or junkies, set apart from straight society through their drug use, drug using friendships, and their drug world associates, they shared a unique language, an argot which identified them as such. Through this common language, the participants shared experiences, exchanged information, supported their drug use, coped with problems, protected themselves, bonded together in their community, and identified themselves to their drug world associates, all of which gave them a sense of being someone, of belonging, and of sharing. As one participant put it:

A fucking straight like you wouldn't know what the fuck I was on about. Like, if I want some fucking dynamite [high grade heroin] or some primo [high quality cannabis] you'd think I was wanting a fucking milkshake, a fucking vanilla one. You're not one of us [drug users] so you don't have a fucking clue what I'm on about. What I get up to, like, all us dope heads geeze [get high] together, share our works [injecting equipment], talk shit [drug talk], and you don't know jack shit about it. You gotta be in the know, what the fuck we're on about. You gotta know the fucking words. You straights think it's all mother fucking bullshit what we say but that's 'cos you don't know the lingo [language]. Dan

To the participants, their shared drug world language also represented a conscious choice of one lifestyle over another, drug using friendships over straight ones, and a tool for manipulation, deceit and coercion, both within their world and the straight

world, the society in which they lived. In the following exemplar a participant expresses her views on a number of important ways language functions in her life.

*I suppose part becoming a drug addict was learning how to talk like one, like, if you want to score you've got to know what you're on about or you'll get ripped off. You've got to have the gift of the gab to talk yourself out of all sorts of situation, to get drugs or to get money. You've got to speak the same language to let others know what you need, like, if you don't know what you're talking about they'll take you for a ride. You've got to be able to pretend you're straight, that you're not really who are especially if you're caught with drugs. You've got to be able to con people, keep your cool, so yeah, you've got to know, you've got to learn how to speak the same otherwise you don't know who's okay or not. **Jenny***

Essentially, through the use of addict language the participants were able to identify themselves to others who were drug dependent, share experiences, convey feelings, obtain drugs, and share the reality of being drug users together. It was with these others with whom the participants had a shared reality that they found an understanding which those who are not drug dependent cannot know, found support and protection, and felt most at ease with. To the participants, the relationships they formed with these others, although important, were not comparable to pre-drug friendships. Based mainly on the shared experience of being drug users, the participants' relationships with these others lacked trust, a key element of friendships. As a result, most of the participants spoke of their drug world friends as associates, friends but not really friends, just the others who are there, with them, in their world as expressed in the following exemplar:

*To call other drug addicts friends is a bloody joke. Most of them'll stab you in the back if they thought you had some drugs and they didn't. They're nothing more than connections, associates, acquaintances, just others who are looking to score same as you. Some of them are okay but they're not friends. I don't see any of them as friends. I just don't trust any of them. I used to have friends but when they know you're a user they stop seeing you. Things change. You've got nothing in common with them any more, so you end up with other drug users as friends....and they're okay. They're another contact, another person to use with or score from. **Rosemary***

As the participants found, it was not only friendships that underwent changes the longer they were part of the drug world. Their relationships with their lovers and families were also affected.

Lovers and families

The most significant of all the participants' relationships in the drug world were their partnering ones. Extremely varied in nature, partnering relationships sometimes endured for long or short periods, were supportive or exploitative in nature, were functional or undetermined, and were either gratifying or unsatisfactory. Most often, the participants' intimate relationships were forged among other drug users met within the participants' drug world. Some participants, however, reported having or having had partners who were non-drug users, and a few were not involved in intimate relationships at all. Of the participants who have had or were having intimate relationships with non-drug using partners, two of them kept their drug dependence hidden. Keeping their drug dependence concealed from their partners allowed them to escape the disapproval and condemnation they would experience if their drug dependent status were known. For them, keeping their drug use hidden meant moving between two worlds; the straight world of their partner and the drug world, forever hoping the two would not meet. However, moving between the two meant being deceitful, dishonest and exploitative, which in turn led these participants to experience feelings of guilt, frustration and vulnerability. The following extract captures the conflict experienced by one participant in keeping his drug dependence hidden from his partner.

*Like, she [wife] knew about my drug use to start with. Then I gave up. It was give up or she'd take the kids and leave. I gave up for about six months but carried on using again after that. I was using behind her back. She never knew I was using behind her back. She never knew how much I needed it [opiates]. Like, I didn't want to lose her. I was torn between her and being a druggie. I hated myself for it. Always wanted to, you know, tell her, and I hated myself for doing it. I'd feel so guilty. I didn't want to lie to her. It's the only thing I've ever lied to her about. I knew she wouldn't understand. She'd just hate me. To her, it's like, **just give them up**. She doesn't understand that if I could just give them up I would. You know, that's what she said [laughs], "oh, just stop using." To someone who doesn't take drugs they've really got no idea. Like, I need them [opiates] to function, I can't do without them. I get too depressed and I'll just end it, so to me, it's like I need both my family and my drugs.so I had to lie. I felt, you know, I felt horrible about it. I hated myself for doing it, not telling her. **Alistair***

Paradoxically, one of the non drug using partners viewed a participant's drug use as a means through which he could control her. Fear of losing her and his children

motivated him to keep the participant supplied with drugs once he knew of her drug dependence. For the participant, being supplied with drugs impacted upon her Being in both positive and negative ways. Not having to keep her drug use hidden and having drugs supplied by her partner meant she experienced less stress, less vulnerability, and more security. On the other hand, the participant experienced a sense of entrapment, of being controlled and a personal sense of weakness, and indebtedness. In the words of this participant:

*He didn't know until, um, I'd, um, brought some stuff and had an OD. He, um, came home and found me and I had to go to the hospital and, so I had to tell him, you know, that's when he started bringing it [pharmaceutical drugs from the drug wholesalers] home. Yeah. He did that for a long time. I'd ring him to bring the pethidine home and he would do it. It was great having it all laid on. I didn't have to worry about getting it any more. It was convenient for him to maintain my addiction because that kept me in the house and I was taking care of his children, and his mother, and his family, and it kept me there because I didn't love him. I didn't want to be in the marriage. It was a really uncomfortable place for me to be. I didn't want kids and, um, I found myself stuck in this situation and so I'd get stoned. And I think he could sense it, sense that I didn't want all these things or him. It was easier just to keep me stoned than work it out. When I was stoned it didn't matter to me. Like, I couldn't have sex with him if I wasn't stoned. I didn't like having sex with him. I hated it and so, during my drug using that was the time we would have sex. I felt like I had to because of the drugs. He did it [stole drugs] to keep me there and I let him because I wanted the drugs. **Eliza***

In recounting their intimate relationships with non-drug users all of these participants described how hard it was for the relationship to be maintained. Regardless of whether or not a partner was in the know about a participant's drug use and dependence, relationships with non-drug users were fraught with guilt, deceit, dishonesty, and disrespect. When the partner was aware of the participant's drug use, the participant was on the receiving end of their anger, resentment, and disgust which often led to the participant experiencing feelings of being torn between two worlds, especially when confronted with ultimatums, such as "the drugs or me", by their partner. As drugs took precedence over all else in the participants' lives, pleasing a non-drug using partner became more difficult. Because of the difficulties encountered such relationships were not enduring. Rather, as the participants became more involved in a drug lifestyle and drug using friends, their intimate relationships tended to be more with other drug users. In sharing a mutual interest in drugs and drug use, some of the participants and their drug using partners worked together to support and maintain each other's drug

dependence. Such relationships were usually rooted in pragmatism and centred around the pooling of their resources and a division of labour according to their abilities and expertise. Through pooling their resources and dividing the work involved in getting their drugs with their partners, the participants felt a sense of collaboration, of joining forces, and of shared endeavours. To them, having someone to share in the cause meant less stress, less risk, and less effort. In the following excerpt a participant describes his working partnership.

*She [partner] taught me a lot, how to make money, you know, how to go into Wellington with no money, nothing, and at the end of the day come out, you know, with whatever you wanted. Ever since we joined forces it's been much easier, you know, money wise and drug wise. I learned a lot from her, like, we were never without anything. If we wanted some drugs she'd make appointments at doctors, you know, go and see them and score. She was good at that. if we needed money she'd go and shoplift something and I would take it back and get the refund, yeah, you know, with her, I always had money and drugs. Yeah, it was so easy. You know, like, I didn't stress out as much knowing that we'd always get something. She used to say, 'c'mon Gerard, it's all for the cause'[scoring drugs]. Everything we did was for it. Yeah. Yeah. Yeah. She taught me how to shoplift and take things back. She taught me a lot like that. We did it together. We were partners in every way. I'd never had someone to share it all with before. She was better than a friend. Yeah. **Gerard***

Not all of the participants' intimate relationships were as symbiotic as Gerards. Rather than being mutually supportive and beneficial, some of the participants' intimate relationships as being unequal and exploitative. Typically, such relationships occurred when one of the partners in the relationship functioned only as the support system for the other, or when one of the partners took advantage of the others weaknesses, vulnerabilities, inadequacies, or insufficiencies. Of this type of relationship, the most common among the participants was when one of the partners lived off the earnings of the other, these earnings generally being from prostitution or such criminal activities as shoplifting, theft, burglary, or fraud. For some of the participants involved in exploitative relationships, being taken advantage of by a partner was perceived as having a major impact on their experience and acceptance of self, yet they felt powerless to leave the relationship. These relationships, begun out of a mutual interest in drugs and once supportive and trusting, had, over time, become unequal as one partner's need for drugs took precedence over their concern for the other. To be in such a relationship was for these participants to feel resentment at being wanted for what they could provide rather than for themselves, disgust in themselves for feeling

powerless to change their conditions, and shame that they let themselves be used in this way. In the following interview extract, a participant describes how she supported her partner through prostitution and the resentment she felt both at him and her inability to change her circumstances.

I can't remember when it started really, probably about a year after being with him. We didn't have any money to score so he said he knew some people who'd pay to sleep with me. That was cool 'cos it was one way to get the money, but then it started happening more and more. I ended up going from one to the next while he stayed at home. He'd give me a list of names and they paid him and he gave me drugs and some spending money. I was very angry. I thought, you bastard, but the craving I had for that utopia was more important to me than what I had to do to get it. I didn't really give a damn about myself. I just wanted the drugs. he just gave me enough to maintain my habit. He controlled my drug use. I wanted out but it was the drugs that really made me stay. I didn't have the strength to just go. I wanted the drugs and he got them. All I was to him in the end was a piece of shit that he could sell while he sat on his arse using the drugs that I paid for. I basically did what he told me 'cos I was living in fear of him. He just used me because of the drugs, he knew I'd do anything for them, and he.... Fuck, I get so angry when I think about it. I just let it all happen.

Trish

Like Trish, other participants involved in similar relationships were aware of the disparity between themselves and their partners, yet they chose to remain in these relationships. To them, no matter how unsatisfactory their relationships were, how exploited they felt, or how damaged their self esteem was, each relationship could be endured if they were perceived as a means of obtaining drugs and of feeling wanted or needed. Whatever form their intimate relationships took, the participants experienced them in many different ways. For some, such relationships heightened feelings of powerlessness, resentment, resignation, and shame, whilst for others, intimate relationships were found to be mutually supportive, both emotionally and in maintaining their drug dependence. Essentially, each of the participants found that their drug dependence impacted upon their intimate relationships and their intimate relationships impacted upon their drug dependence in a myriad of ways. This impact was also reflected in their relationships with their families.

Beyond each participant's relationship with society, drug world friendships, and intimate relationships was the smaller group of family members with whom they related. For the participants, families comprised of all those others, not of their choosing, whom they found themselves alongside of in their everyday world through

their facticity, their being born into their family. Although determined, given to them and not of their own choosing, many of the participants continued their relationships with their families, particularly their parents, after becoming drug dependent. Like their relationships with others, the participants' relationships with their families were varied in nature. Some were distressing, some heartbreaking, some strained, some problematic, some no longer, and yet, others were supportive and hopeful. In becoming and being drug dependent several of the participants chose to stay away from their families, to no longer have contact. Behind these participants' decision to stay away were fear of the consequences of disclosing their drug dependence such as rejection, feelings of shame and embarrassment, being thought of as a failure, and feeling as if they had let their family down. As the following exemplar shows, making a decision to stay away from family could have a harrowing effect on a participant.

*They're totally against it [drug use]. Neither of them have ever tried drugs or even want to know about them. Mum's a Christian and she always sort of goes on about God and that.... that I'm doing something wrong, bringing shame on them. I get along with mum okay but I don't get along with him [father]. He's always on at me... it was easier not to go home, to stay away, pretend like I haven't got a family... but I miss my mum. I miss talking to her ...yeah.....if I went back she'd get too stressed out, you know, too uptight.... So I don't go. I don't have any contact with them anymore. It's just easier that way. I let them down. I've got a lot of good memories, that's one of the better things.... I've got a lot of grouse memories of my family. **Herman***

Unlike Herman who deliberately chose to stay away from his family out of concern for the way they felt about his being drug dependent some of the participants chose to stay away because of the tremendous violation and betrayal they experienced through the abuse of power by incestuous fathers and brothers and other family members in their formative years. Through their experiences of familial sexual violence, these participants were left feeling violated, unclean, bitter, devalued, ashamed and humiliated, feelings which have permeated their family relationships and left them with a diminished sense of self worth. In the words of one participant:

He [father] used to come in and rape me. I was really young and didn't know what to do. He'd push me down and then rape me. He'd hit me on the face. My face was always swollen and when he got what he wanted he left. When I got older he stopped doing it to me but started doing it to [younger sister]. After awhile my brother started raping me. He made me get stoned afterwards to stop me crying and sometimes he'd pull out his knife and tell me he'd cut me. That's what he said. "Just a small cut there." On my face. When I cried he'd punch me so I just stayed quiet. From then on I always cried inside myself. It wasn't crying like you could hear. I don't know how to

explain it.... It was a crying inside myself. I hated myself. I felt like it was my fault he was doing it. He used to tell me I made him do it. I didn't want to live. I didn't have anything to live for. I was like I was dying inside so I used the drugs just so I wouldn't cry. He made me feel so dirty, so dirty I can't really get clean anymore. Even now I feel like that.... I tried to tell mum but she wouldn't believe me. She didn't want to believe me. She said I was a dirty slut leading them on and that's when I left. I've never been back and I'm never going back. I don't ever want to see any of them again. I'm like this [drug dependent] because of them. They did it to me. Tui

For Tui and several of the other participants, such experiences of violation and betrayal by family members were perceived as profoundly painful and as having a major impact on their experience and acceptance of self. Using drugs, to them, became the means by which they coped with and battled the feelings of inner pain caused by the incestuous abuse. For these participants, still experiencing the pain, families had become of no consequence, no value. They had been spurned. Incestuous abuse was not the only form of abuse to drive the participants away from their families. Among the participants there were very few whose childhood was not characterised by some form of abuse, deprivation, or violence at home. Although some of the participants like Tui lived the abuse everyday of their lives, others like Tony and Toby viewed familial abuse as just one of the many experiences that they had lived through. Such experiences, however, not only affected the way they viewed themselves and their situation in the world but they also led them to alienate themselves from their families. The following interview abstracts show vividly why these two participants alienated themselves from their families.

My family, the earliest, um, the earliest memory I have is sitting around the tea table. I was about three and a half years old. We, um, we had a, um, we were having tea, my parents were drunk. They were having sex on the table. If we didn't watch we got the bash. That's my earliest memory. Um, a lot of screaming, ambulances, violence. Three and a half, believe me, that's not something you easily forget. It was more awful than that though. One of my brothers, before he was twelve, had his skull fractured three times, while I was watching....//...um, I, um, I very much doubt there'd be many experiences that a male can go through in life that I haven't known about. I mean, when somebody talks to me about abuse and violence I say to them, "I know what you mean"..... in my family there was always violence, always blood. Broken heads, broken hearts. It was all we knew. When my father died it was the best thing he ever did for me. I've paid a heavy price. My childhood was taken away from me....To them [parents] I was just a piece of shit, something you scrape of your shoe. That's all. Just a piece of shit. I can talk about it now, but, um, thankfully all that I, thanks to the drugs, I don't feel too much. I take drugs to make me feel nothing. Tony

I had a very violent upbringing right from childhood. I went to drugs, started using drugs, cannabis and alcohol about 13. I had a stepfather, large sort of step family, hmm, that was a violent scenario... ah, I first started taking drugs, well, copious amounts to try and forget, to forget about it... the violence. They [stepfather and mother], I tried to spend as much time away from them as possible. They, um, like I was targeted by the stepfather, it was both of them, they'd line us up and if the old lady was doing it, fuck, you all got it. It was, it's be mean, man, you'd get an alkathene pipe, she stopped using bits of wood 'cos she broke them on my head several times, 'cross my back once, um, so they went on to alkathene pipes and um, if the old lady was wielding that, it was all out. She'd, um; She'd hit you 'till you cried then she'd hit you some more and I wouldn't cry, not by that stage anyway, fuck you. You can get fucked, I'm not going to give into you. I'm just not giving in. So, of course, she'd hit me until I cried and sometimes I'd come to and, I'm out cold, like I got knocked out by her so many times, I can't even think how many it would be, but, you know, I'd come to and, fuck you, you're a little kid, you'd be crying your arse off, think to yourself, what are you doing that for, and I'd actually go away and punch myself in the head, you know, 'cos I'd cried, I gave in and that sucked, you know, that's bullshit, you don't give in to nobody, so yeah, fuck them, fucking eggs, fucking psychotic fanatically religious fucking eggs. I fucking hate the cunts. Fuck them.

Toby

When speaking of their families, these participants reported their relationships and interactions in a negative manner. Family members, amongst whom the participants once lived, were perceived as non supportive and devaluing of their personhood and needs. Being regarded by their families as nothing more than a “piece of shit” that needed discarding led these participants to feel stripped of their dignity, value, and worthiness, and to experience an impaired sense of self. For these participants, any contact with family members was not seen as meaningful. Rather, any contact contributed to these participants experiencing feelings of anger, bitterness, and hostility toward family members as a result of the extreme violence and debasement they suffered at their hands. In staying away from their families, these participants were able to feel a sense of empowerment, and of having a choice - choosing not to interact with those others who are not of their choosing, but who are there through their facticity.

For several of the other participants, rejection of or staying away from their family was not of their choosing. Rather, it was their families who outrightly rejected them when faced with the knowledge that the participants' were drug users and drug dependent. For the families, finding out about a participant's drug use and drug dependence came about in a variety of ways. In some cases, the family gradually became aware that something was up, that something was not quite right through noticing differences in

the participant's usual way of life. Such differences included a noticeable change in the participant's circle of friends, a change in capabilities, and a change in the participant's physical appearance. The following extract from a participant's interview illustrates the growing awareness her family had of her drug dependence and the feeling of doom she experienced anticipating their confrontation.

*She [mother] knew something was up, that something was wrong because I was hanging out with people that maybe didn't influence me the way she wanted to. I was scared of her finding out. She'd always gone on about drugs and how she'd have nothing to do with me if I took them. She was always on my back about that very much. I think she got more suspicious all the time because she went on about them and what I was doing, like missing school and not coming home. She was very demanding, what she would like me to do with my life. She always wanted me to be the best. But I didn't want to be the best. It was like she knew about the drugs but didn't want to know and I didn't want her to know because I knew what she would be like if she really did know. It was awful living like that... she found out in the end. I ended up getting very sick, no one told me that you shouldn't mix opiates with alcohol and I ended up spewing and collapsing at home when she was there. That's how she found out. **Lilian***

In some instances the participant informed their family themselves of their drug use and drug dependence either as a consequence of being busted for possession of drugs and/or committing crime, or when seeking support and/or help whilst experiencing withdrawals. For these participants, approaching their families and telling them of their drug dependence was a daunting experience, especially when they were aware that the family rejected the use of drugs and upheld values antithetical to the use of drugs. Faced with the threat of rejection these participants found it took courage to come clean to their families. Coming clean also gave them a sense of taking responsibility for their own addiction. In the words of one participant:

*I rang them up to tell them that I, that I was going to prison, that I was arrested, that I was a drug taker, that I was dropping out of university, all in one phone call, and that went down like a fucking fart in a space suit. I had to do it all in one go. It took a lot of courage to do it but I didn't have any choice. I had to come clean. They were the guarantors for my overdraft. The bank was going to call in my guarantors to pay it off when I went to prison so I knew I had to take responsibility. I had to tell them. It was a real shock to them. The phone call when I rang up to tell them what sort of trouble I was in, fucking, you know, what have you done to the family name, fucking look what you have done to your father, look, he's crying, I've never seen your father crying in his life, fucking we're never having anything else to do with you, you're not our son. I felt like, fuck, you know, wiped their hands clean of me. Fuck, it was hard telling them. **Hugh***

The reaction of some families when faced with the knowledge of a participant's drug dependence was to reject them, throw them out, and no longer have contact with them. In experiencing rejection and lack of support from their families, these participants felt angry, unloved, hurt, and abandoned. In the following exemplar one participant describes how he felt when he experienced rejection from his family when they found out about his drug use.

*Man, they [parents] over reacted. They found out about my addiction when I dropped out of Uni. They told me they'd have me arrested if I stepped foot in their house again. They threw me out of the house. Like, fuck man, I'm still their son. They're still my family. That hasn't changed. It's like they've fuckin' disowned me, I'm not good enough for them. Fuck, I was angry at them. It wasn't like I was going to rip them off or anything. They gave me a fuckin' ultimatum. Drugs or us. Nothing in between like can we help you through this. They didn't even want to know what it was all about, what'd happened to me. Said they didn't know me any more. Fuck, what'd I do to them. **Jimbob***

As illustrated in the above exemplar, rejection by a family was often a painful experience. For some of the participants, the pain they experienced was ongoing and some resentment was still felt towards family members. A few of the participants described their experience of rejection in terms of a grieving process where they went from being angry to being sad to eventually not holding it against their family. For these participants, their lifestyle was so very different from their family's that they could understand the rejection, and as drugs took precedence, they abandoned the struggle to keep up a normal relationship with their families. In the words of one participant:

*I got sentenced [for possession of heroin] on my mother's 50th birthday. I had to tell my mum before it was in the paper. I didn't want her to just read it in the paper so I told her. Some of my family knew [about the drug dependence] but they weren't, we'd not talk about it. We don't talk about things like one of the family using drugs. In a dysfunctional family everyone just pretends it's not happening. They just tell you either to stay away or they watch you like a hawk in case you steal something from them. I could understand how they felt. They had this picture in their heads of a drug crazed addict and that was me. It was hard pretending to be a part of that dysfunctional family when I was so different from them all. It was bloody hard work so I just stayed away. My relationship with my family is still not good but that's okay too. **Eliza***

For a few of the participants, rejection from family provided them with a sense of relief. They no longer had to work at keeping their drug dependence a secret. No

longer did they fear being exposed. Although hurt by the rejection, it was not the end of their world, in fact, it enabled them to feel free from the expectations of their families that they were not able to meet, and of not living up to their families' standards. In the following interview extract one participant describes the freedom he felt after his family washed their hands of him.

My family life stopped after the olds found out about my drug use. They just washed their hands of me, just like that. didn't give a shit about how I felt. No one in my family used drugs. I never did see them ever use any drugs but it was through my parents, I still haven't been able to identify whether I jumped into the drug scene because of my life growing up and, you know, sort of being quite an emotional type of person and forced to be sort of shy and reserved because my father was always quite loud and, I don't know, anyway, they said I didn't learn it from them. They couldn't understand it. I didn't mind too much. Getting the shaft from them. I could be myself. I didn't feel like I had to live up to their hypocritical standards any more. Their fucked work ethic -you have to work. it was like, fuck, I'm not going to work for a living, you know. I have an easier way. The drug world, you know, the criminal scene, so yeah, I don't have to live up to their standards. I can do what I want... I'm just a full blown drug addict to them. I'm free to do whatever I want without them shoving their standards in my face. Simon

As illustrated in these exemplars, a common reaction of some of the participants' families was to reject them when faced with the knowledge that the participant, one of their family members, was a drug user. As a result of the rejection, relationships between the participant and their family members became strained and often reached breaking point with either the family throwing the participant out or the participant choosing to stay away rather than experience more outright rejection. Although not so common, another response of families was to provide support after their initial negative reaction of shame, embarrassment, hostility, contempt, and abhorrence. Despite some other members of these families using drugs on occasion, in no instance did any of the participants' families condone drug use, rather, drug use remained abhorrent to them at all times. For the participants whose families were supportive after overcoming their initial reactions, there was a general feeling of acceptance, of still being loved no matter what, of still being a part of the family. Relationships with family members, however, remained strained. As one participant expressed:

When they found out it was horrifying for them especially because of their religion [Jehovah Witness]. I had to go in front of all these elders and all that, of the church. For awhile it caused a big stink at home. Yeah. Because my father was an elder then

and he lost that. Yeah. He was gone and my mother had some, some position but she lost that too. It [drug use and drug dependence] was a big stink. It caused me a lot of trouble. // Later on, much later on, it was better. My father sort of avoided talking about it. We never got into that. it was easier not to. Yeah. Sort of avoided it. But, yeah, my mother, after awhile, has always, always been there throughout the whole thing, you know. She's the one who will get the phone call 4 or 5 o'clock in the morning. If I was in deep trouble and didn't want to spend the time sitting in the cell, she would be the one that, if it was in the bottom of the North Island, I'd ask her to come and pull me out, you know, and she'd do it. Yeah. You know, she has known throughout the whole thing what I've been up to and what I've done, she doesn't agree with it, she doesn't like it, but yeah, she's been there for me. Gerard

Just as Gerard expressed great appreciation to his mother who was loyal to him and willing to help even though she did not agree with what he was doing, so too did several of the other participants express appreciation of their families sticking by them no matter what they did. All of these participants acknowledged that it was not easy for their families to carry on believing in them when they had become strangers to them. As drugs took precedence over all else, the participants lied to their families, stole from them, betrayed them, and manipulated their love and concern for them to get what they wanted, all of which resulted in strained relationships. In spite of this, the participants believed their families still wanted to be a part of their lives and for the participants to be a part of their lives. Thus, through their acceptance and their presence, family members were able to demonstrate their support. For the participants, the presence of support from their family, and the knowledge that their family still believed in them, still saw them as worthwhile people despite their drug use and drug lifestyle, was important. Although types of support varied from family to family, each of these participants gained a sense of strength and validation from family members through their acceptance and hope. At times, the participants felt overwhelmed by their support as illustrated in the following account.

I stole from them [family members]. I stole [brother's] collection of 50 cent pieces. I stole mum's engagement and wedding rings. I sold their TV, I even sold their car on them - all of it just to score some more drugs. Everything was going down hill, they [parents] wanted me out 'cos of what I was doing to them. They told me that I was still part of the family but I was tearing the family apart, that their whole lives were centred on me and what I was doing. It was pretty awful but yeah, I left home and, yeah, they still hung in there though.... They'd contact me nearly every day to see how I was going, if I had enough to eat.... they'd try and talk to me, tried to understand what was happening to me. I think it was because of the accident that they were like that, always thinking that I'd get better, wouldn't need the drugs. Even though I've been a real shit to them they've never given up on me. It sort of bowled me over 'cos I

don't know if I could've done that, you know, hang in there if my kid was ripping me off. **Timothy**

For many of the participants, sustaining a relationship with family was not easy. The strain that their drug dependence had put on their relationship with their family was enormous. However, through the presence of family support, many of the participants were able to continue to interact with these others who were there, not through their choosing but through their facticity.

As illustrated in the exemplars, the participants' drug dependence not only impacted upon their family relationships; family relationships also impacted upon the participants' drug dependence. For all of the participants in the study, the nature of their relationships served to shape profoundly their lives and the way in which they related with family members. As in all their relationships, the participants sustained those in which they felt accepted, loved, and supported, or stayed away from those in which they were rejected and looked upon with contempt. On the whole, the participants' relationships with their families were perceived as highly defining in their experiences of becoming and being drug dependent. For the participants, family bonds and relations not only formed a large part of their social world, they were also a significant part of who they were in the world – their Being.

Being one's self - one's relation with one's self

For the participants, Being-in-the-world is a Being-with-others and Being-oneself. In Being-with-others in the world, one's own Being, *Dasien*, dissolves into the kind of Being of the others, in such a way that one comes not to be one's self, one comes to exist in relation to others. Being one's self, then, entails a shift in consciousness from one's self in relation to one's self, a re-examining of whom one is in the world and the way in which one is in the world. Being one's self, within the context of re-examining whom one is meant recognising one's individuality, of not acting in such a way as not to be one's self but of acting to recover the self they had lost through becoming and being drug dependent.

Because of the experiences the participants have had in becoming and being drug dependent they found themselves thrown into an uncertain and incomprehensible existence in which, thrown among others, acting and understanding their own Dasien as an everyday being with others, they came not to be themselves. Rather, they came to exist in reference to and in respect of the others. However, some of them, having come to terms with the convolutions of their drug dependence, their being-in-the-world and their being-with-others, have projected a world of particular significance to themselves in which they have learned to trust one's self, to accept both sides of one's self, the self they present to others and the self they truly are. For these participants, being one's self was an active process of relying on, reflecting, being, thinking, understanding, and growing in relation with self. To them, being one's self meant a sense of subjectively knowing one's self as a unique person, of being true to one's self and not falling into the everydayness of the others, the anonymous they, *das Man*, acting as everyone acts, of doing what every one does. In the words of one participant:

*I got caught up trying to be like the others, do what they were doing, you know, the drugs they were using, the crimes they were doing, all that bullshit 'cos it seemed like the thing to do at the time even though I didn't particularly like doing what they were doing. I wasn't really into all of their shit but, yeah, it was like I was trying hard to be someone I wasn't just to be one of them. Now it's like, look, I'm not interested in this or that. Talk my way out of anything or walk away. You know, if someone goes 'this will get you really, really, really, really out of it' and I don't know what it is, then I'll probably go 'I'm not really interested in taking that because I don't know what it's going to do to me.' It's like I know what works with me. Got to know myself better, what I'll do, what I want, shit I'll put up with from those other cunts. I'm sorta more in tune with myself, have a better sense of myself now than I did when I first started up with drugs. Yeah. I don't get sucked in. I stand my ground, like giving up crime. That was a big one. I won't do it now. It's not me. Not what I want to do. **Brian***

For Brian and the other participants who had come to trust one's own self, working towards being one's self in the world meant confronting challenges in one's everyday being and experiencing a range of feelings in coming to terms with a more integrated and true sense of one's self. Further, it meant moving through feelings of pain, rejection, condescension, and prejudice on the one hand to feelings of freedom, relief, and acceptance on the other.

Unlike Brian and the other participants who had worked at developing a sense of self, a relationship with one's self, several of the participants had no sense of self. For these

participants, not having a sense of self was experienced as emptiness, an emptiness that led to their feeling alone, of mourning for their true self and of having lost contact with their true feelings, needs, and desires. Being in the world for these participants had a sense of unreality about it. They were there, but they were not in it. Because they were never who they really were, they were never truly present in their everyday Being. In their accounts these participants spoke of having a false self, of being in an act, of their true self being absent from their everyday experiences. As one participant expressed it:

It's like I'm standing on the footpath watching life go by. I'm just not a part of it. It's quite unreal really. It's like watching a movie, you're the star in it but you're watching it happen at the same time. I just don't know, I just don't know who I am anymore. Like, nobody knows me, nobody knows who I am. Sometimes I get beside myself, do you know what I mean. Like, I pretend, I pretend I'm this somebody that I'm not and people think it's me but it's not, I'm just acting a part that I think they want me to be. It's unreal. I just act how I think I'm supposed to act and forget that I'm just acting as I think I should be and that it's not me. It's sort of like a hole in my soul. I've really lost who I am. I'm just not in touch with my own reality I suppose.

Tui

For Tui, not knowing who she was, not having any inner sense of being one's self, was distressing and depressing. Her everyday being was characterised by emptiness, a kind of absence, and a self-absorption in who she was meant to be, an insatiable neediness. As Tui and the other participants found, being one's self was not something that merely happened. For them, being drug dependent involved a loss of their previously known and familiar selves. For some of the participants this was a temporary loss that they were able to overcome notwithstanding some pain and effort. For them, becoming one's self again meant leaving behind feelings of powerlessness, anger, helplessness, uncertainty, and fear, and learning to trust one's self, to find one's way in life. For others, a loss of their previously known selves was a devastating experience, an ongoing emptiness from which they could see no way to recover the self they had lost.

In their descriptions of being their selves, the participants lucidly portrayed what the lived experience of drug dependence is like for them in their everyday lives as being one's self. For all of the participants in the study, being one's self was a relationship with one's self in the world as drug dependent. The experience of being one's self and believing in one's self is essential as the basis for being with others - a sense of self separate yet attached to others.

Review and summary

The discussion in this chapter has focused on the way in which the study participants found themselves alongside-others-in-the-world. For Heidegger (1927/1996), being-with-others is an intrinsic part of being-in-the-world. Being-in-the-world is a being-with. In Being, one can not be separated from the world or from others. Rather, one's Being is inseparably connected with others whether or not they are present within one's everyday being. It is the others amongst whom one lives who determine how one acts and the way in which one behaves, the others who hand down the background of practices by which one understands one's Being-in-the-world, and from others in the world that one chooses one's friends and happens upon one's family. It is among these others that one experiences acceptance, rejection, or indifference, and it is only through the others that one can know and be one's self. For the participants, the world into which they found themselves thrown was one in which historical, social, and cultural understandings of drug dependence not only coloured the attitudes and reactions others held toward each of the participants but also influenced the ways in which the participants interacted with others in their everyday lives. In being connected into a different group of people and a different social category, the participants found they possessed a stigma that altered their social position, marginalized them, and made them feel different from the others in society. In being perceived as different in the wider social world because of their drug use, their drug lifestyle, and their drug dependence, many of the participants experienced rejection, prejudice, misunderstanding, contempt, and hostility from others in society.

Several of the participants believed the attitudes and perspectives held by many others in society were greatly influenced by sensational media coverage that demonizes both drugs and drug users. Such rhetoric only served to further encourage hostility and prejudice toward drug dependent people among society in general. Because of the societal negativity experienced by the participants, many of them felt uncomfortable with non drug users, the others in society, and thus avoided them, only maintaining social contact when necessary. Most of the participants, however, sought contact with other drug users. With these others, the participants developed a sense of identity,

shared experiences, felt at ease, and found joint support and a mutual interest in maintaining their drug dependence. Although most participants' relationships with these others were mutually supportive, a few were exploitative, yet these participants often choose to remain in such relationships.

Beyond each participant's relationship with society and their drug using friendships was their relationship with family. Family relationships, like all the participants' other relationships were varied in nature. In their encounters with family, the participants were met with both rejection and/or acceptance. As in their relationships with all others, the participants stayed away from those in which they were rejected and maintained those in which they felt supported.

For all of the participants, a being-with-others was also a being-with-one's-self, the self through which they interacted with others in their social world. Being one's self for the participants was to develop a relationship with self, to know and trust one's self and not to fall into the everydayness of the others with whom one was alongside, both in a personal way and as part of the wider society within which one lives.

As described in this chapter, others formed a substantial part of the world into which the participants were thrown. Only through these others were the participants able to know or come to know themselves, to project a world of particular significance for themselves. In projecting a world of significance and in looking forward to the future, each of the participants must deal with those things that are of concern to them. In their everyday Being, each of the participants makes choices and decisions about the way in which they exist in the world and about those things which are important to them. In the next chapter, the concerns and choices of the participants as they relate to their everyday Being-in-the-world are explored and described.

Chapter VII

BEING WITH CARE

The context of the study participants' experience of becoming and being drug dependent, the ways in which they found themselves thrown into the world, the ways in which their drug dependence impacted upon their experience of being-in-the-world, and the ways in which they found themselves alongside-others-in-the-world have been presented in the preceding chapters. Because Being-in-the-world and Being-with-others is essentially a Being-of-care, of concern, a complete representation of the experience of the participants in this study living with a drug dependence must include some exploration of the things that matter to them, the things that they care or are concerned about, those which they worry about, and the choices that they make about those things that are of importance to them. In this chapter, my aim is to describe the concerns and choices of the study participants as they relate to Heidegger's (1927/1962) notion of care (*sorge*).

For Heidegger (1927/1962), the basic relationship between human beings and the world is that of care (*sorge*) (p.193). Care, as Heidegger defines it, is "taking care" of things and "caring, worrying" about things or other beings encountered in the world (p.121). In Heidegger's sense of the term, caring or being careful is also being uncaring, not taking care, or being free of care. Care, as it signifies care-for, concern-for and -with, can take countless forms: concern (*Besorgen*) for the ready-to-hand, the things that are important to one, and solicitude (*Fursorge*), a concern for others (Heidegger, 1927/1962, pp.57, 121, 193). Human beings exist in terms of the things or others that one cares about and takes care of, what one worries about, what matters to one, that which one is concerned for and with, and that which one is answerable to. Essentially, care, or concern, is the significance which being in the world has for human beings. Through caring, through being concerned one is able to be involved in the world and give sense to one's existence, to *Dasein*. As expressed by Heidegger (1927/1962), "Dasein's being reveals itself as care." (p.183). Care is fundamental to the existence of *Dasein*. To be *Dasein* is to care, to be careful, to be caring towards others, to be concerned for things; and to be concerned for being. Care is *Dasein*'s being (Heidegger, 1927/1962, p.58). To Heidegger, the meaning of *Dasein*, of being-

in-the-world, is to be found through the realisation that to be is to care, to be concerned. In coming to understand Dasein, a being's being "there", in this study, that of the participants, it is essential to understand the everyday meanings of care as revealed in the actions of caring or being concerned.

In his work *Being and Time*, Heidegger discusses his concept of care and its connection with the Latin word *Cura*, the history of the signification of which further enables us to understand how care is fundamental to Dasein's existence. Considered by Heidegger in an existential and ontological way, *cura* as care can be understood to signify such aspects of care as "carefulness" and "devotedness" as well as "anxious exertion". As Heidegger (1927/1962) expresses it, "all man's ways of behaving are 'full of care' and are guided by his 'devotedness' to something" (p.199). As such, these aspects of care, this caring for, a concern for the cares of life, an answerability to Being itself, are not only what sets Dasein apart from every other being - a being which simply is what it is without being concerned for what it is or is to become, but are also some of the ways in which Dasein is involved with or encounters the tasks or cares of the everyday world.

In being involved with, or encountering the tasks or cares of life, Dasein, as human Being, comes to understand the very structure of its own existence, to view its life as a whole, a temporal unfolding between its birth and its death. So long as Dasein has not yet come to its own end, whilst life is incomplete, Dasein exists by projecting itself toward a future that is *not yet*, but yet-to-be. Thus Dasein is a being with potential for being what it may, a potentiality for being in the world realised by Dasein's possibilities - the ways in which Dasein acts and the choices it makes about that which it is concerned, the things that matter in living a life which signifies something and on which Dasein takes a stand. For Heidegger, it is through these possibilities - the actions and choices that one makes or one engages in in one's everyday existence during the temporal unfolding from birth to death, that one comes to constitute one's self, to make a life that has significance, a life that matters to one's self. Although one is constrained by one's facticity, that which is determined by being thrown into a particular cultural world and about which one has no choices, one has choices about those possibilities which are not given, possibilities for actions, attitudes and feelings.

In Heidegger's view, the making of such choices is encompassed within his concept of understanding, of taking a stand on one's own Being in terms of choosing a particular possibility or project. For Heidegger, the choosing of alternative possibilities, any conceivable goals or projects one wishes to envision, signifies an understanding of the very nature of existence, of what it is to be a human being. It is through the making of decisions or choices from alternative possibilities that one becomes who one is, that one's life will be seen at its end to have had some meaning, some significance, some value. However, who and what one is in the world is limited by the roles that one takes over in making choices for one's existence, one's existence determined by one's choices, of the possibilities which are open to one in a given situation. Because life matters, because who one is constitutes an issue, one takes a stand on what kind of being one is, one's choice of self, one's casting of one's self into a worldly role, either in an authentic or an inauthentic mode of being.

The stand which one takes on making one's own choices in living out a life defines what one's life is. In living out a life, one's being, Dasein "is in each case mine" (Heidegger, 1927/1962, p.42) to be in one way or another. Being is not something that others can fulfil for one in choosing the course of one's life and making something of it as a whole. According to Heidegger (1927/1962), every human being is a unique individual, each with their own possibilities to fulfil, each solely responsible for what their life adds up to in the end, each free to make of their life what they freely determine upon. What one is, what one is going to do, how one copes with things, the life one makes for one's self can only be understood in light of one's relationships to the past and the future. One's everyday experiences make sense and have meaning because of the ways in which they are connected to what has been experienced and remembered from the past or what is *not yet* but yet-to-be in the future.

In determining for one's self one's being, one is engaged in the world in a future oriented way in that each of one's actions and choices contribute to the realisation of one's being as a totality, what one's life adds up to in the end, a bringing to *fruition* in which one comes toward what one finally is to be as a totality. This temporal structure of everyday Dasein, a being with a past, a present, and a future, is named by Heidegger

as Care. For Heidegger, “to be Dasein is to be temporal; to be Dasein is to care; to care is to exist in time” (Soloman, 1981, p.52). Heidegger’s conception of Dasein in temporality, the temporal structure of care, is correlative to Van Manen’s (1990) lifeworld existentials of lived time - the way in which one simultaneously lives in one’s present situation, is determined by the past, and is projecting one’s self forward to a future, and lived space - one’s place in the world, the personal space in which one exists and experiences everyday being. Like care and temporality, lived space and lived time form an intricate unity, a single structure of one’s being which gets expressed through all the different ways in which one is involved in the world. For Heidegger, it is through an examination of caring, of the everyday concern that human beings feel about their world that the nature of Dasein, what it is to-be-in-the-world, can be understood.

To understand the everyday lives of people with a drug dependence, therefore, it is necessary to understand their everyday meaning of care or concern - that which matters, the way in which they understand themselves in their present situation which they determine for themselves through their choices and actions and on which they take a stand, the way in which they comport themselves toward their world, and their living of a life which has meaning. As such, in this chapter, care is explored in relation to the participants’ concern for things in their everyday choices and actions, their involvement in the world in making a life which for them signifies something, and on which they take a stand. Through the process of data analysis, interpretation and ongoing reflection, two main themes emerged and are considered to best capture the essential qualities of the study participants’ involvement in the world, their everyday actions and choices which make their being-in-the-world significant. The two essential themes are Taking care, being careful and Choosing a life.

The first theme, Taking care, being careful considers the everyday concerns of the participants, the way in which they understand their own Being and their situation in the world, and the way in which they feel about the world. Embodied within this theme are the underlying themes of Being vigilant - an individual awareness of the need to take care in living with chaos and in handling one’s health; and A coming of what has been and looking forward - a bringing to mind of the past and a coming to terms

with their situation in order to look forward. The second theme, Choosing a life, deals with the making of a life which adds up to something in the end through the everyday actions and choices the participants make and the stand they take in living out their lives. Encompassed within this theme are the subthemes of Hopeful possibilities, the participants' outlook on life and their future hopes and aspirations; and Reflections of self in the world, the participants' endeavours to make of their lives what they freely determine upon.

Taking care, being careful

For Heidegger (1927/1962), one exists in terms of the things that one cares about, one's everyday concerns. Being concerned is fundamental to Being-in-the-world, and it is through an examination of one's everyday concerns that the meaning of Being, the nature of existence is to be understood. As illustrated in the preceding two chapters, the study participants hold specific concerns related to their Being-in-the-world and Being-with-others which may be directly connected to their drug dependence. For the participants, in living their everyday lives, the experience of drug dependence itself, its maintenance, its treatment, and their encounters with others in the world are all of concern.

It is through their concern for, concern-with, and care-for those things that matter, or people encountered, that the participants act and make possible choices in their everyday living. In this section of the chapter, care is examined in relation to the everyday concerns of the participants with a focus on the actions and choices they make in living their lives. In their accounts of living with a drug dependence the participants voiced concerns which have been divided into two underlying themes: being vigilant and a coming of what has been and a looking forward.

Being vigilant

Being vigilant was an expression that was frequently used by some of the participants. Being vigilant emerged to mean a looking around, a watching out, a circumspection, a carefulness, in the participants' everyday choices and actions. In this sense the meaning

of vigilance is congruent with Heidegger's (1927/1962) notion of circumspection - "a kind of awareness in which one looks around before one decides just what one ought to do next" (p.98). In order to continue on in their drug dependent lifestyle, to avoid the risks involved in living the lifestyle, to cope with the chaos brought about as a result of being drug dependent, and to live amongst the others, the participants maintained vigilance, tried to take precautions in their everyday activities, and made decisions and choices about the ways in which they managed their lives.

The decisions and choices each of the participants made in managing their lives and being vigilant differed greatly depending on the situation they found themselves in, their abilities, and their own personal nature. Similarly, the participants' understanding of their becoming and being drug dependent, their encounters with others, and their acceptance and resignation of being in the world in this way were, for each of them, also different. As such, each participant was characterised by their individuality, their uniqueness in dealing with or coping with the world, the situations within which they found themselves, and within which they acted and made choices about that which matters to them, that which is of concern to them in their everyday lives, that about which they were vigilant. Identified within this theme of being vigilant are two main areas of concern in which vigilance is called for: living with chaos and handling one's health.

Living with chaos

In their accounts of their lived experience of drug dependence, many of the participants described their lifestyle as chaotic. For these participants, their lives were characterised by very little structured routine, much risk, and much uncertainty. Although the average day of these participants consisted of the overriding routine of hustling money, scoring drugs, using drugs, and sleeping, there was little structured routine in their day. As much as many of the participants would like to have had a structured daily routine to help avoid feeling stressed and to lessen their chaotic lives, the activities they were involved in that are a part of maintaining their drug dependence made the establishment of a regular routine almost impossible. For some of the participants, the lack of a

structured routine was experienced as nerve wracking, emotionally draining, and upsetting as shown in the following exemplar.

I would shoot up then go and look for some more money to score then I'd shoot up again.....God only knows, it's fucking insane. I'll use and use whatever I've got then I'd sleep then I'd have to start the whole fucking routine all over again. But that's not what pisses me off. It's 'cos it changes each day. I never know whether I'm going to get any money, score any drugs or whether I'll be hanging out and that's what pisses me off. Like, I'm a nervous wreck most of the time and if I can't score anything I get really pissed off. I just want some regular routine each day. You know, I want to know I can score drugs at 11 o'clock, I want to know I can get the money each night. I want to know that I can get up in the morning and not hang out. I just want a normal life 'cos this one's just driving me nuts. I get really stressed out 'cos half the time I don't know if I'm here or there..... I can't take care of myself like this. I can't.

Lauren

For many of these participants the activities of the day were usually determined by their first thoughts on waking each day. Unlike the participants who had a ready supply of drugs to enable them to carry on their usual everyday activities, the waking thoughts of the participants who were without drugs centred around how they were going to find the money to score the drugs to stop them feeling sick and to help them get through the day. Knowing they were without drugs to use upon wakening led these participants to experience feelings of dread, of desperation, and of being trapped in a circle from which there was no way out. In the words of one participant:

*I dread it. Every morning I dread waking up 'cos usually I've got nothing to use. It's like a vicious circle that never ends. It just keeps on and on and every morning I dread it going around and around. Like, I wake up, my eyes are watering. I feel like shit. I don't want to get out of bed but I know if I don't I'll end up getting more and more desperate and end up doing something I don't want to... .. like, I can't focus on anything. I can't think about what I'm supposed to be doing. I can't plan my day. All I know is that I've got to get something. I've got to get some money and when I'm like this I'm not careful. I'm not careful. I'll do stupid things, make really stupid choices and don't watch out for myself as well as I can. **Timothy***

Often because of their inability to focus on anything other than their immediate need for drugs, many of the participants, like Lauren, were unable to think out discerning ways to get the money to buy their drugs. the main priority each day for them was to ensure their drug supply. Nothing took precedence over that. Consequently, many of these participants' undertakings to finance and score their drugs were disorganised and unplanned further contributing to their feelings of desperation, dread, and chaos. Not

having any organised plan each day for their hustling activities led these participants to engage in a range of unplanned random activities from prostitution and shoplifting to breaking and entering and robbery, all of which required the participants to be vigilant, to be careful with themselves in order to evade the consequences of the law, to deal with the possibility of not having any drugs and being left to face the rigours of withdrawal. Living each day this way, with no patience or foresight to think out their actions, of having no regular routine to follow, and of having to be vigilant to avoid the consequences of their actions led the participants to also experience feelings of fear, anxiety, bedlam, and turmoil. For them, it was as if they were living moment by moment in a world full of chaos over which they had no control. In the following exemplar one of the participants describes what it is like for her not having a regular routine and having to get by each day.

Being a junkie is like living in a fucking madhouse. You never know what the fuck you're doing day to day 'cos each day's different depending on whether you've got something to use or not.. if you've got something, you're sweet and if you haven't, it's fucking bedlam. You never know what you'll be doing, like you could be on your back [prostituting], shopping [shoplifting], ripping some cunt off or spending all day doing the doctors and, you know, racing around having to watch out for yourself 'specially if you're hanging out 'cos the more desperate you get the more hare brained you get doing stupid, stupid things. You know, you end up racing around getting money, scoring, worried shitless you'll get busted, won't score then end up sick. Like, it's crazy. You don't know whether you're Arthur or Martha.you end up with knots in your stomach, stressed out to the hilt... yeah... it's a fucking mad house. Sometimes I wish I could just feel normal, have a normal life, like, you know, get up each day and know what I'm going to do that day, know that I've got something to use, get on with my life without all this hassle. Tui

Not only did Tui and these other participants experience feelings of turmoil in their lives as a result of the lack of a structured routine, they also experienced feelings of uncertainty, which in turn, contributed to the general feeling of living with chaos. Uncertainty was a common experience among the participants. For many of them, uncertainty was a dynamic process that evolved from the beginning of their drug dependence journey to living each day with a drug dependence. Living with the vicissitudes of the drug lifestyle - the endless pursuit of money, keeping up the supply of drugs, bearing the brunt of public contempt and rejection, the possibility of overdosing, the health consequences, and changing relationships, was a prevailing aspect of uncertainty. In their experiences of uncertainty many of the participants

experienced an overwhelming spectrum of emotions such as fear, depression, anxiety, and hopelessness.

For many of them, the feeling of fear was associated with uncertainty when they perceived that withdrawal symptoms would occur if they were unable to get money or score any drugs. When the participants had money and a supply of drugs, their fear associated with uncertainty diminished, however, when things got harder, their fear could resurface instantly. As they came closer to experiencing withdrawal symptoms, their fear often intensified. The intensity of their fear often surprised these participants to the extent that they felt controlled by the unpredictability of their future. Fear also forced the participants to recognise their own vulnerabilities surrounding their drug dependence and the never ending possibility of going through withdrawals, particularly because their supply of drugs and the money needed for them could not be assured. In the following interview extract a participant captures the intensity and unpredictability of her fear connected to uncertainty.

I needed at least \$200 a day using misties [MST] and that's what really freaks me out. You know, it's like what I have to do to get it and if I can't get it I start panicking, panicking that I'll have to go without. Like, some of the time I try and plan how I'm going to get the money but most of the time..... I try and plan, like, say, you got something the day before and you're feeling okay so you try and plan the next day, but, you know, you think, "how am I going to get it", but you can't be bothered thinking about it after thinking that. You think, "I'll think about it tomorrow. Tomorrow's tomorrow and I'll deal with it then." That's how it is most days. You think about it then you put it off and don't do anything then suddenly you've got nothing to use and you start panicking, then you work your self up into a real mess and then it's like, oh my God, I'm so scared, what am I going to do? Then I really freak out 'cos I've, like I'm panicking thinking about what's going to happen to me, I'm not ready for this. Then, you know, someone might come around with something and then it's all right for awhile..... then it happens all over again 'cos you keep on thinking tomorrow's tomorrow, I'll deal with it then. Jenny

Another aspect of uncertainty commonly experienced was anxiety. Like fear, it fluctuated throughout the uncertainty experience depending on such specifics as whether or not drugs were scored, whether or not the participants had any money, the uncertainty of not knowing what tomorrow would bring, and the uncertainty of even getting through the day. Most of the participants described their anxiety as an

unpleasant vague feeling with no real focus of concern, more a general feeling of worry, of nervousness, of unease. In the words of one participant:

I'm a bit of a worrier, worry about things constantly, worry about what might happen and what hasn't happened and why it hasn't happened and will it happen and what will happen if it does happen, it's like, it's like, it's all really pointless worry because some of the time, or most of the time, none of what I worry about ever happens. You know, it's sort of like a nervousness, my mother would have said a nervous disposition, a feeling of not being able to feel relaxed and that's why, I think that's one of the physical effects of being stoned, you know, I'm probably more relaxed, maybe I don't worry as much about things. When I'm on drugs it's less of a problem.

Lilian

Depression was another facet in the participants' uncertainty experience. For many of the participants who experienced depression, the intensity and duration of the depression fluctuated depending on the uncertainty of the situation. For some of these participants, anxiety and fear would change to depression when the uncertainty in their lives became overwhelming or when they were unable to maintain a positive outlook on their predicament. For others, depression developed when they no longer felt they had the energy or resources to keep themselves supplied with drugs. In their accounts these participants spoke of their depression as a feeling of hopelessness, of misery, and of having no future. Stripped of all positive feelings these participants envisioned themselves as hollow empty shells just going through the motions of living a life that was devoid of anything worthwhile. For them, there was no sense of enjoyment in doing their everyday activities. All they could feel was despair, fear, and anxiety in the uncertainty of their lives. In being depressed they all felt that no one could really understand the nightmare they were going through. As their feelings of depression prevailed they tried to hide their sense of hopelessness and misery in drugs, but when they hid such feelings they buried them alive and they remained active eating away inside of them. Not even the effects of the drugs could alleviate their depression for long as illustrated in the following exemplar from one of the participant's accounts.

It's [drug dependence] like going to the gates of hell and back. There's absolutely no way out of it. It's so hopeless. I've got no future. I've lost everything worth living for. I've lost my family. I've lost my job. I've lost everything worthwhile. I've told people I'm depressed. I've told them at A&D. I need to go on methadone. They don't understand. They don't know..... I'm so miserable, just so miserable. It's all so pointless. I need so much [\$700-\$1,000 morphine weekly] everyday and I can't always get it. Everything seems so..... everything's crap. Sometimes I'm not able to

get it and, um..... I look around and realise I'm stuck in a van and I've got nothing. It's fucking terrible. Fuck it's horrible. Terrible.... The only thing I've got to look forward to each day is putting that needle in my arm. Nothing else.... And that doesn't change anything for long.. I shouldn't have ever got into it. I can't see anyway out. I just can't. Alistair

Just as it was for Alistair, the intensity of the depression experienced by some of the other participants was associated with the uncertainty of being able to keep themselves supplied with the drugs they needed to feel normal, to carry on their usual everyday activities. While they were immersed in their depression they felt trapped, as though there was no way out of their living hell. Getting and using their drugs provided the only glimmer of hope to the end of their living nightmare, but only until the effects of the drug wore off or they awoke in the morning, eyes watering, aching all over, and feeling rotten. Generally though, for the participants, the waxing and waning of their feelings of fear, anxiety, hopelessness, and depression were aspects of uncertainty that further contributed to the overall feeling of chaos in their lives. Also adding to the chaos in the participants' lives were the inordinate lengths they went to and the inconceivable risks they took just to carry on taking drugs once dependent on them.

Initially, one of the biggest risks the participants were exposed to upon embarking on the drug journey was the possibility of dependence. Having embarked upon the journey in earnest, each of the participants headed down the slippery slope of dependence until they abandoned themselves to this risk. Once dependent on drugs and living a drug lifestyle, risk was never ending. Each drug related activity the participants engaged in was immanently risky, from getting money to buying and using drugs. For many of the participants, the lengths they went to and the risks they took were contingent on the degree of dependence they experienced and the desperation they felt when they ran out of drugs. For those participants who needed copious amounts of a drug to feel well enough to lead their normal lives or to get themselves straight, and whom, without it were on the edge of withdrawal, the risks taken were more extreme, more perilous, and more uncertain. Being on the edge of withdrawal often led to a participant being less vigilant, less careless, more impulsive, more disorganised and more chaotic in the activities they engaged in thus increasing their risks in all spheres. For many of the participants, their thoughtlessness and rashness in taking risks led them to feel

vulnerable, unsafe, uncertain, and open to attack. In the following interview extract a participant describes her feelings about taking risks that are potentially perilous.

*You leave yourself wide open to attack every time you take a risk. We all take risks and if you're hanging out you take more risks than you should. It's like when you're hanging out you don't really give a damn about yourself, you do pretty sordid things that leave you feeling exposed and defenceless, especially when you've been in some of the situations I have. I've even got to the point where I've thought about killing myself, felt really unsafe, but, yeah, what the hell, when you need something and you need it right now, you're not into thinking about what you're doing or watching out for yourself. It's all just head first into what ever, you know, every fucking day you're taking risks and you don't know, shit, whether you'll be here tomorrow or not. You don't think about some of the heavy shit you get into or else you'd probably not do it. Like, I've done stuff, you know, taken a shit load of risks that'd make anyone turn over in their grave which I wouldn't've done if I hadn't been hanging out. **Trish***

Like Trish, most of the participants were willing to engage in risky behaviours in order to get drugs into their bodies. In the early stages of their drug dependence many of the participants perceived the risks taken in getting and using drugs to be exciting and satisfying especially when they were united with the object of their desire. Once these participants became well and truly entrenched in a drug dependent lifestyle, many of the risky behaviours they engaged in lost much of their allure and stimulus. The once captivating and exciting world of the drug user had begun to reveal itself as a squalid roller coaster upon which they were riding a nightmare wagon not knowing when the ride would end. For most of the participants, the best times were over, or were lessened by the bad times and the ever increasing risks that needed to be taken, or they were exposed to, in order to live the life. In living the life, the greatest risk of all for the participants is death, either through a drug overdose or as a consequence of their drug related activities wherein drug use is a contributing factor but not the cause, for example, suicide, accidents, homicide, and disease.

In their accounts, many of the participants expressed the notion of “do and die”, in which death was viewed as inevitable, either through drug over dose and related physical complications such as heart attack or stroke, or by the hazardous activities they engaged in in living the drug lifestyle. For these participants, the “do and die” attitude usually developed over time when they recognised that their continuing drug use was threatening their lives, or had been the cause of death for other people with whom they associated. However, as drugs took precedence over all else and the

participants were more concerned with getting drugs into their bodies, the risk of death was best forgotten, or put aside. Consequently, this risk for many of the participants was experienced as an inevitable part of their lifestyle that engendered feelings of nonchalance, heedlessness, recklessness, and impassivity. The following exemplars capture the participants' indifference to the omnipresent risk of death in their lives as dependent drug users.

There was no one like [friend], I missed him a lot when he died [drug overdose]. I really did. I really did miss him. We had a lot of fun, yeah, I miss having, yeah, I miss him. There's not much I can do about it. You know. He'd gone over [overdosed] before. We were always going over, but one of us was always there to pull the other through. Yeah. I think he must have just had too much, in the early hours of the morning.... Too much. I called the ambulance and they were working on [friend] but yeah, he just had too much..... and yeah, I jumped off [stopped his drug use] after [friend] died, and um, I was quite ill for about 3 or 4 days and I didn't have the strength or energy to do anything, to,....yeah, I was sick for a few days but, yeah, [another friend] came along with some homebake and that was it. It didn't make any difference that [friend] had died, I just carried on with the drugs. It was, like, yeah, you do them and you die. Gerard

After I got out of prison I was working at [workplace]. Most of the projects were to do with HIV and AIDS. In amongst that I thought I might get tested and um, I thought I'd better get tested and um, I thought I better get tested because of my lifestyle and what I did [intravenous drug use], so I got tested and the test came back a positive result. That was in 1990. For HIV. I know I didn't get it from sex. I know that I got it through injectable drug use. That's the only other risk activity, I know that I didn't get it through sex because I haven't had sex with a male for, I've had sex with two men in my life, and, um, they both don't have it....//.....so yeah, I carried on working a bit. When I got sick I really panicked and thought, "oh, this is it. I'm not going to get better. This is it." [laughs] And um, so, um, I started hanging out with the HIV support group and through them it came real easy to get, um, narcotic drugs. it still is. Yeah, in terms of HIV, most doctors are, they don't really know a lot about it but they're quite easy in terms of writing scripts, so yeah, after being HIV positive, it was like, what does it matter what I do. I've already got my death sentence. What's the point in taking care anymore? Eliza

Although many of the participants expressed indifference to the risk of death, for some of the participants, the ever present possibility of death, either by overdose or some other drug related means was experienced as exhilarating and alluring. For these participants the risk of death through their drug lifestyle led them to feel a heightened sense of adventure and an intense excitement which was likened to the adrenaline rushes one would expect to feel playing Russian roulette. Essentially, they were playing Russian roulette. In the word of one participant:

*I've been to near death several times. I don't give a fuck about dying. I had an understanding of what dying meant. When you're a drug user you're always on the point of death whether you're blasting a cocktail of dicetyl, morphine tartrate and morphine sulphate liquids or whether some cunt's got a contract on you for ripping some other cunt off, it doesn't really matter. It's all fucking adrenaline pumping shit, what ever's going down, fucking living in the fast lane, a fucking game of Russian roulette and you don't know when the bullets going to go off. Could be today, could be tomorrow. Who gives a fucking rat's arse. It's today that counts. Now. This fucking moment in time. That's what counts. **Toby***

Although the omnipresent risk of death for Toby and a few of the other participants led to heightened feelings of excitement and adventure along with a feeling of intense satisfaction when they realised each day they had once again defied death, these feelings, like those of depression and uncertainty, waxed and waned. At one moment these participants could be taken from the heights of euphoria to the depths of despair if they were unable to keep themselves supplied with drugs, if they began withdrawals, or if they were arrested and incarcerated. Arrest by the police and incarceration were very real threats all of the participants faced in their everyday lives because of the furtive and illegal nature of drug taking and the criminal activities many of them engaged in to keep themselves supplied with drugs. To many of the participants, the police were viewed as adversaries, their presence an occupational hazard which they hoped and did their best to avoid. Some of the participants felt fearful of the police. For them, their fear was centred around being busted and the possibility of having to go without drugs if arrested. Even the sight of a police officer was enough for them to feel agitated, nervous, or to break out in a sweat. In the following interview excerpt one of the participant's describes her feelings on being confronted by the police after a raid on her home.

*I was scared shitless when I opened the door and the pigs were standing there. I broke out in a sweat and it was like I was swallowing golf balls. My heart was going [demonstrates pounding on her chest], like, it was beating so fast and all I could think of was, like, I'm going to be busted. They had a search warrant and I had to let them in. like, I've been busted before for drugs. possession, possession for supply, manufacturing for poppies, um, I got caught in an armed robbery for, yeah, I was part of it but I didn't do it....//....yeah, like, just the sight of the fuckers just gets me going, you know, like, the thought of hanging out if you're busted, it's scary... **Jenny***

As illustrated in the above exemplar, one of the participants biggest fears, if arrested, was the possibility of having the drugs they need taken off them and being left to languish in a cell experiencing withdrawals. Such fear often made these participants more vigilant, however, their carefulness was not always enough, and as a result, they experienced more chaos in their lives. The police were also resented by many of the participants. In their accounts, several of the participants spoke of being subjected to intense humiliation and bullying by the police, particularly if they were known drug users. One participant recalled feeling vulnerable and very self-conscious when asked to bend over with no clothes on other than his socks in a body search. He then suffered the indignity of having the police doctor insert his finger into his rectum to check for a cache of drugs. Not only did this participant feel embarrassed and debased, he also felt as if the police was making fun of him. In his words:

*The fucking cunts [police] got me for armed robbery and 'cos they know I was into junk they thought they'd do me for it as well. They took me to the station where I had to strip off then they called in the doc who said they had the right to search me 'cos drugs were involved. Then the fuckers made me lean over while the fucking homo cop doctor stuck his finger up my arse. The fucking cunt didn't just check to see if anything was there, he fucking was getting off on it and when I told the cunts I'd do them for it, I got a fucking kick in the back of the shins and told to fuck up. Then the cunts fucking laughed at me. "It's our word against yours" was all they fucking said, "and who'd believe a fucking junkie." It's fucking bad enough dealing with those cunts but what the fuck, you've got no fucking rights with cunts like that around. Fucking hell, standing there while some fucking homo jerk fingers your arse and gets off on it. It's fucking degrading. Fucking bastards. I fucking wanted to smack the cunt in the head. **Toby***

Many of the other participants like Toby were also subjected to humiliation by the police. The participants, in being humiliated through sexual, verbal, and physical abuse, harassment, and persecution by the police, experienced feelings of embarrassment, shame, mental anguish, and loss of face. Often, the extent of the humiliation was far greater than that warranted for many of the violations the participants were apprehended for. It was as if they were being punished by the police for being drug users. On the whole, however, the participants accepted the presence of the police and the possibility of being arrested and incarcerated as some of the risks of living the lifestyle. It was, nevertheless, risks that often led to much chaos in their lives if they were not vigilant. In living the life, the participants were also exposed to such risks as that of being ripped off, of not being able to score drugs, of buying low quality or

inferior drugs that did not satisfy their needs, and of being known as a *junkie* or an *addict*, thus limiting their access to services, housing, and employment opportunities. Each of these risks held both actual and potential problems for the participants.

Some of the participants were able to establish a structured routine and organise their lives to avoid activities and behaviours that were both risky and chaotic. Through being vigilant, looking ahead and taking care, these participants were generally able to ensure that they had resources to keep themselves supplied with drugs, clean equipment for using, and that when they used drugs, they had some mechanisms in place in case problems arose. For these participants, being careful and solicitous was part of being able to enjoy their drug use with less risks. The following extract from a participant's interview shows the care and forethought taken when using drugs of which the quality was unknown.

A lot of the smack [heroin] that was coming in, some of it would be pure and other times it would be powder cut with something, you never knew what you were getting. But with brown rocks you did. Or pink rocks. With brown rocks you knew what you were getting but with powder you didn't. so you'd go halves with somebody. Yeah, you'd go halves with somebody as long as they went first. Just to check it out in case they'd go over and die, you know, or if you were on your own you'd ring somebody up, you know, "I'm having a blast now, I'm jacking the fit now", so if you went over, the other person's on the phone, they can ring the ambulance. Tui

Although a few of the participants were sometimes able to look ahead to lessen their risks as Tui did, most of the participants were less successful in managing their risks. In their desperation for drugs, they failed to take care, to be vigilant, to look ahead, consequently, their everyday lives were often extremely chaotic as a result of the riskiness of their drug related activities. The risks the participants faced, however, did not stop there. Living a life that involves using illicit drugs also brought many health risks, thus further contributing to the chaos experienced in the participants' lives. Like the many other hazards that accompany drug dependence, the health risks not only impacted upon their being-in-the-world in many ways with far reaching consequences, they also were a cause of concern over which the participants needed to take precautions and make choices to avoid other risky activities that could further harm their health.

Handling one's health

In using drugs the participants ran the risk of damaging their health. Such health damage was related directly to both their actual drug use and to the activities surrounding their drug use and included overdose, blood borne diseases such as HIV and hepatitis, collapsed veins, abscesses, septicaemia, bacteria endocarditis, pneumonia, malnutrition, sexually transmitted diseases, and being sick. Drug overdose through administering an excessive dose of drugs was a very real health risk faced by all of the participants. For them, overdosing on drugs was perceived as one of the inevitable hazards of living the life, and most of the participants, at one stage or another of their drug dependence journey had experienced an overdose, yet they kept on with their drug use. Overdosing on a drug, particularly injectable drugs, meant not only the possibility of death but also the risk of prosecution if emergency services and health professionals were involved through hospitalisation of a participant.

When a participant did overdose it was generally another person who found them and called in the emergency services. When confronted with an overdose, the participants were faced with the awkward choice of calling or not calling emergency services because of the possible threat of police involvement. There were several situations reported by the participants where such a choice was to be made. Sometimes no action was taken and the participant walked away, at other times the participant put the overdosed person's life before their fears, concerns, and uncertainties. Whatever decision they came to about what course of action to take was ultimately decided by the degree to which the overdosed person meant something to them, and the participant's concerns about being busted. As shown in the following exemplar, a participant who had to deal with a friend who overdosed on a mixture of drugs experienced feelings of panic, fear, uncertainty, concern, and stress. To her, it was a catch-22 situation.

When he went over [collapsed after a large dose of drugs had been injected] I didn't know what to do, whether to call the ambulance, clean up the messy drug shit, throw him in a cold shower. It was like, ahhh fuck! What'll I do? Call an ambulance. Fuck, I can't the cop's'll come, I'll go down for giving him the shit, it's my place. Fuck, oh fuck me, if he dies then I'm really fucked. Oh no, fuck, I'll call the ambulance, I can't let him die. Fuck, it was a hard choice, you know, do you save your mate's life and

worry about the police later or get the fuck out of there. It was one of the more fucking stressful experiences I've ever had. Stressful is putting it mildly, it was like a fucking catch-22 situation. You're caught both ways. Tui

Uncertainty, fear, and ambivalence were not the only feelings experienced on discovering someone who had overdosed. Because an overdose was regarded by most of the participants as not uncommon, as just another part of living the life, some of the participants expressed indifference or very little concern when it occurred. For some of these participants there were periods when they or others overdosed several times a day for long periods of time. Overdose, for them, was nothing out of the ordinary. It was an everyday happening that was inevitable with the type of drugs they were using. In recounting his experiences of overdosing, one of the participants told of how, through his own intoxicated state, he was unaware his friend was slowly dying alongside of him. Discovery of the death meant nothing more than a feeling of fatalism, of indifference, of "so what!" In his stark words:

*I honestly didn't know [friend] he was going to die. I was with two other people at his house and, ah, the three of us were watching TV and we were knocking back the Tuinal, yeah, you know. He had some 2's [200mg tablets of amobarbital sodium] and a couple of bottles of beer and stuff. I just wasn't a drinker. I didn't want to drink on barbiturates anyway, it's a death recipe for anybody who goes to sleep. We thought he was asleep. He was actually dead. We were sitting there watching TV, you know, whacked off our heads, completely out of it and um, I, you know. It didn't **phase me at all** when we realised he was dead. So what. It's like, you use, you die. [Other friend] didn't want to call the ambulance in case the police got involved. He freaked out and didn't know what to do. But, yeah, over the years, you know, I'd seen people, several people, some on barbiturates, you know, die, and none of this put me off, people dying **just** didn't put me off, I **just** didn't feel, you know, it **just** didn't scare me at all. I was on borrowed time anyway. Like I said, you know that's, that's honestly how I feel even today. I'm on borrowed time... so yeah, I phoned the ambulance and um, said, "oh, by the way [friend's] dead at [address], have a nice day", and um, we got out of there. You know, I **just** didn't care. Tony*

Many of the overdoses experienced by the participants happened for silly reasons. One common reason was the mixing of drugs in which their combined effect was greater than the individual effects. Mixing drugs such as opiates or benzodiazepines with alcohol also increased the risk of overdose. Other common reasons reported by the participants for overdose were using after a period of no use such as after being released from prison, and using unknown gear. Essentially, for all the participants, overdose was a very real threat that impacted upon their health and well being.

Overdose and repeated overdoses could sometimes lead to pneumonia and other health complications through aspiration of saliva or vomitus into the lungs after having their stomachs pumped (gastric lavage). For one of the participants, an overdose on Valium resulted in her stomach being pumped. Because of aspiration of vomit into her lungs during the process she developed pneumonia and was hospitalised for a period of time. What stood out in this participant's description of having her stomach pumped and the sequelae of contracting pneumonia was the distress and suffering she experienced as illustrated in the following exemplar.

*It wasn't the first time I'd ODeD. I'd done it before for silly reasons but it was the first time I had my stomach pumped. I'd taken a heap of valiums and [another drug user] found me out of it. He called an ambulance and I was taken to [hospital]. The shits [hospital staff] strapped me to a table and rammed a bloody great tube down my throat and pumped me full of saline or something 'cos I was a druggie. They didn't give a rat's arse about me. They didn't care what they did to me, like, pushing the tube down, they didn't tell me and my throat hurt like hell. Then I started vomiting...//... I ended up with pneumonia, that's what the doctor said, from the vomiting. They all looked down on me, I was just shit to them. Because I was so sick I had to go back to hospital. I had cramps, sweating, shaking, coughing. I didn't get out of bed for days 'cos I was going through cold turkey as well. I was coughing up blood, I felt sick all the time. It was really, really hard. I didn't care what happened to me. I wished I'd died. **Trish***

Like Trish who experienced much distress and suffering through her drug overdose, so too did some of the other participants who had overdosed. For all of the participants, overdose, or being around when someone else had overdosed, was stressful and unpleasant. Not knowing what to do in such a situation was a very real concern to many of the participants. They had to decide at the time what was important and for many of them, this was a hard choice to make, especially when drugs were so important to them.

Overdose was not the only health risk the participants took living the drug life. There were other dangers attached to using drugs, particularly by the injection method. Most of the participants suffered from one drug-related health problem or another. As a consequence of their drug use, the participants' health had slowly eroded to the point where, for some of them, permanent damage had been done. Once dependent on drugs, the participants pushed their bodies to the limit. Many of them were living in damaged bodies, willing to take health risks and suffer the consequences. In their need

to get drugs into their bodies they did not always take care, or show concern, for their health and well being. For some of the participants, the practice of injecting drugs had led to the development of abscesses, collapsed veins, bacterial endocarditis, septicaemia, and/or tissue damage which they attributed to either the use of dirty and/or blunt needles, or too much injection of drugs. For one of the participants, hell-bent on “a mission to get fucked up”, collapsed veins and ulcerated abscesses were the price he paid for regularly injecting Ritalin. The rush he got from injecting the drug was so impressive to him that he was prepared to pay the price and endure the weeping sores and damage to his veins. For him, injecting Ritalin was a form of acknowledged self-abuse and a total lack of concern for his health. In his words:

It [Ritalin] fucked my veins real quick eh. I tried filters but they're fucking messy cunts. The way it is done isn't that hygienic, you know, you use a fuckload of liquid to get the fucking stuff out, gotta use 5ml barrels, and when you put it in, you gotta do it real slow....yeah, the rush comes on real quick. Ritalin's a fucking beautiful rush but it's only got two hours and then your fucking brain's saying "give me more." It's a fucking self-abusive drug eh. You could say I'm on a bit of a mission to get fucked up... yeah, Ritalin's really fucked my veins. If you're putting in that much fucking liquid, if the fucking strap [tourniquet] aint released properly there's a fuckload of pressure. You get these fucking horrible sores too. They won't fucking heal, they just fucking scum up real bad 'cos there's a fuckload of shit in it. Some of the pings [injections] were taking half a fucking hour to get into me. It's such a beautiful fucking rush! Willie

Because of some of the participants' collapsed veins and abscesses, it was not unusual for them to spend 20 minutes or more searching for a vein into which they could inject their drugs. For those participants with collapsed veins, the resulting health consequences were enormous, yet their fear of going without drugs was greater than the associated risks and sequelae. What was happening to them now meant more than what might happen to them in the future. They were willing to bear the drawbacks in order to get their drugs into their bodies as illustrated in the following two interview extracts.

I suppose later on in life when I get older it'll [injecting drugs] have an effect on my health. My blood circulation and that won't be as good because, see all the, quite purple around there [shows his arms and hands where he injects into], all those little veins, that's where I used to go in, just inside my pulse, which is very dangerous. Right there. I used to go in my feet too and they're quite, the blood won't circulate when I get older. I suppose I'll feel it a lot more because of how bruised they are, see [shows legs]. Those bruises are from having used the needle in my legs. They've just

never gone. They're all bruised. I had to do it in my legs because I couldn't get a vein, lost most of my veins. Both feet are bruised like that, so yeah, when I get older I imagine it will have an effect. I never bothered to show the doctor. I'm more concerned about not having anything to use than what's happening to my veins.

Angus

My veins have crapped out, you know. I've got really bad veins and I need them now. I mean every body needs their veins but in terms of my health I need my veins to be, well, okay. So they're accessible for the hospital when I go there. And, um, they're not so much. I usually inject in this arm, sometimes I use my legs but never this arm now [shows left arm]. I'm trying to keep this arm relatively well, try and keep it clear and okay so the hospital can have access to it [HIV treatment]. You just don't think about how you need your veins until you get sick and it's too late. All you are concerned with is using your drugs, not keeping your veins okay until it is too late. **Eliza**

Just as many of the participants developed collapsed veins and abscesses as a result of injecting drugs, so too did many of them suffer from some of the other health problems previously mentioned as a result of their drug use. The participants attributed many of these health problems that they suffered from also to their use of dirty equipment and dirty drugs, needle sharing, drug cocktails, too much injection of drugs, the injecting of drugs into unsafe sites such as the neck, groin, and penis, and injecting insoluble drugs. Of these health problems, one of the more common ones was Hepatitis C (HCV), a virus that attacks the liver over a long period of time. Among the participants who had contracted HCV, transmission was believed to have been through the sharing of drug using equipment with other infected users.

In HCV positive many of the participants experienced a wide range of debilitating symptoms such as chronic fatigue, aching joints, digestive problems, and depression, that for some of the participants were experienced continuously yet for others, they came and went. The main impact that HCV had on the participants was their experiencing symptoms that reduced the quality of their lives. For many of the participants who were infected with the virus, HCV affected their energy levels and their emotional and mental well being, giving rise to a greater vulnerability to depression, anxiety, "brain fog", and worry in an already stressful and chaotic life. The following exemplar comes from a participant describing what it is like for him to have hepatitis C.

*By this stage I found out that I had Hep C as well so, you know, I didn't, I was worried about my liver, you know. Yeah. I mean, I actually think that I picked it up from sharing way back from one of the first times that I ever used. From my boyfriend, yeah. he used with [friend] too. He had Hep C from way back. It was when I started getting real sick, like the flu all the time. It wouldn't go away. My brain was sort of in a fog. Like, I couldn't do anything. I didn't have any energy even to go out scoring. I went to the doctor and he found out I had Hep C. I was just feeling awful all the time. I felt like shit, like, it didn't matter what I did. You know. He said that drugs weren't good news for your liver and that if I kept on using I'd damage my liver more. Yeah. but, like, the Hep C, it sort of affected everything I did and I had to be really careful that I didn't spread it around anymore because I didn't want anyone to feel real shit like I did. **Jenny***

For a few of the participants like Jenny the fact of being HCV positive sometimes led to a reckoning of their drug use and a determination to try and reduce it in order to better manage their health. However, it was clear from their accounts that they found carrying out this intention very difficult. In the face of being HCV positive, there was amongst these participants, not only a feeling of utter resignation in that contracting HCV was just another part of the life, but also an underlying sense of the futility of giving up or cutting down their drug use, in that, once infected they no longer had to take care not to become infected. For those reasons, it was their belief that they might just as well carry on with what they were doing without having to worry or be concerned about HCV. As one participant expressed it

*What the fuck eh, once you've got it [HCV, HIV (human immunodeficiency virus) or anything else] you've fucking got it so what's the fuck worrying about it. It's not like you go out fucking looking for it. Some cunt just passes it on to you, part of the life eh. You wanta fucking hit up, then you gotta be a man and take the fucking consequences, take it in your stride. No fucking point doing anything different. I'll probably be croaking by a fucking OD so what the fuck does it matter if I've got Hep C. Reckon I got it from [another drug user], filthy cunt, said he was lean, no fucking disease. What the hell. **Dan***

It was obvious from the participants' accounts that having HCV did not lead them to either stopping or cutting down their drug use, in fact, for two of the participants it led to an increase and more chaotic use. Other than Dan, who expressed no concern about safe practices or the risks of infecting others, the other participants both with and without HCV, were aware of the risks and health consequences of sharing their equipment and purposely sought ways to minimise the risks for the others with whom they shared drugs and equipment in order not to pass on the HCV. Uppermost in these

participants' minds also was the transmission of HIV, a far greater health risk with a more life-threatening outcome than HCV.

In their concern for reducing the risks for others and also for themselves the participants used a variety of strategies to avoid sharing drug-using equipment. Such strategies varied according to the person but two common ones for avoiding sharing were the explanations that one was HCV positive and did not want to pass on the infection, and the other one being that one was concerned that the person requesting to share may be HCV or HIV positive and that they did not want to be infected. Having such strategies, were for most of the participants, often hard to put in to effect, particularly when the opportunity to use drugs with others presented itself and the participants were without their own injecting equipment. Often this meant going without if they stuck to their resolve not to share. In facing such a situation, the participants experienced feelings of frustration, temptation, and uncertainty, vacillating between resolution and desire. In the words of one participant:

You get caught between the two, wanting to do it [share equipment] but not wanting to catch anything either. Like, I've taken a bit of care not to get Hep C, you know, clean needles and all that shit, but, yeah, if you score something and the Union's [needle exchange] not open and you can't wait, it gets pretty frustrating. You don't know what to do. You're with someone and you're not sure if they've got Hep C but they've got the works and you want to use. You know, it's tempting and I've done it. I say 'nah', but when it's in front of you, it's pretty hard to walk away. You don't know what to do but the odds are that you're going to use 'cos you just can't resist it. You've gotta have them [drugs]. so you do it and then you're left wondering if you've got it [HCV].

Jared

What was apparent from the participants' accounts was the concern with which they at least attempted to reduce the risks to themselves and to others. Whether it was a declaration that they were HCV positive and leaving to others to decide if they wanted to take the risk in sharing equipment, or whether it was an outright refusal to share, most of the participants felt as if they had to show some responsibility in preventing the spread of HCV and informing others of their status if positive. This sense of responsibility, however, did not always carry over into other areas of managing their health. In their sexual behaviours, many of the participants took risks that were potentially damaging to their health. Such risks included sex with multiple partners,

exchanging sex for drugs, unprotected sex, prostitution, and unsafe or compulsive sexual activities.

Although many of the participants were particular about not sharing drug-using equipment, they were less so about the sexual behaviour. For them, the health risks associated with their sexual behaviour were not as salient as those connected to their drug use, therefore they were prepared to take more chances as far as sexual risk was concerned. Despite having awareness of the possibilities of catching or passing on sexually transmitted diseases, HCV, herpes, HIV, and/or getting pregnant, many of the participants had unprotected sex. Faced with the choice of using condoms or not, most participants chose not to, despite their intentions to or an expectancy that they would use condoms before engaging in sex. For them, not using condoms was viewed as a risk they were willing to take, a risk that was more acceptable than sharing needles. Likewise, using condoms was viewed as unnatural and restrictive, decreasing the pleasure experienced. The following extract is typical of many participants' experiences of unprotected sex.

*I know I should use a condom but I don't. it's sort of unnatural, not the same. You don't get the same sort of feeling when you use one. You sort of think you'll be okay. I suppose you really take a risk because you don't know what the other person's got, but yeah, when it comes to it I never use them, though I suppose if the other person insists on it I might but I probably wouldn't have any with me. yeah, it's different with needles because, like I said, I don't share them mainly because I've got Hep c but yeah, I don't have a problem sleeping with someone without even thinking about using a condom. I don't know any one who uses them really. Anyway, sex when you're stoned sort of goes by the wayside. Half of the time you don't even feel like it or you can't come no matter how much you want to. **Jimbo***

Generally, for the participants, unprotected sex was viewed as an acceptable practice with little consideration given to the health risks. Getting and using drugs carried a much higher priority than spending time thinking about whether to use a condom or not. The same applied to the other sexual risks the participants took in the course of their everyday lives. Their need for drugs overrode any concerns for the risks they took. To them, any sexual risk behaviours or activities they took in their everyday lives were perceived to be of much greater benefit than cost at that time. To them, what was happening at the time was of more importance than the health costs of the future as illustrated in the following exemplar.

When I first started out [prostituting] I used to take better care, make them use condoms, shower and all that, but, like, at the peak of my using I'd sleep with about 6 or 7 different people a day to get enough money to pay for the drugs and I just wanted to get it over and done with. Also, they'd pay more not to use condoms. I know my health has suffered, I've got liver damage, I thought I had AIDS a couple of times just because my health was so bad but the tests came up negative. Yeah, and I've got pelvic inflammatory disease which is very painful and, um, I've just had so much VD and um, clap... the only reason the doctors think I've never got pregnant was because I got pelvic inflammatory disease because I didn't need any abortions and I didn't use condoms. At the time, it's like all you want are drugs and you do anything to get them. You never think about what's going to happen to your health later on. That's the last thing you think about. It's always now. You have to have it now, not tomorrow, now, and the only way you know how to get it is by having sex so you don't think about what else you're doing or about these things catching up with your health.

Trish

Other things catching up with some of the participants included a range of health problems associated with under nourishment and/or malnutrition such as irregular periods or none at all, weight loss, anaemia, constipation, tiredness, and increased susceptibility to colds and the like. Once drug dependent, many of the participants abandoned all thought of eating regular nourishing meals. Although the appetite suppressing effects of many of the drugs they used played a part in this abandonment, it was more to do with the fact that when money was tight, buying drugs took precedence over food. Generally, a supply of the basic essentials needed for a simple diet were on hand for most of the participants, however, a meal was more likely to consist of lollies, toast, biscuits, or cheap cereals which did not require much preparation or cost. For these participants, the money, time, and energy involved in preparing and providing nourishing meals meant less time spent feeding their drug dependency. Food was, to them, an extravagance that they could no longer afford, and although not eating well was sometimes experienced as a worry, it was not so worrisome that they would go without drugs to make it less so as expressed in the following interview extract.

I worry about my pains and things sometimes, like I feel sick a lot of the time. I pretty much always get a clean needle these days, like, I don't share with anyone. I haven't checked if I've got hepatitis but nearly every druggie in [town] got hepatitis. I'm bound to have it. Like, I feel sick a lot of the time. How do I know if I've got it, whether I'm hanging out or whether I've got hepatitis or whether I don't each much. If I eat, it's just shit stuff. Like with pains it could be anything. I don't eat. I don't think I've eaten except those biscuits there, I probably haven't eaten for about three

days I suppose. Like, I feel hungry, fuck yeah, starving [laughs] but yeah, I can't worry about that when I've got to worry about getting the drugs. I have to get the drugs. there's no money left to buy food, or electricity, like I'm sleeping in my van. I hop into the van at night and sleep in it. I can't spend a hundred bucks a week on a flat or food or electricity, they're an extravagance now. I need that hundred bucks, you know, to score. Alistair

As evidenced in the above excerpt, living a drug lifestyle often involves very poor nutrition and living conditions, both of which have played important parts in the participants' handling their health. Without good nutrition, the health of many of the participants suffered. Because of their lifestyle - the day to day hustling, scoring, and drug taking, many health problems often went unnoticed or were not attended to. Many of the drugs used by the participants not only dulled their emotional pain but also diminished their ability to feel physical pain, consequently many of the symptoms of illness they experienced that would have alerted them to more serious problems with their health were masked by the effects of the drugs. When experiencing any symptoms of illness many of the participants were also reluctant to seek medical care. To them, contacting a doctor for any physical ailments or being admitted to a hospital often meant facing contempt, condemnation, and scorn once their drug dependence was disclosed. Being told that their illnesses were the result of their drug abuse was not only unhelpful but also nerve wracking and humiliating as illustrated in the following exemplar.

It was after I'd tasted some misties with some Marzine. Like, a few days later one of my fingers started swelling up real bad, like it was causing me grief so I was a bit concerned and fucked of to the doctor. I thought it was infected but didn't know why 'cos I'd used clean needles, so yeah, I went to the doctor 'cos I was feeling quite sick by that stage and yeah, it was okay until the egg discovered the facts, you know, that I'd injected drugs. like, the egg told me that I'd got what I deserved, that it was 'cos I was a fucking druggie that I was sick and because it was self inflicted if he had his way he'd chop my finger off. Man, he was a real sicko, like, he wasn't even helpful and, yeah, he tried to make me feel this fucking big [demonstrates with his fingers] with his holier than thou attitude 'cos he didn't like druggies and that we'd all being the world a favour if we all overdosed. It's no fucking wonder that I felt like, shattered after seeing that egghead. Yeah, I had to get out of there and have another taste just to calm myself down. Talk about heavy shit. Then I went to A&E at the hospital and they fixed me up without any of that bullshit. Jimbob

Like Jimbob, many of the participants were reluctant to seek medical advice. For them, to seek medical help was, in many cases, to be met with an unsympathetic response, a

feeling that they were a waste of time, that they were not valued as human beings, and that they would not receive any treatment or helpful advice because their health problems were self inflicted. Another reason many of the participants expressed much reluctance in seeking help was because they attributed many of the symptoms of their illnesses or problems to the beginning stages of withdrawal particularly if they had been without drugs for a period of time. Once drug dependent, all of the participants experience withdrawal symptoms at one time or another. When they failed to score any drugs there was nothing else the participants could do other than try to ignore their aches and pains, runny noses, edginess, sweating, tiredness, and strung out feelings. From experience they knew things would get worse if they were not able to get what they needed. Withdrawal symptoms were just another part of the life that they had to accept. However, many of the withdrawal symptoms they had learned to accept also resembled the symptoms of more serious problems. For the participants who had gone without drugs for a period of time any such symptoms would be attributed to withdrawal rather than a health problem or illness they might be suffering from. It was only when further doses of drugs failed to alleviate any such symptoms experienced that they thought to seek medical attention, that they were not handling their health very well. In the words of one participant:

I didn't think to go to the doctor. I'd gotten used to being sick, feeling sick from not having anything to use, feeling like I had the flu all the time - just going through turkey and, um, like not holding anything down, sweating, shaking, convulsions, the whole bit, because I couldn't get anything. I've been crook for two weeks or more sometimes so I didn't think to go to the doctor, but then I got some smack, you know, heroin, and I thought I'd be okay but, like, I didn't get better. I just kept feeling like shit, like I was really fucked so I went to see the doctor and he said I was, that I was run down and had an infection, you know, pelvic inflammatory disease [PID] and that was why I was feeling like shit. He said I needed to go to hospital, it was that bad and then he blasted me about looking after myself better. After that I sort of looked at it [PID] as an occupational hazard, kind of [laughs]. **Trish**

As reflected in the above exemplars not all of the participants maintained vigilance when it came to their health. To them, the health risks and the health problems they encountered and experienced were occupational hazards that had to be taken in their stride, just another part of living the life - a life that involved chaotic living conditions, poor nutrition, money problems, public contempt, and the never ending search for drugs. Because drugs were their *raison d'être*, the love of their lives, the participants

would take huge risks - share needles, inject into their groins, have unprotected sex, and face the possibility of overdose, just to carry on using drugs.

Although each of the participants recognised and expressed concerns about the health risks and problems they encountered in living the life, not all of them were able to organise or manage their lives to avoid them. Generally though, the participants, as much as they were able, were vigilant about taking care and being careful, about looking out for themselves and taking precautions, both in matters of health and their everyday activities and about making choices in managing their lives. In most cases the participants' concerns were to avoid health problems, to avoid the consequences of the law, to avoid humiliation and public condemnation, to avoid distress and difficulties, and to be able to get the money to get their drugs to keep them feeling well enough to carry on their everyday activities, and to do so by whatever means they felt were most seemly to them given their possible choices.

Although many of the participants spoke of their concerns, that with which they have to deal with and that which matters to them, in a different and nonchalant manner, such concerns were often accompanied by an anxious state of mind. This feeling of anxiety for the participants was centred around their being thrown into the world as drug dependent, around realisation of their ownmost potentiality for determining their being-in-the-world as such through their freedom of choosing and defining themselves, and around the recognition that drugs took precedence over being ahead of themselves. For Heidegger (1927/1962), anxiety is an aspect of Dasein's worldly existence, conditioned by one's state of being-in-the-world as thrown. Through anxiety, one's being is revealed to one's self in such a way that one's existence, the kind of life to be lived, matters and is an issue. *Anxiousness as a state-of-mind is a way of Being-in-the-world; that which we have anxiety about is our potentiality-for-being-in-the-world. Thus the entire phenomenon of anxiety shows Dasein as factually existing Being-in-the-world.* (Heidegger, 1927/1962,p.235).

Thus, for the participants, anxiety was revealed as a way of being in the world as thrown and the necessity of making choices for the kind of life they would like for themselves. In spite of living a chaotic life interspersed by overdoses, withdrawal,

sickness, health problems, imprisonment, and the loss of credibility and respect of others, the participants cared for a normal life, as normal as it could be for them, given their being in the world as drug dependent. The care for a normal life for the participants is a future oriented one, a life in which they are not caught up in everyday risk and chaos, one in which their actions and choices are directed toward taking more care and control over their lives given the restrictions of the way in which they find themselves thrown in the world. Hence, the various aspects of being vigilant discussed in this section encompass an understanding for the participants that their being-in-the-world as drug dependent embodies their past, present, and future.

What the participants hope to bring about, that which they want to achieve, the future that they project for themselves, can be understood only as that which has grown out of their past and present experiences. Essentially, what the participants have been, what they are, and what they make of themselves, their past, present, and future, are a unity, a temporal whole, and as such, each can not be understood apart from the other. It is in this way, through the inseparability of Dasein's past, present and future that "temporality reveals itself as the meaning of care" (Heidegger, 1927/1962, p.234).

Through recognition and acceptance that their present is inseparably connected with their past and future, in what they are doing now, makes sense only if it is seen as an acceptable projection of what they have done before and that their present actions and choices are related to what they want to be, the participants are better able to understand that care is needed in organising and managing their lives to avoid the risks, chaos, and other difficulties associated with being drug dependent. As such, the participants are able to bring their experiences of the past to mind in the present and then use them to look ahead toward their future life in the light of the understanding they have from such experiences - a coming of what has been and a looking forward. It is these experiences which constitute a part of who the participants are in the world.

A coming of what has been and looking forward

In becoming and being drug dependent each of the participants in this study found themselves thrown into situations which they had no option other than to do their best

to deal with or cope with. Within such situations the participants made choices, some reflective, most not, about things that mattered, things that they felt affected their sense of self. Finding themselves in such situations was, for them, an inescapable part of their experience of Being-in-the-world, and impacted upon their Being-with-others. In remembering such situations, the participants talked of things that matter, of how they saw things differently after experiencing the situation, of the possibilities that were open to them, which of those they choose, how they choose, and those they missed because of the reality of their thrownness, and of how these experiences needed to be recognised and accepted if their lived experience of drug dependence was to be integrated into their sense of self. Thus, in this way, remembering the past and using their remembrances to choose or rule out possibilities emerged as important aspects of care. Accordingly, the participants' remembered accounts reflect what Heidegger (1927/1962) named "a coming of what has been" (p.10). This "coming of what has been" can be understood as a reflective thinking back, the "coming" being an opening to experience "what has been" - those memories that the participants had that were not always reachable or accessible at certain times but which they felt were part and parcel of their becoming and being drug dependent. As such, the participants experienced this "coming of what has been" by letting their past experiences shape and mould their present being as well as create new possibilities for themselves - a looking forward to what could be in the future.

It was clear from the participants' accounts that they each brought with them a wealth of past experiences that informed their present being, experiences which also affect their future. By allowing themselves to experience what has been through remembering past experiences along with the accompanying feelings, thoughts, and impressions, the participants were able to create new possibilities for the present, come to terms with possibilities chosen, not chosen, missed or forgotten, given the reality of their thrownness - the situation in which each of the participants found themselves in. Remembering also gave meaning to their lives through the connections they made between their pasts and presents. Respectively, for each of the participants, the coming of what has been, the bringing of their experiences of the past to mind in the present, and the using of them to look ahead to the future, required an understanding and a reckoning of what has been, of the participants' own distant and not too distant past.

For Heidegger, remembering, that what has been, is constitutive of Being-in-the-world. Dasein always remembers. Remembering shapes and is shaped by one's lived experience.

For all of that, not all of the participants were able to bring together their past and future. For them, there was no awareness of possibilities, no openness to the possibilities for new understanding of being. The meaning of their Being was lost, or covered up. Through seeing themselves as victims of experience and searching for answers they lost sight of the self, and closed down their understanding. In the words of one participant:

I wanted some answers. Like, I know, I know shit all but I wanted some answers. Why me? why did it have to be me? [become drug dependent]. Why did it happen to me. why couldn't I be like you? You know, have a normal life. I keep on looking for answers, even to the point where I don't think there's any. I'll probably always be like this. I can't see myself getting out of it. I'm just a nothing. I haven't even got a life away from drugs. I've never had a life. I can't talk to anyone about it because they don't want to know. Nobody wants to know. Nobody cares. Tui

Although aware of her drug dependent situation, Tui was unable to come to terms with it, to understand it. The meaning of her existence had been covered up by her drug dependence and in searching for explanations and answers, Tui had objectified herself and her experience, shutting of all possibility of understanding herself, her Being-in-the-world. Also, just as Tui found it hard to talk to others about her experiences so too did many of the other participants. For these participants, there was a general feeling of shame, self consciousness and/or embarrassment about their being drug dependent, accompanied by an uncertainty as to how others would react to them once they found out about their situation.

As was discussed in Chapter VI, Being with others, it was a common experience for the participants to be met with rejection, punishment, and contempt by others in society once their drug dependence status was known. Such reactions which the participants faced were the result of not only the stigma and prejudice attached to drug dependence but also fear and misunderstanding of drugs and the belief that drugs cause dependence. In spite of being met with such reactions many of the participants felt from their experience of becoming and being drug dependent that they would have

benefited immensely from less societal negativity, treatment on demand, less second rate care when care was sought, an acceptance by others that they are people with feelings, and greater support and understanding from which they could have gained strength, hope and a belief in a future. As one participant explains:

*It's like they've [society] got no idea. No idea at all about people who are addicts. They treat addicts like they're nobodies yet they're all human beings before they're anything else. You know, it's all this crap with negative stereotypes and the fucking loathing they have for anyone who uses drugs. they don't understand, they don't understand what's happening to people who use drugs let alone those people understanding themselves. Like, look at [another drug user]. When he needed help, when he hit rock bottom, they weren't there to help. They treated him like shit, like a fucking criminal when all he needed was someone to help him understand what was happening to him. You know, someone to support him in helping to give up, someone to help him see that life was worth living, that there was something worth looking forward to, that he could clean himself up and get on with his life. You know, there's a few addicts around like [name] who need some help because their drug use has got too out of hand. They're not all like me, like I've never found drug taking to be a problem. I've always found drugs to be a help. What's been the problem has been all this other crap, the fucking moralistic attitudes and their [society's] sitting in judgement on me and what I choose to do. That's what stopped [name] from getting help when he needed it. They didn't understand him. He didn't even understand what had happened to him. He didn't have any where to go. He didn't even know who he was. He needed help just to work out who the fuck he was. The only help he got was an overdose. **Hugh***

As implied by Hugh, some people who have a drug dependence often need help in coming to terms with what has happened to them, an understanding of how they have changed, how drugs have numbed their awareness of their own Being, and how their drug use has affected the way that they view themselves and the future, particularly if they are to make sense of their experience and integrate it into their lives as a whole. The help that Hugh foresees is not of the sort that some of the participants commonly found available. For some of the participants, the help they were offered was likened to a punishment for being drug dependent, a set period of time residing at a confrontational treatment centre that stipulated detoxification and abstinence and where the notion of being powerless dominated; for others, help consisted of sexual harassment in treatment programs; for a few, dealing with bad counsellors; and for others, help was an appointment at a clinic where their needs were either silenced or minimised. What Hugh envisaged was the sort of help that treats the person with dignity and respect, that which acts to integrate one's experience into one's life as a

whole, and that which provides a framework for one to understand what has happened to one. In his words:

*People need good help. Not that crap residential stuff you wait 5 months for and get sent to hang out there after they've detected you and then fill your head full of that 12 step crap that tells you you're powerless when every fucking Joe Bloods is there telling you to come outside for a toke or a taste. [laughs] What they need, what [name] needed was to be treated like a human being with some respect even though he was a fucking crime, but, yeah, he asked for help and he didn't get it. He didn't get what he asked for when he needed it. He needed to work through all that shit from his past, why the fuck he even got into drugs in the first place and why he let it all get so out of hand. He needed some help to work it all out and get on with things. Instead he got that fucking dickhead [counsellor at local A&D Centre] who pushed him over the edge with his wankerish if you don't do this we won't do that. **Hugh***

As Hugh stated in his account, a person's past experience and the way in which they found themselves in the world was often very difficult. Likewise, for some of the participants, it has been hard for them to come to terms with their becoming and being drug dependent and the ensuing drug lifestyle. Although resigned and accepting of their drug dependence, these participants often felt disheartened and gloomy about their lives. One participant summed up his experience as:

*It's hard being a drug addict. The only reason I haven't got a job is because I can't work. I can't work when I'm like this. I can't work when I'm hanging out. It's just impossible. When you're working you work to buy your drugs, all you're doing is working to buy drugs. it's just pointless. I know I'm fucking myself up. I know it's bad for me. I know all that. But the fact is, I can't do without it, you know. That's what I think. I can't do without it. The last 15 years of my life I've been hitting up morphine every single day, more or less, every single day for the last 15 years and for someone to just go phewitt, and take that away from me, it'll kill me. I just, I won't be able to handle it. I'm an addict. I'm definitively an addict. I'm a drug addict and I've never, to me, the only way to cure me, to stop me, to get my life normal. Is to get me on that methadone program. I'm down there all the time trying to do it and their waiting list is a couple of years long. A couple of years. I mean, a couple of years. Fuck. I never thought it'd be like this. I just can't see the light. I just can't. **Alistair***

Not all of the participants found their experience of becoming and being drug dependent as gloomy as Alistair. No matter how chaotic, costly or consuming their lived experience of drug dependence was, a couple of the participants were able to find some positive aspects in their experience. As a result of all that had taken place in their past, their life situation, their experiences with others, these participants were able to

identify some advantage, happening, or moment of truth which had arisen for them and could be integrated into their sense of self as the following exemplar shows.

*Along with everything else [drugs used daily] I was taking mushrooms once every three days for a couple of months and it was not particularly much fun. It was, however, very interesting and very informative but it wasn't much fun. I was able during that time to actually work back and figure out the source of a lot of my behaviour, where it originally came from, what it was there for, what it was doing, then I'd examine that against what I believed in, see whether it stood up. Um, and I got, I was able to get very objective. I was able to get perfectly objective about my life. I was able to examine it under a tiny little microscope. And, so it wasn't, so yeah, and I was going some place scary, somewhere in my brain. Yeah, it was like, um, the drug comes on.....it's like a light goes on in your head...mushrooms pull heart strings and fucking play with your emotions something horrid, but yeah, I started getting some revelations and I thought, fuck, I have to pursue this to the end. This is important. I had to pursue it to the end. Like, the revelations were about me. I mean, it was like, where did my attitudes about some various things come from, what was their origin. Did they equate with what I paid lip service to, which was anarchism. Um, and in a lot of cases they weren't. it was like a moment of truth, something happened, I don't know, the pathways that I follow with my thinking have been irrevocably changed. I have been on trips where I've had to make a decision of whether to try and maintain my sanity or follow the path and I found that hard. Um, but yeah, that's where most of the damage that I've suffered from drugs has come from. I'm not sure whether it's just change in the way I think or what. I mean, I've felt things tear in my brain during trips and it's never been the same since... it was this revelation thing I was talking about before, say a particular way you act, a behavioural pattern that you have and to get right to the root of it, you have to strip away you, so that you can see where the thing is, you have to tear away all the facades, you know, 25 odd years of experience. The whole thing and get it out of the way, entirely, so you can see the thing, what ever it is that you're trying to find, and that's not always easy. Yeah, it's sort of like, there's a line you cross when you're tripping and on one side it's safe and on the other it's not, and I stopped coming back to the safe side. I stayed on the dangerous side but I've got a lot of information. Like I know who I am, absolutely and irrevocably, and totally. There is nothing that I don't know about myself. Yeah. I did that big binge on mushrooms and there was about 5 years of analysis of the information I got afterwards and yeah, it paid off in the end. It took me a long time to sort it out, I got my life sorted out into a position where I was enjoying what I was doing. I felt like I was living a more regular type of life, more controlled. And then my depression went. **Hugh***

Although prompted by drugs, Hugh, through allowing his past to enlighten his present was able to create new possibilities for himself. By living his coming of what has been and looking forward, Hugh gave meaning to his life, found out who he is, got to the root of his behaviours and let go of his depression. As painful as it was for Hugh to work through his 25 or so years of experience, he had, through reconstituting his sense

of self, integrated his experiences with his life as a whole and consequently felt as if he was pursuing a more normal regular life despite his being drug dependent. Another participant also spoke of the importance of putting the past aside and looking forward rather than keeping things raging inside and having to conceal his pain in drugs. For this participant, remembering past experiences - those events that he felt contributed to him becoming and being drug dependent, was a painful process. To him, what seemed like everyday events to most other people served as painful reminders of the past, and it was only through recovering those memories that he was able to create meaning in his life and feel as if the missing piece had been found. In his words:

*I felt absolutely devastated by it [separation] and I know now that that was the beginning of it, you know, my addiction. It was a real shock to me, her leaving and all, bugging off with that bastard, I didn't even know. I got so angry. I felt like I was going to explode. It just kept raging inside of me and the drugs blocked it out. It was the only way I could stop it. I would have killed him otherwise. It took ages before I could even deal with it, feeling rejected, but by then it was too late. I was well and truly hooked.....I used to think about it, you know, I'd see couples together and wonder why it happened. Everybody was happy except me. I'd see them together and it kept reminding me about [wife] but yeah, it took awhile but I got to thinking about it and sort of realised the part I played in it. I had to sort of go through it all and think about it so I could understand it. Then I realised how deep I'd gotten into drugs and crime and all that shit, you know, the endlessness of it all and yeah, it was like, one day, it sort of all fitted together, like a jigsaw I suppose, I'd used drugs to stop hurting and it was like wow!. I didn't think something like this would ever happen to me but look at me. I think I understand myself better and all I have to do is start looking at getting myself out of here, some help. I will do something about it getting my life back, yeah. **Jared***

For several of the other participants besides Jared and Hugh, their opening to remembrance emerged as being of central importance in the way in which they understand themselves and their situation and the way in which they comport themselves toward their world. In their accounts, they told of the different paths they took to remembering what has been and of how it could create new possibilities for a return to a more normal sort of life. These participants, however, found that although they had come to understand themselves better and wished to continue with their lives in as normal a way as possible, it was often difficult for the others with whom they lived alongside in their everyday lives, to see or accept them as anything other than junkies or addicts who could not be trusted or believed in. Such beliefs from others led not only to these participants feeling as if they were unable to seek advice, support, or

care from these others in looking forward to creating new possibilities for themselves but also to feeling valueless, uncertain, and of being alone in the world. As one participant expressed it:

*I talked to them [parents] about it, I thought I'd give it a go, so I said to them that I'd go to detox and see how it goes....yeah. And, um, then dad said to me that drug addicts can't stop, that I couldn't do it, and, um, so I went to hospital, and I kept thinking about what he'd said about not being able to stop, I remember thinking that I wanted to stop, you know, but I wanted them to help me stop but he kept saying that I couldn't, there's just no way I could do it. It's like they didn't believe that I could even try. But, um, yeah, I went to detox by myself, I wanted them to come to the hospital with me but they wouldn't, they didn't believe that I would do it... it was like I didn't mean anything to them any more. They didn't believe in me, so, yeah I went to hospital and um, yeah I was in there for two weeks, but I used while I was in there. I kept thinking about what dad said, that I couldn't do it. He was right. **Jenny***

Similar reactions to those of Jenny's parents were experienced by many of the other participants. Because of the perceived lack of care and concern from others, particularly family members, the participants refrained from talking many things over with them preferring instead to deal with as many problems as they could on their own. This, however, only added to their feelings of being alone, of being worthless, and of sometimes being uncertain about what to do. Also, for the participants, the lack of care and concern they felt others had for them, along with the difficulties others had in believing they could be anything other than junkies or addicts, was perceived as an inability of the others to let go of their stereotypical perceptions of the participants as junkies or addicts and to look forward to seeing them as human beings with possibilities. In the following interview extract one participant describes how his potential to end his drug dependence journey was thwarted and undermined by those from whom he sought support. As a result, he was left feeling discouraged, worthless, and all alone.

I never found drugs easy to get in jail. Not the ones I wanted. I certainly couldn't supply a habit so I had 14 months off, not using. Fourteen and a half actually. It was murder. It was a bastard having to think about things. I used to think about how I couldn't wait to get out to get stoned. Then, you know, I just, I suppose, I sort of looked at myself and thought I'd give it up, give it all up and see if I couldn't make something out of my life. I thought I could, you know, so when I got out I went to see [doctor at the A&D Centre]. I went to talk to him, like I was dead straight and could talk about not using, about what happened to me [abuse], I mean, the memories were so vivid, so yeah, I went to see him to get some help because I kept thinking about

*getting out of it but didn't want to do it, and, and you know what, like I told several people that I wasn't going to use, and you know what, they all did, they all laughed at me. the doctor laughed at me and said, "Tony, the only time you'll stop being a drug addict is when you're dead." I tell you. I go to the doctor and he tells me that. Each time I thought about giving up that's what I got. When you've been using for so long no body believes you. You know, you really are on you're own. I've learned that from hard experience. I really wish it didn't have to be that way, I really do, but it is. They don't see that when you're trying to help yourself, yeah, you're really on your own, nobody really cares what happens to you as long as you don't bother them. You know, I had a desire to stop. I **had** a desire to stop but nobody wanted to help me. That's how I know what alone is, what being alone is. Tony*

As a result of being known as a drug addict in the past, Tony believed that he did not get the help he needed when he was released from prison. For him, the loss of his physical dependence through not being able to supply his dependence in prison was seen as an opportunity to seek help for his psychological dependence, his thoughts of wanting to get stoned. However, the negative attitudes he encountered from others had a discouraging effect that only set him further on the road to greater dependence. Paradoxically, it was the caring missing from the remembrances of past memories - their experiences of becoming and being drug dependent and their experiences of being with others and the integration of these experiences into their sense of self that has enabled many of the participants to take care, to care for themselves, to give sense to their existence, to accept their drug dependent identity, to look forward to the future, to have a more normal life, and to live out a live that means something and on which they take a stand. As aspects of care, these concerns are explored in the remainder of this chapter under the following main theme: choosing a life.

Choosing a life

It is an inescapable part of what it is to be human that humans are thrown into the world that they then have to deal with. It is in this sense that the world matters, that things matter to humans, that humans make choices in living their lives. As such, it is this feature of what it is to be a human being that Heidegger (1927/1962, p.193) describes by his term *care* (*sorge*). By virtue of being thrown into the world - surrounded by others, by things, by having feelings, needs and wants, the participants had to deal with the world, with the situations within which they found themselves. In finding themselves in situations, the participants made choices, some thoughtful, some

less so. Accordingly, their choices and actions revealed what matters to them, that which they take a stand on in living a life, which, for each of them, has meaning and which adds up to something in the end.

In living their lives, each of the participants were engaged in the world in their own individual way, either living authentically or inauthentically, each taking a stand on their own being through their actions and choices. Although all of the participants in the study had their drug dependence in common, their Being is in each case its own, free to make of itself what it freely determines upon through the choosing of its own possibilities. Respectively, each of the participants clearly demonstrated their individuality in their determination to look forward and get on with their lives in spite of the effects of the stigma, prejudice, and rejection attached to drug dependence, and of being caught up in the chaos of a drug lifestyle. In looking forward and getting on with their lives, each of the participants had perceptions of, and plans, for the future. Although a few of the participants in discussing their sense of the future expressed a feeling of futility, of having a future in question with few hopes or dreams, most of the participants anticipated a hopeful future, of living the best they could and of realising their hopes and desires, hopeful possibilities yet-to-be, the reaching forward-of-care. As such, the participants' experiences of realising their hopes and dreams are discussed in the next section.

Hopeful possibilities

For Heidegger (1927/1962) hope - the expectation of a future good is found in one's *having been*, the facts of one's past experiences, past hurts, difficulties, and setbacks. As an attitude, hope is related to what one wants for one's self, what one wishes for, what one looks forward to. In looking forward, in having hope, one recognises that one is constituted by one's situation, that one lives in thrownness. As such, hope, in being futural, is also related to the past and present, and to the opening of one's eyes to one's position in being-in-the-world, to Dasein. According to Heidegger,

"Hope has sometimes been characterized as the expectation of a *bonum futurum*, to distinguish it from fear, which relates itself to a *malum futurum*. But what is decisive

for the structure of hope as a phenomenon, is not so much the 'futural' character of that *to which* it relates itself but rather the existential meaning of *hoping itself*. Even here its character as a mood lies primarily in hoping as *hoping for something for oneself*. He who hopes takes himself *with* him into his hope, as it were, and brings himself up against what he hopes for. But this presupposes that he has somehow arrived at himself. To say that hope *brings alleviation* from depressing misgivings, means merely that even hope, as a state-of-mind, is still related to our burdens, and related in the mode of *Being-as-having* been. Such a mood of elation - or better, one which elates - is ontologically possible only if Dasein has an ecstatico - temporal relation to the thrown ground of itself" (p.346).

Hope, for the participants in this study, was experienced as an evolving process, individually shaped by their life situations. Because each of the participants were engaged in the world in their own way with varying life situations, there were varying aspects of life which hope featured or was called for. For instance, those participants who committed crimes and experienced close calls with the law held hopes that they would not be busted. Many participants who were estranged from family and friends held hopes for better relationships in the future. Those participants who had difficulties in getting their drugs held hopes that they would not have to hang out whereas those who were able to score their drugs easily hoped it would always be so. All of the participants held hopes for an endless supply of the drug of their choice. Because their lifestyle is one in which the pursuit of drugs is unending, risky and chaotic, the participants all spent a great deal of time daydreaming about how good their lives would be if they had enough drugs to last them forever. An endless supply of drugs to the participants meant never having to experience the fear of being without drugs, never having to feel the intense longing, the passion of craving drugs, of hanging out, never having to worry again, and sheer happiness of endlessly being able to enjoy the utopia. In the words of one participant:

I'd dream about a whole truckload of it [heroin]. I wanted enough heroin to last me a lifetime. It's all I ever hoped for. I wanted enough heroin so I'd never have to worry about getting it again. It's all I wanted. I never wanted to hang out, to go without. I wanted it to take me away, I wanted that feeling of utopia to never end. It was what I hoped for, I hope that I could be in that state forever. I wanted enough heroin to last me forever. I'd keep on using until there was almost none left then I'd have one last

blast because I wouldn't want to be without. I'd do anything to get that much so I wouldn't have to go without. **Trish**

Like Trish, many of the participants would endure indignities, difficulties, uncertainties, and risks to realise the daydream of having enough drugs to last forever, to get what they hoped for. Drugs, to the participants, meant all their hopes and dreams were possible, everything was worthwhile, the disappointments of life were so far away, there were no pressing needs, hurt or unhappiness, and fear could no longer worry them. Having enough drugs also gave them a sense of safety, of being protected, of soothing the seriousness of their situation. As one participant expressed it:

When I've got drugs I've got no other needs. I'm safe, my problems shrink away and I feel like anything's possible. All the things I hope for, like a job, like getting my degree, like having a family, like getting clean seem possible. If I had enough [opiates] to keep me going I could do anything, like, I dream about travelling around the world, did I mention that I'd like to be a war correspondent, yeah, like buying a house, about not having to use, meeting other people, yeah... I guess they're only dreams, they're not really real. **Lilian**

Just as Lilian had varying degrees of hope that she would stop using drugs, that she could change her life and have a family, or that she could finish her studies, so too did some of the other participants. However, they also knew that such hopes were not long lasting, that they came and went just as the drugs did, for the participants, holding on to their hopes when drugs were plentiful and loosing them when drugs were scarce in many ways reflects Heidegger's viewpoint that hope is related to one's burdens, that hope brings alleviation from one's worries, uncertainties, and anxieties, that in hoping for something for one's self one brings one's self up against what one hopes for. As such, many of the hopes expressed by the participants related to living a normal life, a life in which their situation was different from their present one, a life worth living, one in which there will be good things, one in which it is worth getting up each day for, one in which they no longer wake up feeling sick, one in which they are not caught up in the risks and chaos of a drug lifestyle. As in the following exemplar.

I'd like to get my life sorted, you know. Even though I like the drugs I'd like to have a good life, a more normal sort of a life, you know. Like I say, now I've got to the age where your knowledge and everything from the past and stuff that I, ah, know now about, like I say, my junk use, you know, I'd like to get it all under control, in moderation, like I want to get it sorted, you know, to get up each day without having to go off scoring because you feel sick, like, I want to be able to learn from everything I've done to know that I can live normally, do things in a normal way without having

to worry about drugs. you know, I can't be a father with my son like this, I can't deal to my boy and I want to, I want to be a father, you know, I want it to be normal like everybody else. I need a job to fill my time because that's where the junk life falls in its hole. You know, to be able to have a day, to have a life and what not with out having to worry about getting caught up in all sorts of shit like I am. Simon

The longer the participants allowed drugs to be a part of their lives the more difficult it became to return to the world of the others. For the participants, drugs not only shut out the pain of living and of dealing with others, they also shut the participants into a more closed and diminished existence shared almost wholly with people living the same lifestyle, a drug lifestyle in which hopes came and went as their drugs did. While several of the participants held hopes of living a normal life, of being able to parent, of completing their studies, of having a relationship, of improving their lives, of having a job, it was clear that some of these hopes were unobtainable and unlikely to be achieved whilst drugs took precedence over all else. Thus, it was not of as much importance to the participants whether or not their hopes were achievable, but more that their hopes, the expectation of a better future, served as an antithesis to their past and present experiences, hurts, difficulties, and set backs, their having been and being, as Heidegger designated the meaning of hope to be.

As long as the participants held onto their hopes and aspirations they looked forward to a future of possibilities. Through looking forward to a future of possibilities, new possibilities emerged for their living today, new possibilities that provided meaningful insights into how they chose to be. Part of one of the participant's new possibilities for living included experiencing care and concern from a new girlfriend as illustrated in the following exemplar.

I had thought about giving up drugs but hadn't got around to it, like, you know, there was this girl who was a friend of mine and had been for awhile and, like, I'd been hoping to have a relationship with her because I really fancied her. I told her as much and she sort of went, "I don't know", then she went away for the holidays and came back and went, "yeah, I fancy you too", and it was exactly at that time I decided to give up drugs. like, this girl didn't use and she's, she was really good about it, but, like, she knew I did because I made sure she knew long before we ever got together because I wanted to get together with her and I thought it would be unfair if she didn't know so I told her and it kind of freaked her out a bit but she handled it better than anyone I've ever come across, yeah, so I was surprised basically that she didn't think I was a monster when I told her, so yeah, I made an effort to give up because she said she worried about me using and she was really nice and stuff so I gave up and I got really sick for a couple of weeks, just the hanging out thing, and I stayed in

bed for a week and that, she looked after me and I sort of got it back together again and then I got on with life and stuff and it was really nice being with her, like she showed me I could really enjoy life without using drugs. Brian

Through taking his friendship with a woman to a more intimate level Brian found a reason to stop using drugs that outweighed his desire to keep on using. For him, hope manifested itself in actions he took for his own good to deal with his dependence. However, just as hope leading to future possibilities could be fostered, so too could it be shattered as Brian later experienced. For him, shattered hope was devastating. In his words:

Then in late September [6 weeks later] she said she had to go away for the night so I went to a party and, like, I walked in, and oh, my God, there she was with this other guy, they were obviously together, I mean he was covered in lipstick sort of thing and I just went, oh, my God, I'm not coping with this, and I ended up cruising back to a friend's place and I just, phew, lost it completely. I just went, fuck it, I don't give a shit, and you know, that's the worst, the worst possible reason for taking drugs is because you're too scared of reality or don't want to deal with it. It was all so fucking hopeless. Brian

For Brian, hopelessness emerged as a giving up of hopeful possibilities, of losing purpose and meaning of life, and of feeling vulnerable. Just as Brian experienced hopelessness, so too did other participants. When hopelessness was felt by them, they were unable to take hold of anything. To them, in their hopelessness, the future became non-existent as drugs insulated them from the realities of the outside world. Although hopelessness was experienced by Brian and others as a giving up, a folding of possibilities, a narrowing of life, it did, however, change as future possibilities unfolded in their lives along with a renewed belief that life is worth living at the present and in the future.

In believing that life is worth living, that they were able to recreate a future of possibilities, several of the participants expressed hopes for regular maintenance on prescribed drugs, in particular, methadone. To these participants, not yet ready to stop taking drugs, not intending to give up drugs permanently, but wanting a more normal life, a maintenance dose of methadone over an undefined period of time would mean respite from their risky and chaotic drug lifestyles and an opportunity to achieve a balance between the life they led and the effect of the drugs they used. Basically, a regular supply of a drug such as methadone, for these participants, would lead them to

experience feelings of relief and freedom from worrying of fear of overdose or death, of incarceration, of having to go without drugs, and of having to find the money for drugs. Having a prescribed dose of methadone would also lead to these participants experiencing some stability and some routine in their everyday lives along with the possibility of holding down a job without having worry about scoring drugs and of finding money. In the following interview extract one of the participants describes what maintenance on methadone would mean to him.

*Unless you're getting it prescribed, it, it's just another drug, it's just like morphine, no different. The difference is when you get it prescribed and you get it for nothing and it's just there everyday. You don't have to worry about what you're going to do tomorrow. You don't have to spend your food and electricity money on it because that's what you'll do when you're a drug addict. You won't buy food, you won't pay bills, you have to get the drugs. to that, if you go on methadone, you have everything sorted out, you can now, from that stage, you can sort your life out because trying to score drugs and that, that takes up your whole life. Like, methadone would make so many changes in my life. Like, it's not going to cure me, it's not going to keep me off drugs, maybe it will, I don't know, but I'd be able to function. I'd be able to work. I wouldn't have to worry about scoring or nothing. My medication would just be there, you know, I'd get it each day and I could just, I could get a job. I could work, and I could be normal. Like, fuck, yeah, it would sort me out if I could get it. To me, getting on methadone is, because I need my drugs to survive, I'll die, I'll kill myself without them, I get too depressed and, I'll just end it, so, to me, it's like, if they, if I can get on the methadone I can pick up the drugs each day, I can, I don't have to worry about blowing all my money on it that I can spend with my family. It's always there and I can just be a normal person. I don't have to steal. I can just get my methadone each day and go to work each day and be normal. It would be so simple. **Alistair***

Although in Alistair's view, methadone treatment would help in him achieving his hopes for a normal life, the possibility of being maintained on it was not hopeful. In his town there was a two-year waiting list for people to get on the methadone program. In spite of several attempts to be put on the waiting list and being turned down, he still held out hopes for methadone. Tied up in his hopes for a place on the methadone program were his dreams of being able to provide for his wife and children, of being able to function, of living a normal life in which he could cope with work, and of having something better than what he had. To Alistair, the hope of getting methadone in the future served to create a future of possibilities that had meaning for him in his present and insight into how he chooses to be. In the following exemplar he reflects the possibility of a worthwhile future.

I tried to get on the methadone, I tried several times. It felt to me like, they just sort of, when I went there [A&D Centre] they just sort of listened to me and went, "oh,

*yeah, right". They didn't really take much notice of me really, like I would try to explain to them that I need to get on the methadone, I've been doing this [using drugs] all my life and how I feel, I need this to function, I've got a wife and kids, I've got to, you know, I've got to support them and stuff like that, I can't do it without the drugs, I can't just come off the drugs straight away and be expected to have a job and support my family and, you know, I need to get on the methadone but they wouldn't do it. It's hard to know why they didn't put me on the methadone. They wanted me to go away for 6 months to some treatment place but it was totally unreasonable. I couldn't do that. so yeah, I'm still hoping to go on it. I've been in there today, 10 times in the past two months and I keep trying to explain to them, you know, they don't understand. If I go to a treatment place, when I get out in 6 months I'll start using drugs again. I know I will. That's just how it will be. People get on it for the rest of their lives and for someone who is so fucked up, why not just give it to them, get them that way they can get on with their life and be a normal sort of a person and do stuff. Like, if I could get on methadone and even if I had to pay for it I would. Hell, yeah. it would still be better than what I'm doing now. Just knowing that I'd be able to get on it sometime would give me more hope that I could get on with my life, that I could understand what's happening to me, why I'm so fucked up. **Alistair***

To several of the participants, including Alistair, the replacement of illicit drugs with methadone, a prescribed legal drug meant a possibility of improving their future lives, their being with others, their health, their everyday well-being by removing the need to engage in criminal activities and be involved in other risky and chaotic behaviours that are characteristic of a drug lifestyle. Although these participants all held out hopes for a place on the methadone program, the long waiting lists meant that it was unlikely that such hopes would be realised in their immediate future. Just as several of the participants held out hopes for a daily dose of methadone which, to them, would mean a return to a normal and stable life, so too did several of the other participants hold out hopes for a drug free future, of learning to live without drugs. To these participants, being drug free was a future possibility, one that could emerge and take hold as they searched for a return to a more normal life. As one participant explained:

*I'm starting to think about it [life] without drugs. I guess I'm thinking about a career, a real career [laughs], being debt free, um, leading a responsible life, being happy, having a career, and it's money, honestly, I like to have a career as an A&D counsellor here in town. Yeah. but I've got to have two years clean time. If I'm not clean I'd be asking the clients to hand over whatever they're using [laughs]. Two years clean time. That's my goal, to kick drugs. yeah, I dream of the day. If I want to stop I have to believe that I can. I have to be ready. I've got lots of things to work through. It's 35 years I've been using. When I stop it's my goal to be clean for two years then have a career. **Trish***

Hope for a drug free lifestyle for Trish and for some of the other participants was a future aspiration, a belief that they could kick drugs when they were ready, this readiness being an elusive state which was not-yet, but yet to be. Many of these participants had in the past tried to kick drugs, but because they were not ready, the results were often catastrophic. To them, being ready meant not failing, feeling that they would be able to handle their fears of experiencing detoxification, withdrawals, and staying abstinent from drugs and that they would have the courage to leave their drug lifestyle and become a part of the conventional We world. In the following exemplar one of the participant's describes how being ready is not only a feeling that the time is right but also how being ready is an important aspect of looking forward to getting off drugs.

*I'd like to quit... in the near future, maybe. I've tried several times and it's very hard. Drugs have been a part of my life for a long time but I'd still like to be able to give up completely, but it's really hard. Sometimes I just think it's too much of a good experience to ever consider giving up for ever but I see the need for it, if the going gets rough to give my body a break, you know, just for the health aspect...but I guess I really have to be ready for it to work. like, I wasn't, I haven't really been that ready yet. It's sort of, I think I'll know when I'll be really ready. It's not like I would have to hit rock bottom or something, I'll just know, I think I'd feel it was time. Like, if I really want to get off drugs I'll have to be ready to do it, that's probably the most important part of getting off, knowing when you're ready. I'd know in my head that the time was right, you know, when I've got the courage to face everything, cold turkey, not using again, becoming a different person, you know, taking on a new identity in a different place so no one would know you and offer you drugs. I would have to move away, get away from everyone. **Lilian***

Part of Lilian's not being ready to give up drugs was tied into the good feelings she experienced when using drugs. At this point in time, the going had not yet got rough enough for her to leave drugs alone yet she could see the possibility of doing so sometime in the future when she was ready. Likewise, for many of the other participants, drugs had become a part of their lives. They wanted to use drugs, they did not want to stop, they were not willing to relinquish that which made life easier, that which formed a barrier between them and the unavoidable disappointments of everyday life, that which softened the harshness of everyday experience. In truth, it was only when the going got rough, when they felt they were overshadowed by a crisis, when there was a need to choose, when they began to suffer, that a cure was considered.

Caught in the paradox of their own feelings for drugs, the good experiences against the bad, the participants often failed to find the determination and volition to stop using. What they all hoped for was that they would really want to get off drugs, a future hope for a motive or a reason to stop that overpowered the compulsion to keep on using, something akin to a bolt of lightning striking them into a cure. Without this there was no hope. In the words of one participant:

What I hope for is some day I'll really want to stop. At this stage I don't. I could say that I'm too scared to stop, that I don't feel like I want to. That my life is actually better when I'm using than when I'm not. What I suppose I need is a reason to stop using, who knows, perhaps if I had something to work towards, I don't know. I sort of expect sometimes I suppose a bolt of lightning to strike me, electrify me into being cured... or someone to send me away, you know, a treatment place I suppose. I don't know. Anything's possible. Tui

For some of the participants, treatment was seen as a hopeful possibility. It was not that the participants really wanted to come off drugs but when the going got rough, when they were unable to keep themselves supplied, or when circumstances dictated, for example, arrest, illness, or some other crisis, then they either sought help or they accepted treatment as a last resort. Generally, seeking help to the participants meant the hopeful possibility of acquiring a prescription for drugs to help them through whatever ordeal they were experiencing rather than a hopeful possibility of a cure. Sometimes, if a doctor was not forthcoming with a prescription, a participant would feel angry, resentful, and bitter. Although coming off drugs was desirable for some of them, they did not want to experience the short-term distress and discomfort of withdrawing from drugs in the hope of achieving the long-term goal of coming off and being drug free. As such, there were always reasons, justifications, or explanations as to why they had a need for drugs and why a cure could not be faced. For the participants, drugs had impregnated their whole being and although some held out hope for wanting to stop, to kick drugs, it seemed like an impossible task. Any efforts to go without were marked by tension, fear of failure, indecisiveness, and lack of inner strength. Most of them needed a vision, a looking forward to a better life before they were ready to set off on the gruelling road to recovery as illustrated in the following exemplar.

I tried stopping several times and, yeah, I did, like when I was pregnant and when I went to prison, but after that, after I got back into it again, there wasn't any real reason to come off. Each time I did get off I worried about relapsing. Every where I

went I worried about relapsing and when I did relapse I felt really bad about it. It was like, like, I just didn't feel like I had any inner strength, I didn't believe that I could do it for good. I'd been using for so long, using was sort of etched into the fabric of my being [laughs], that's probably why I kept drifting back into it. It was hopeless. I don't think I ever really stood a chance. It was like, without something to look forward to, without a reason like being pregnant, I'd drift back to it. I used to hope that I'd be able to go without but I couldn't. It would all be wasted; the effort would be wasted because I drifted back to it. Anyway, now that I'm HIV positive, it's hopeless to think about not using. I don't see any point in it. I think if I wasn't HIV positive I'd probably go away for treatment, it'd be something that I'd consider, like I know a few people who have stayed clean after treatment, not all of them, just a few.

Eliza

Although Eliza no longer felt a pressing need to get off drugs because of her HIV status, she could see that having treatment was a hopeful possibility for others to get off drugs and stay clean. Several of the other participants had, at one time or another, received some form of treatment. For some, substitution pharmacotherapies such as methadone treatment, benzodiazepine treatment and morphine treatment had given brief hope for a chance to change their lives. However, for these participants, the substituted drugs were not the drugs of first choice. Although legally prescribed, substitution drugs, in particular, methadone, were just as addictive as their drug of choice. For the participants who held out hope of getting off drugs altogether, methadone maintenance simply turned out to be a protraction of their use of drugs, the only sacrifice being the high, the getting out of it. Admittedly, methadone treatment helped in removing some of the chaos from their everyday lives, was less risky, and gave them time out from the endless task of keeping up a supply. However, the tight controls around their receiving the drug, the daily pickups, the urine testing, and the side effects left these participants feeling disillusioned, frustrated, and let down. To them, methadone was a far worse drug. Not only did it take control of them but it also led to a dependence of greater intensity than previously experienced without any of the enjoyment. In the following exemplar one of the participants illustrates the disappointment, disillusionment, and frustration he experienced when he genuinely wanted to come off drugs and was prescribed methadone. Because of the legality of methadone, this participant experienced less risk and chaos in his everyday life but he still felt he was a part of the drug world. To him, the "once a junkie, always a junkie" prognosis was very real. In substituting methadone for opiates he felt he was still using drugs, in particular, a drug which had the frightening potential of hooking him for his

lifetime because of its ability to produce a sense of well-being. As such, the hopeful possibility of coming off drugs would not be a part of his future.

It [the chemist break ins, the robberies, etc.] was all getting to much, and yeah, so I wanted to get off drugs for good so I went into the A&D in [town] and [doctor] said to go on the methadone. The methadone would help me. I didn't know what methadone was. I guess they sort of wrote me off. That was it. The doctor got me on some dose of methadone that was just too much. It really knocked me around. Yeah, I guess it just built up in my body and I got used to it, you know. Because I had only been using 20 milligrams, 30 milligrams of morphine, you know, and I got on some dose that was just too much. But, yeah, then I got used to it, having it each day, but it was not a good thing, you know....when the methadone gets, um, it's a bad thing, that methadone. It gets into your bones and, yeah it's a bad drug. It's bad. You know, I still see it as, yeah, I'm still taking drugs but not methadone. It's just the governments, they gave it to me. I guess they handed it out, they decided that they were going to give it to me, shut me up, see if it kept me out of trouble. It was the lesser of two evils....but yeah, it's a bad drug. I was never going to get off drugs with it. It was like I was a junkie and I was always going to be a junkie to them, only they could control me now, keep track of me every day. Like I was still using drugs but it was like I was getting high from them so I jumped off the methadone . I told them they could stick their methadone and um, I was quite ill for a long time and I didn't have the strength or energy to do anything, to get out and get anything for ,you know, to help myself. Yeah, then as soon as I got it together I started baking the homebake. You know, you don't realise it until, I could actually feel a cloud lifting off my brain when I was coming off the methadone. I could feel my brain clearing. That methadone is a bad drug, it's bad what it does to you, like I went in to the A&D Centre to get some help to get clean and all they did was to give me something different to use that I didn't have to pay for. Where's the sense in that. Anything would probably have been better than the methadone. He [doctor] could have sent me off to a treatment place. That might have been better. Gerard

Gerard was not the only participant who was prescribed a substitution drug when he felt ready to set off on the arduous road to recovery, to come clean. A few of the other participants had similar experiences, and although not experiencing the same side effects and degree of control as Gerard felt, found that substitution of one drug for another was nothing more than a continuation of a lifestyle and a behaviour that they hoped to change. Unlike those participants who desired methadone or some other form of drug maintenance, these participants differed in that they did not want the maintenance; rather they wanted help in achieving abstinence. In his account, Ted stated that being sent to a residential treatment facility might have, in his view, been a more hopeful possibility in terms of his sincerity in wanting to get off drugs and looking forward to a more meaningful life.

In the past, some of the other participants had been to residential treatment facilities. For these participants, being in such a facility was not of their choice. Attendance was either the result of coercion by family members or mandated by the courts as an alternative to prison. Although seen by the participants at the time as a possible way out of their drug dependence, and as an opportunity to deal with past experiences that might underpin their chaotic drug use, their stay at the facility only served to strengthen their identity as an addict/junkie/druggie and further connect them into a wider group of more deviant drug users. The sense of having no choice, of not being in control, of being forced to seek treatment before they were ready led these participants to feel angry, hostile, and threatened. The residential facility was a place they did not want to go to, and despite some hopes that it might provide some direction and meaning in their lives, the participants only found disadvantages and disappointment. The following exemplar captures one participant's experience of being coerced into being in a residential treatment facility and the fear, anger, humiliation, and shame she felt whilst she was there.

Mum and dad were really pushing me to go away for treatment and I remember thinking that I wanted to stop, that it might be okay and I would be able to stop but I was just too, I was just too..., I learned that I was not really ready to stop but I ended up going, maybe just for them, you know. They were really pushing me to go away for three months.. I didn't like it, I found it very humiliating, shameful, it was heartbreaking to me. It was hard to open up and be honest about my feelings, about using drugs, about everything, especially because lots of the others there didn't want to be there too, and all they wanted to do was go outside and use. I hated it in the groups because most of them were men and some of them started to hit on me, like some of them kept trying to have sex with me. It was awful... lots of bad things were going on there, just because I did drugs I was treated like a whore. They thought, they always put me down and we were made to do things, you know, be in groups and that, that I didn't want to do. It sort of scared me, being there...//..I couldn't get out of it, I couldn't talk to people there, they were all religious, Christians, you know, give ourselves over to God if we wanted to get better. I didn't like the groups - hello, I'm Jenny, I'm a junkie sort of thing. It made me feel like I was being judged... and yeah, there were more drugs in treatment than there is in town. They were just there, you know, you've got a room full of users there that're hanging out so someone was going to do something, no one wants to hang out so everyone was using in treatment. I was in there for three weeks and it was like the worst three weeks I've ever had. I think I went four days without using but I didn't do it everyday because I sort of started feeling guilty doing it. I hated it. I shouldn't have gone and I hope I never go there again. It was horrible. I think the only way I'm going to stop when I'm ready to stop is to do it myself, cure myself when I'm ready. I just need something to hold on to, to focus on, a job or something, something more important than drugs. I have to do it

myself, I do dream about it sometimes, being clean, but not yet, sometime, but not yet. **Jenny**

As Jenny pointed out in her account the only hope for a cure is through one's self. One gets one's self into drugs. Others can help one, but for the journey to end, one's self can only stop it. However, as previously pointed out, one has to be ready, and believe that it is possible. For Jenny to stop her drug dependence journey she has to believe that she can possibly stop. To help her achieve this possibility she needs to have a vision of something better than drugs, some sort of future life, such as a job, to set her sights on and work towards. To her, having something to hold on to is symbolic of the worth of the dreams and aspirations she owns. Although not yet ready to stop using drugs and be clean, it is the forward looking dreams and aspirations Jenny holds that will provide her with the resolve to let go of the past and present and choose a different path for the rest of her life.

Residential treatment and drug substitution were only two of the hopeful possibilities the participants held for relinquishing their drug lifestyle and building something new in its place. In their accounts several of the participants told stories of holding out hope for recovery or a cure through having, in the past, engaged in 12 step programs (Narcotics Anonymous), psychotherapy, abstinence whilst incarcerated, hospital detoxifications, self help groups, counselling, and religious faith. Religious faith, a belief in God or a higher power was a commonality amongst some of the participants that provided a future hope of recovery. When they felt they would be ready to come off drugs, to clean themselves up, these participants believed they could find the strength they needed through their faith, their belief that something that was greater than and more powerful than them would get them through the ordeal of getting through drugs. Paradoxically, these participants felt that they had no faith in themselves but in hoping for recovery, a cure, they had to have faith in something, in God, or a higher power. Without this faith these participants had no reason to believe that they could possibly ever get off drugs, that a recovery was possible. Having faith, for them, was not only a feeling of hopefulness, a sense of relief, and an acceptance of God's plan for them, but also a feeling that they were powerless over their addiction, that for recovery they had to hand over their will and allow God to guide their lives. In the following exemplar one of the participants gives evidence of God's influence in his

life and his belief that developing a better relationship with God will lead to the possibility that he may no longer need to use drugs.

*I sort of think sometimes that it is God's way of punishing me for all the shit that I've done, it's like it's some form of penance or something. I never used to believe in all that crap, you know, God, heaven, hell, but sometimes I wonder if it's not real. It's sort of like you're damned if you don't and you're damned if you do. I wouldn't go to church when I as younger, I didn't have a conscience. I used to think that I couldn't ever do it, you know, give up drugs but now it's more like I know that when God wants me to stop, when he's stopped punishing me, then I'll know it'll be easier. I have to believe that. if I don't believe that, well, what's going to happen to me. like, I've got away with some pretty horrid things, I'm sure that's only 'cos He was watching over meyeah, I reckon when God's ready for me to finish being punished it'll be easy to stop using. You can't stop if you haven't got the belief that you can. You know, it's like I've chosen to believe in God now and I know He'll help me, He'll make it possible. I'll just have to get more of a conscience. I'll see what happens. **Timothy***

Developing a conscience was for this participant part of his forward looking, his waiting to see what will happen, his hope that life could be better without drugs, however, at the present time, it was only a vague expectation. What was important to him, and to several of the other participants, was their belief in a God, in a higher power, or something of a spiritual nature. This belief, to them, meant having a source of hope, encouragement, reassurance, and meaning for the future, an envisioning of the not yet, an anticipation of possibilities. In anticipating possibilities, most of the participants held out hopes for a cure for their drug dependence. Essentially, what they hoped for the future was that they would really want to stop, however, this wanting to stop was not yet but yet to be. As such, what their hopes revealed was that their drug dependence did not exist in drugs, it existed in their everyday lived experience, the situation in which each of them found themselves.

Because of the varied life situations of the participants, they experienced many situations, which commanded hope. Hope, for the participants, was a common experience in that it was a way of propelling themselves toward future possibilities in their everyday encounters with the world. Not only was hope an important way of becoming for the participants who found themselves looking forward in those uncertain life situations but it was also a chosen way of becoming and being that was a part of the everyday looking forward to something. Hope, in the form of dreams,

wishes, aspirations and beliefs, gave birth to a certainty that life was worth living at the present and in the future.

As such, the participants' hopes, dreams, and aspirations became a constitutive part of their being, a part of the background that brings forth understanding, understanding being the taking hold of possibilities, the stand the participants take on their own being (Dasein), in terms of the ways in which they take care of, make sense of, or deal with the possibilities, the everyday choices or actions which are available to them. Through making their choices and acting, the participants became what they are, the kind of being each one is, that their lives will be seen *in the end* to have had some meaning, some significance, to add up to something. Whilst hope had to come from within the participants, others were important in fostering their belief in an unknown future, a future in which there were hopeful possibilities regardless of what has been. The living of hope, for the participants, revealed itself as a way of becoming and being, thus, it is an experience of drug dependence.

In his work, Heidegger (1927/1962) suggests that for something to become meaningful for one's self, it must be seen as a possibility. For the participants, the hopes and dreams they fostered and cultivated were all unfolding possibilities, each of which provided insight into how they chose to be and served to move them forward into the future. For Heidegger, it is in taking a stand that one becomes what one is, that one's life will be what one freely determines it to be through the choices one makes among the possibilities offered, one's innermost potentiality for being one's self, one's existence in the world. Such is the significance of care.

Reflections of self in the world

In Heidegger's (1927/1962) view of things, understanding, taking a stand on one's life, Dasein, is a projection of one's self towards a possibility of being, a projecting or a casting of one's self into a role, a lifestyle, a relationship that gives significance to one's life. This casting of one's self into roles, a projecting in terms of possibilities, is to Heidegger, a self understanding, a choice of self, a competence with one's self, an ability-to-be, to play one's role, to act. According to Heidegger, whenever one acts,

one does so in accordance with some role that one has thrown one's self into, this role being for-the-sake-of-which. For Heidegger, the for-the-sake-of-which is a way to be Dasein, to be Dasein is the point of one's actions. When one becomes a drug user, one tries to accord with the role of a drug user. One's specific actions, for example, getting the money and scoring the drugs, are instrumental to using drugs. Essentially, the role that one plays as drug user is for-the-sake-of-which, one uses drugs as part of being drug dependent. Thus, in acting, one constitutes one's self as whom and what one is. In using drugs one constitutes one's self as a drug user, a deviant, an outsider living a particular lifestyle. As Heidegger (1927/1962) sees it, "the-for-the-sake-of always pertains to the Being of *Dasein*, for which, in its Being, that very Being is essentially an *issue*" (p.84).

Thus, to Heidegger, the kind of Being one is, the kind of life to be lived, is presented to one as an issue, and one is called to understand, to take a stand on that issue. As such, in this study, part of the participants' self understanding is the casting of themselves as addicts, druggies, junkies, outsiders, members of the *Them* group, society's deviants. To cast themselves into such roles is to take on the norms and values, both in the sense of connecting into the drug lifestyle and in the sense of holding themselves to it. In casting themselves, understanding themselves as drug dependent people, and holding themselves to it, the participants shape themselves. Through their choices and actions, the participants take their stand, they make of their lives what they freely determine, create the meaning of their existence, and take responsibility for what their lives add up to in the end. As Heidegger (1927/1962) puts it: "*In each case Dasein is mine to be in one way or another. Dasein has always made some sort of decision as to the way in which it is in each case mine [je meines]. That entity which in its Being has this very Being as an issue, comports itself towards its Being as its ownmost possibility. In each case Dasein is its possibility.*" (p.43).

As stated by Heidegger, the existence of Dasein, the being with which Dasein is concerned is always its own - *mine*. As such, the essence of one's being lies in its existence, in one's choice of the possibilities that are open to one such as to be drug dependent or to be drug free. In taking a stand, one projects one's self into one's chosen possibilities, every choice made forming part of one's stance. In making such

choices, however, one does not always do so in consciousness of their significance and value. Rather, one merely engages in everyday preoccupations of everyday life. In the first place and for the most part, one chooses from among those possibilities offered by the conventional world, the world of publicness, of everyone. One merely acts as everyone does in a similar situation. In acting this way, one is in a state of fallenness. One is so preoccupied with the concerns and necessities of everyday life that one falls into acting in such a way as not to be one's self, but in a way that is in accordance with everyone in a specific social and cultural situation. Through their preoccupation with drugs and drug using, the participants in this study took on new ways of acting in accordance with others in a social climate favourable to drug using and a drug lifestyle. One essentially becomes lost in the ways of those who are there in everyday Being-with-one-another, the anyone, the *They*, and as such, in making everyday choices and acting, one fails, at times, to realise that one alone is responsible for the source of significance for one's life.

Falling into the anyone, into acting and encountering things and others in the ways anyone does, in choosing one's self from possibilities which are for the most part anyone possibilities is inauthentic existence. While in an inauthentic mode, one chooses and acts in the normal and customary ways of others to whom one wants to conform to, a commonality of being, basically, one leads one's life according to the way things are understood and done by others amidst whom one finds one's self. For many of the participants in this study, being connected into a different group of people, the *Them* group, and acting as they act, served to provide a sense of identity about their own being-in-the-world, their situation. Authentic existence, Heidegger's other mode of existence begins when one recognises one's own freedom to determine one's own individuality as potentiality-for-being-in-the-world, a set of possibilities yet to fulfil. As an authentic being, one's concern with the world becomes authentic concern, a necessity to realise one's own uniqueness, to fulfil one's real potentiality in the world and take responsibility for one's life rather than the mere concern of inauthenticity, to act in ways which anyone acts, to live as others live, and a blind acceptance of being caught up in the ways of anyone, and the failure to acknowledge this acceptance as being of one's own choosing. Authentic being, for a few of the participants, occurred

when they could deal with the reality of their drug dependence, when they took responsibility for it as being of their own choosing.

For Heidegger, an understanding of authenticity and inauthenticity is grounded in a consciousness of death, that one is a Being-towards-death. Death, as a possibility is not just one possibility, it is also the possibility of there being no more possibilities. At death, being comes to an end, there is, after death, no longer any future possibilities since one is no longer a Being-in-the-world. In an inauthentic mode of existence, one's attitude toward death is that it is something that happens in the end but now has nothing to do with one and one need not be concerned with it. Death is hidden from one by one's everyday preoccupations for the necessities of being and by one's concern for the anyone, the They and the ways in which they act. As such, one avoids facing one's own death and in doing so fails to face the uniqueness of one's self. For many of the participants, death was an ever-present possibility, one they encountered daily yet one they were not concerned with or wished to consider. To them, death would happen when it happened but at this time, drugs took precedence over all else, death included.

Living authentically does not necessarily mean acting in a different way, more so it involves a different understanding of one's death. To view one's death authentically is to see it as the end of one's possibilities and that no one is free to determine all possibilities that come before one's unique death. To choose acceptance of death is to identify with it, to break away from the anyone and their preoccupations with the present, to look at one's life as a totality, a wholeness that is not yet complete until death. Unlike most of the participants who chose not to be concerned with death, a few of the participants welcomed death, yet death had not yet come to them. Paradoxically, for one participant, death was his life. He lived it every day, and as such, death shaped his whole life. Because he was living death, he had made an authentic choice about his own way of Being as illustrated in the following exemplar.

As far as I'm concerned I died when I was 10. I've just been walking around ever since. I'll be 44 years old in a few days. I've been dead since I've been 10. I've just given up...//... I'd been told by, you know, doctors, heart specialists, all those sort of people that knew it all, you know, if you don't stop using you'll be dead before you're 20 [after being in hospital for overdosing on heroin several times]. I told them that

more and more it might encourage me. That was before I was 20. I just didn't care really. I was indifferent. I suppose 'cos of the fact like I said, you know, to me I was already dead anyway. I died in that shed when I went to get that rifle and shoot myself. I mean, I was already dead anyway, I was already dead. I've been dead for 23, almost 24 years. Tony

For Heidegger, authenticity and inauthenticity are each modes of Dasein's taking a stand, each revealing the possibilities which one is free to determine upon and each signifying Dasein's finitude. Essentially, the difference between authenticity and inauthenticity is a difference between kinds of self-understanding. No one individual is wholly authentic or inauthentic, one either exists authentically or inauthentically at different points in time depending upon the situation in which one finds one's self and the attitudes or moods with which one faces the situation or are constituted for one by one's situation. In considering the way in which one experiences a situation, be it with fear, anxiety, dread, uncertainty, responsibility, one can uncover the meaning of one's situation, one's experience in the world. Neither mode of Being signifies any less Being, rather, each reflects one's relationship with self, things and others, one's mineness, one's concern, and the role that one has in one's experience of Being. According to Heidegger (1927/1962), *"As modes of being, authenticity and inauthenticity are both grounded in the fact that any Dasein whatsoever is characterized by mineness. But the inauthenticity of Dasein does not signify any "less" Being or any "lower" degree of Being. Rather it is the case that even in its fullest concretion Dasein can be characterized by inauthenticity - when busy, when excited, when interested, when ready for enjoyment"* (p.43).

Basically, for Heidegger, inauthenticity and authenticity as modes of Being constitute one's existence. They are necessary to the understanding of Being, to one's relationship with self and others. The meaning of one's situation can only be uncovered by considering who one is in the world, by examining one's attitudes or moods, by acknowledging the choices one makes and through accepting responsibility for one's own choices. Through reflection on one's existence in the world, one's mode of Being, one may open one's eyes to one's situation, one's uniqueness, that one alone is responsible for what one's life adds up to in the end. For Heidegger, the necessity to realise one's own uniqueness, that one alone is responsible for the significance in one's life, to fulfil one's potentiality in the world is a call to authenticity. However, in the call

to authenticity, the realisation and acceptance that one is alone, that one is the source of significance for one's own life, one experiences anxiety, *angst*.

In experiencing anxiety, one can either face up to the finitude of one's existence, that one has only so much time in which to either flounder or live a life that has meaning; that adds up to something in the end or to drown one's self in everyday insignificance, in altered states brought about by drugs, in being caught up in the way others see one, the labels attached to one by the others, the world at large. Reflection on and recognition of one's total responsibility for taking charge of shaping one's own being can lead one to care about Being. In caring, one discovers one's self as one for whom the kind of life to be lived matters and is an issue. One is called to take a stand on the kind of being one is.

For the study participants, the experience of being drug dependent meant looking at who they were in the world. An acceptance of the reality of their own existence, of their freedom of choice led many towards an authentic mode of Being. However, recognition of their situation then became such that it, at times, seemed all too fearful, uncertain, unbearing, and anxiety producing. They then rejected authenticity and moved into an inauthentic mode of Being where there was no significant meaning to life, no clear purpose for Being, no certainty other than their thrownness and the possibility of their death. At finding themselves thrown into such an uncertain situation they then gave way to the experience of overwhelming anxiety, then in choosing inauthenticity, they then found that through drugs, they were able to convince themselves that their existence was once again more meaningful, leading them once again to an experience of authenticity. In the words of one participant:

If I don't have my drugs I can't think about anything, anything at all except getting my drugs. I get so occupied with them. I can't stop thinking about them, you know, getting them. I don't think about anything 'til I've got them except getting them then I suppose, it's only then that I can even think about anything else, like just ordinary stuff, like, what I'm going to do for the rest of the day, getting my family back, looking for a job., how fucked up I really am, not doing anymore crime....yeah, when I'm hanging out I only care about getting drugs. I don't care about anything else...when I've had my taste I'm right for the day. I can think about why I'm a druggie. I think about it [taste] being the last one, you know, "that's it, no more, last one." Then....., I suppose it's like that tunnel I talked to you about, you know, when

you haven't got any drugs there's no light there at the end. You can't see a light at the end of the tunnel when you've got no drugs. you know there's a light there, it's hard to see one so you keep on using just so you can see the light.....but, yeah, when you have the drugs, you're, it's not as if there is a light at the end, you have the drugs and you just don't think like that anymore, your whole thought, your whole way of thinking is changed. As soon as you've got that feeling, soon as you've had your taste, you think differently. It's just all different. Alistair

Like Alistair, many of the participants found that their drug use brought about short-lived experiences of authenticity, a feeling of being in charge of the way in which they were living their lives. However, when the effect of the drugs wore off existence once again seemed all too unbearable, threatening, uncertain, and anxiety producing. Their actions and choices were once more directed by the necessary concern and search for drugs. Through such experiences, the participants are called to face up to their lives as they are, their position in the world, the truth about themselves, the fact that their choices determine their fate, and that they alone are the source of significance for their lives. Accepting the need to face up to such realisations is, for Heidegger, part of the challenge of authentic existence. In reflecting on their lives, all of the participants found that their experiences of becoming and being drug dependent have had a significant effect on their relationship with self and with others, that while drug dependent, being in the grip of particular relations and preoccupations, their Being-with-others was often uncertain and problematic.

Through their experiences, their connection into the *Them* group - those who do not meet society's normative categories concerning the use of mood altering drugs, their drug lifestyle, the pursuit of drugs, and their drug using friendships, the participants acted in ways which differentiated them and distanced them from the *they*, the others, the straight people in society. Being different and distanced from these others was both disturbing and of concern to the participants. As a result of these differences, of being set apart from those who are there in everyday being-with-one-another the participants experienced many consequences, contradictions, much contempt, censure, and condemnation. Much of what the participants experienced as a result of their drug dependence, their being set apart from others in society, has its roots in historicity - all that which is handed down by culture, a shared background that is inherited from the past that affects the present and future.

As previously discussed in Chapter VI, inherited understandings of drug dependence in our society have generally been negative and moralistic toward drug dependent people. Such attitudes held by others in society have mostly led to societal rejection, stigmatisation, and prejudice of those who are drug dependent. In their accounts many of the participants acknowledged the effects of stigma and prejudice. To them, the societal negativity and the social prejudice they experience in their everyday lives as dependent drug users is in part attributable to inherited understandings of the past, the widely divergent views held by others in society at different times in history, attitudes influenced by religion, medicine, witchcraft, law, and other forms of socialisation. In the following interview extract, one of the participants describes how the negative views held by some nurses towards addicts, attitudes derived from a historical understanding of drug addiction as moral weakness or lack of will power, have directly influenced the care she has received in a health care setting, how *they*, those others in society who hold negative views towards addicts foster and perpetuate stigma and prejudice, and how *they*, through exploration of their negative views, education and training can develop a more positive and non judgmental attitude toward addicts. For this participant, historical understandings of drug dependence passed down in our society also led her to experience feelings of rejection, resentment, shame, frustration, and worthlessness when receiving care from health professionals. In her words:

...like when I ODED. I woke up in hospital and all these people rushing around and I thought what the hell's going on. The nurse said I'd ODED, that I deserved to die, that all drug addicts are sinners, weak willed, that they were scunge, and it was, like, oh my God.... I can still remember her words....I felt bad, like I'd done something real bad. No one knew about me up until then, that I used, like, I'd just woken up in hospital and I had this self-righteous bitch of a nurse throwing this crap at me. she made it more than obvious that I was trash, drug addict trash, like, when she put the needle for the drip in my arm she pushed the needle in twice pretending she couldn't find the vein. She bruised my arm badly and... ..every time she came near me she'd make, she'd make the sign of the cross, told me she was praying for me. I heard her telling the others I was a junkie, really loudly, that I should really have been left to die rather than have taxpayer money spent on me. it was, like, you know, she kept telling the others that drug addicts shouldn't be there in hospital, that they didn't belong there. Then I started noticing the others acting like her. It was like they all followed her. It made me feel like curling up with shame. There wasn't anything I could do about them. I just kept thinking that I was a human being like them, that I was someone's daughter, that they needed to look at themselves before they judged me. it was like their moralistic attitudes were affecting their being nurses. Like, I bet that's not the training they got to be nurses. Yeah. it was awful, it's not like I didn't

already feel ashamed of what had happened, I just didn't need all their morals as well. I really feel like I was being judged by them and I couldn't do anything about it. I couldn't change the way they thought. They really need to learn some compassion, some different ideas about drug users because all they did was make me feel like I wasn't part of the, that I wasn't good enough. Eliza

Through concealing their drug use from others, Eliza and several of the other participants had made an attempt to belong to the others' world, the society in which they lived. However, because of their illegal drug use, their connection into a different group of people, that of drug users, and the social stigma and prejudice against them, they were aware that they were different from the others, that they would never totally belong, not while drugs took precedence over all else. For some of the participants, an understanding of the many difficulties experienced as a result of their experience of drug dependence interwoven with living in the world of the other, the *they*, led them to see, that in their social situation, they acted in ways as not to be themselves, rather, to be one of the anonymous *they*, anyone. To recover the selves they had lost by acting in ways in which anyone acts, a different way of being was called for, a taking charge of their existence or not, a resolution for "*choosing to make this choice* - deciding for a potentiality-for-Being and making this decision from one's ownself" (Heidegger, 1927/1962, p.269). in many ways, realisation of the differences and difficulties of their lives was, for the participants, a call to be one's self truly, to be free to choose one's destiny, to be free from the convention of *das Man*, to be creative of a future.

In their realisation of the differences and difficulties of living in a *We* world, many of the participants had an awareness of the way in which they kept hidden or disclosed their being-in-the-world as drug dependent. According to Heidegger, the nature of one's Being is disclosed or covered up through language. Language is something that everyone is born into, a phenomenon of one's being-with-others in a cultural world, a product of *das Man*. Whatever can be understood can be expressed through language. As such, language uncovers and calls attention to what is there or obscures what is there by covering it up with itself. It is, according to Heidegger, the key to authentic or inauthentic existence for it is in language that one best understands one's possibilities, one's being-in-the-world and being-with-others.

In their accounts, some of the participants reflected on the ways in which they communicated with others. For most of the participants their everyday conversation with others was inauthentic, idle chatter that communicated nothing about the very essence of who they are. For them, idle talk, or chatter (Gerede) as Heidegger (1927/1962, p.168) calls it, was everyday talk, an exchange of superficial information and gossip merely passing on that which everyone already knows. Basically, everyday talk was about drugs, where they came from, how they were used, the effects, where they could get them from, how much they cost - chatter, but not altogether meaningless for it revealed their being in the grip of particular relations and preoccupations in their world. Such chatter, or gossip, preoccupied the participants with trivia in such a way that they were unable to open themselves up to working out their ownmost possibilities, their potentiality-for-being. It was, however, a necessary part of their everyday life. To these participants, talking about their drug use was a way in which they could feel accepted, feel as if they are somebody, feel valued, feel as if they belong. Through such talk, they also received the message from others that there was something fascinating, fulfilling, and satisfying about drugs. As one participant expressed it:

I go and see people from time to time that I know, you know, like the people that I buy certain drugs off. I'll go and see them because they use and I use the same drug. I suppose they're like my friends, use the same drugs. we talk about what we're using. Talk about the drugs we're using. We spend a lot of time talking about them. Um, always looking for new ideas and new thoughts and something like that. how we can get more of them. Yeah. the ways, better ways of cooking up pills so we can get more out of them, or, oh, this helps, if you have this taste and you take one of these this helps, this is heaps better, try this, this is a totally different stone, and, yeah. when we are talking about different ways of cooking up a taste and what to use on top of it sort of thing. You know, which veins are the best ones, drug oriented talk. Which doctors are good, um, which individual person, the best one out of all the people you can score off, um, the effects of one drug mixed with another, the pros and cons of mixing different drugs and what the different drugs, what certain drugs, um, try to read the New Ethicals and committing it to memory. Yeah, it's like, um, most of the conversation would be drug related, drug related activities. Pretty much basically drugs, yeah, what to do. It's, um, like two people who play soccer, what they talk about, people who fix old cars, old cars, what do they do when they go to the pub, talk about old cars. Yeah, if you use drugs that's exactly what you talk about. What we can all get. What to do. Like, the other day, somebody was trying to world out why he was always getting a dirty taste out of this certain pill and nobody else was and the bottom line was because when he was washing his fit out he was sticking his lid back on and he had water from washing it out in the lid and it was infecting his needle and he

didn't realise it, so yeah, we sort of, we work it out, like if somebody gets a dirty taste e try and work out why they get a dirty taste so it won't happen again. Steven

For Steven and most of the other participants, their common chatter, their drug talk, characterised the way in which they are there, in an everyday manner, in a world of their own making. They, however, also lived in a world of the others' making, a social world with mores, codes and laws, in which they interacted, a world in which others determined, in general, how one behaves and the way in which things are done. In accordance with being in such a world, many of the participants understood the way in which their lives were constituted by the choices they make, have made, and will make, and that through their choices, they choose the way in which they give meaning to their lived experience. Essentially, the participants are free to make of their lives what they freely determine upon, a freedom which is theirs to act upon, albeit within the limitations of their facticity, their thrownness, the situated givens about which they have no choices. In the following exemplar one of the participants expressed his beliefs about his capacity for choosing his behaviour in a given situation and how he recognises that his freedom does not lie in whether or not he has the ability to determine what happens to him, rather, it lies in the way he experiences the events, his interpretation, and the significance and meaning he gives to them.

Because of archaic laws we don't have freedom. We don't have a lot of control over the laws that have been put in place. You know, look at it historically. Drugs are illegal because of racially motivated reasons and I do not agree with it. I don't see why pot should be illegal because we don't like Mexicans. You know, opiates are illegal because we don't like, we're not supposed to like the Chinese. They're stupid reasons for making a drug illegal and I have absolutely no interest in those laws. So yeah, I'm open about my drug use. I use drugs because I want to, not because someone says I can't. The Government tries all sorts of things to try and control us but I'll not march to anyone else's beat except my own. I do what I want, when I want, how I want, and I find that the law bends to allow me to. They try and make us do what they want, take away our freedom to choose by impinging all these archaic laws on us. Anyone who is different, who doesn't fit into their mould, they put restraints on. Like, I was busted with pot end of January and I used the ICCPR [International Covenant of Civil and Political Rights] defence. I always use it. I always use it because it's true, and the possibility's, that one day, the UN comes out and says, the Misuse of Drugs Act is being illegally applied in this country. Like, they can't use their Misuse of Drugs Act to stop me. they can't take away my freedom to choose whether I use drugs or not. It's what I decide for myself and it doesn't matter how many times they bust me, you know, they can't control me. they might be able to fine me, it was \$600 when I got busted with pot last time but they can't change the way I want to be, if I want to use drugs, I'll use them, but I'll use them knowing that I live in this society and there is always a possibility of their enforcing their laws on me but they can't

make me march to their beat. Pretty much I just want to be left alone and do what I want with my life. If I want to sit around and do nothing, use drugs, listen to music, and be different, that's what I'll do. **Hugh**

For Hugh, maintaining an independence of thought and action, feeling in charge of the way his life is experienced and recognising his individuality is authentic living. For the other participants, the call to inauthenticity is in understanding and acknowledging their freedom of choice in their experience of the world and in their awareness of their differences from others in society by way of their drug use, drug using friendships and drug lifestyle.

As beings-in-the-world, the participants were caught between falling into inauthenticity or finding their way back to authenticity. In falling into things of the world, into drug dependence, in wanting to be like others, both drug users and non drug users, the *they* of both worlds, the participants were involved in inauthentic being, covering up their potential for authentic being. All of the participants lived inauthentically most of the time, living under the force of habit, doing as everyone else in their world does. Through understanding and awareness of their differences from others and their freedom to choose, some participants were called to an authentic openness, an innermost potentiality for being themselves. In experiencing authenticity these participants took a stand on the kind of being they have in their everyday lives. For Heidegger, this way of being is how one comes to understand the truths of one's life, one's being-in-the-world.

As the participants revealed their thoughts related to reflections of the kind of being each of them have, they spoke of their vulnerabilities, their uncertainties, their hopes, their insignificance in relation to the overall picture of life, the things about which they cared for, their struggles to gain meaning from their drug dependence, and the mystery of what was to become of them. In the act of exploring reflections of self in the world, the participants endeavoured to find meaning in their own lives, to create new possibilities for themselves, to take a stand by choice of self. In doing so, they voiced definite thoughts as to where they hoped their lives would go, a vision of things they might be doing, what would unfold with time, a looking forward. In looking forward,

it was with the recognition that it could be negative as well as positive as expressed in the following exemplars from each of the study participants.

*I can't imagine life without being stoned. I just don't think I'd enjoy it. Like, there's always going to be drugs around so I guess I'm always going to use drugs. If there weren't drugs around then I'd just get over it. That'd be life. You know. But me, myself, I just enjoy using drugs, yeah, and I'll keep on using them.... Yeah. I suppose I'd like a bit more money, like I say \$300 a week or something, like \$400 a week. I'd be rapt with that and um, I wouldn't mind travelling one day. I'd like to travel around the world and catch a couple of countries or something. I could just have a look and see what the rest of the world's like. It'd be good, but yeah, I'm quite happy with my lifestyle the way it is at the moment, yeah, I enjoy using IV drugs. I'll probably keep on using them for awhile I'd say. Until it becomes more of a problem and then I'll sort of have to ease off, mission off, yeah. **Herman***

*I have thought about cutting the drugs out. I've sort of gone through it in my own head like weaning myself off. But like, I'm addicted, I'm sort of, I've got an addictive personality and if I stopped I'd be back to square one. Yeah, I'm going to give it three years then I'll give it a go. Drugs are very important to my life. They're very important, um, because I'm addicted, I have to take my medication, you know [laughs]. Yeah, like I sometimes wonder just how I'd feel without them, if I'm, like if, if I'd feel the same way without anything in my system, you know what I mean, would I feel like this without drugs in my system, like I don't know. I don't know if I would have to have something else to be addicted to. I don't know. I'll just have to wait and find out. I'm just not ready yet. **Angus***

*When you take hard drugs it's your whole life, your whole life is involved in it. It is your whole life. There is no room for anything else. You can't go without. As a way of life it is hard to get over. It's all bullshit. People who take drugs, they've always got good plans and that, oh, I'll go and do that, I'm going to do this. Good plans; but they never go through with them. Big plans about everything. Oh, I'm heading up north. Oh, I'm going to do this. Oh, I'm going to do that. They do it all the time. But there's nothing to look forward to. It's all bullshit. You're just consumed by the whole thing of getting it, doing it. You can't get your shit together when you're like that. I haven't got a fucking future like this. I just know I haven't. **Alistair***

I intend cutting down next year. I can't say that I'll quit altogether because, 'cos I just really like getting out of it as a recreational deal for the mind, that sort of thing. But, um, it just takes up too much time and money if you're doing it all the time and you don't get to, you don't get to put your mind to other things, you know. Like, I reckon if I had a partner then I probably wouldn't be so dependent on drugs. I sort of think about meeting someone and having a family. That's all I want to, that's all I want in life. That's all I want, to have a family of my own. I think that, by the time I actually do find a woman and ready to settle down and have a family, I'll have to, um, cut right down on the drug taking. Yeah. It'll just be once in a while sort of thing. And yeah, I want to finish at university. I'm going to go for a BA in psychology and criminology, double major, I know I've got the intelligence to do it. It's just a matter of putting my mind to it, you know, like sort of breaking out of the cycle I'm in at the moment. Just putting my mind into other activities, like I want a real career, fuck this

bullshit stuff. I want to put on a fucking suit and tie and all that and present myself to the world and, you know, sort of be someone [laughs] rather than just carrying on the way I have been. Wayne

I don't really think about the future. I don't know about giving up. I think I'll give up when I give up. Like, it [opiates] controls you and it doesn't, you can't control it. It takes over your life. You get addicted, um, you actually need to do crime to support it. It's not good [laughs], it's not a good thing, it'll kill you in the end, it'll kill you. Like, my body feels it now. I feel like I'm about 40 sometimes. I don't think I'll live that long. No. I think I'll wear out pretty quick, I'm starting to now. I'm pretty worn out already and I think it's because of the drugs I've been using. Yeah, definitely.. sometimes I think about giving up, sometimes I think about going fishing again, yeah, I have actually quite a lot, I mean I was thinking, yeah, I'll go fishing, but fishing would be a lot more exciting if you're stoned. It will just get boring to me without being stoned. I like doing drugs and I like being stoned so yeah I'll probably find it hard to change, to give up, to do different things. I guess I don't really want to. I wouldn't know what to do. My whole day is taken up, um, you know, scoring it, growing it, looking after it, getting stoned. That's my whole day right up until I go to sleep. Steven

*I've been down that road [drug dependence] for 27 years, it's a well beaten track, like I said, I have the desire to stop using....yeah, I have the desire to stop, probably because of my age. I've thought about it, giving up many times, like, I've been robbed for want of a better term, of 27 quality years of life. I won't get to 60. I won't get to 60. I can tell you that much now. I might get to 50. I'll get to 44 next week and take it from there...even though I've got the desire I don't think I'll stop using. I don't know. It may sound like a contradiction, you know, if, like I said, if, you know, if drugs happen to kill me, I'm certainly not going to kill myself, you know, life's a God given right, no one's got the right to take anyone's life, any type of life, you know, God gives it, God takes it away and I'm not even religious, so yeah, I'll just keep on doing what I'm doing. I'll never top myself, can't see myself doing anything different at the moment, you know, even though I remember 20 years ago I would have said the same thing. Um, you know, I know that deep down underneath there has to be, **Christ**, there has to be something better than this going on. **Jesus**. There must be something **better** than this, there really must be...I just don't know where to find it. I just don't care any more. My life doesn't matter. My value is not important. I've nothing to replace my drugs with, that's basically it in a nutshell. Tony*

I've never really thought too much about my future. It's always been a sort of a day to day existence for me, it's like, this is more so in the past than now. Now, I'm sort of starting to think about it, you know, my options, it's more of a I don't want to give up, phew, burn my bridges basically....having said I don't want to give up doesn't necessarily mean to say that I'm going to keep going either, like, I don't know. At this point I'm not entirely sure what I'm going to do but I certainly think at some stage or another in the not too distant future I will have to make a decision either to distance myself from the lifestyle or not, and if I chose not, then it's going to be that and probably I'm going to, um, I don't know, um, maybe I'll use, maybe I won't but it's a pretty good chance that I will. Like, while it's sort of, like, if it's not working then I might have to stop completely and I don't want to because it [opiates] does have it's

*uses like any drug does. You know, it's a great pain killer and it helps me relax....I don't know as far as the future goes, I can't see me stopping, ever, I suppose it has to be a choice, you have to choose to, yeah, to stop drug use it has to come from within. Definitely. You **have** to want to. No one can make you. So yeah, who knows what the future brings. **Brian***

When I left home when I was 15 and went to live with friends I didn't know that I'd be living here today. Like, my life's been fucking shit from the day it begun. I didn't want a life like this. I wanted it to be better. Like, I've been raped and beaten up. I have some cunts put knives to my throat and all my things stolen, stolen even by so called friends. You know, I look in the mirror at my empty eyes thinking that life could be better, that it could have been better but I guess it didn't happen because my addictions too strong. I think about killing myself but I haven't done it yet. I don't know if I will. I suppose in a way I am with drugs. I don't really think about much at all any more. I just want to be left alone. I don't know what I want out of life. I don't even think about what's ahead of me, all I know is that it's probably just shit. I don't really care any more. I don't care any more. You don't care when you use drugs. I only stay with [boyfriend] because he keeps me supplied. It's not much of a life is it?

Veronica

*When I think about my life it's been a waste of time really. I'd do, I'd do lots of things differently. I think I would have stopped , or backed off, quite a while ago when I started getting in trouble, you know. The drugs just sort of kept taking me further in to, I couldn't stop, I couldn't get off. These days I have nothing but problems, you know. I don't, I don't know what normal life is any more. If it's bills and things I don't like it, I don't like it. I don't like normal life. I really don't. I've never led a normal life, or a so called normal life. And I don't think I could do it anyway. Yeah . if I had a choice of doing it all over again, or parts of it again, and leading a normal lifestyle, I'd probably do what I've done again, parts of it. I can't see myself doing anything different, not now. I'll just keep on the way I am. Yeah... I don't know, life's strange. I just like drugs, I like the lifestyle. I'll just keep on with it I suppose. Just not let it get too out of hand. **Gerard***

*You haven't got a fucking future when you're a hard out junkie like me, eh. I'll either end up 6 foot under or doing a long lag 'cos some cunt's put me away. Fuckin' live for today, that's my motto. 'Cos you might kick the bucket tomorrow. Gotta live your life today, fuck tomorrow, as long as you've got some junk to use who gives a fuck. Who gives a fuck about what's happening as long as you've got something to keep you going fuck tomorrow? **Dan***

I don't know if I'll use for the rest of my life or not, I don't know....like sometimes I feel real restricted , there's lots of things I'd like to be able to go out and spend money on and that but I can't do that because I'm spending money on my drug habit. The morphine restricts you, what you're spending you're money on and that, like, you know, I like buying records and that. I haven't been able to buy a record for months, you know. Supporting a habit makes it hard, but yeah... I don't know, I wouldn't mind having a family one day. Like if I started a family it'd give, it'd give me a reason for getting away from it. I don't know. Maybe I'm a bit more passive through my drug use, it's given me clearer vision I suppose, sort of, you know, makes me sometimes

think about my life, where it's going. I suppose I've got to sort my head space out, find out where I'm going...I think about where I'm going and why I use drugs, I suppose drugs are my friend. They give me confidence, they comfort me, they're there and when they're not there it's a real cunt. Yeah, I guess they're my friend so I'll probably keep on using them. That'll be what happens, I guess that's, that'll be my future. Paul

I dream about the day I'm not a druggie. I'm starting to think about life without drugs. I want to come off the pills. I want to address my benzo addiction. I guess I want to think better but it'd be hard. I guess I still use them because they help me feel normal. If I didn't, I don't know what I'd be like. I think I'm more serious about thinking about giving them up. I guess I've got to be if I want a real career and want to be responsible. Like I told you, I want a career. I want a real career. I want lots of money too [laughs]. Yeah, I think I'm more serious now. Trish

Maybe if I didn't use drugs I would have more time, free time, you know, to study. It's just impossible, virtually impossible to do any study when you're using drugs. Yeah. I think about it. I'd like to give it up for about two weeks, three weeks or something, just to give my body a break, but at the moment my health is okay, so I suppose it's [drug use] not affecting me that much. I can see myself using pot and opiates, you know, recreationally forever. It [drug use] hasn't really given me too many problems this far so I can see it, I can continue on with it, I don't know, until the end of time [laughs]. I don't know, it depends on the circumstances. I see drugs being there, I can imagine, like, maybe they'll always be there. It just depends on the people that I will be associated with. Yeah. Apart from the drugs I'd like, I'd like a career as a journalist very much. I'd like to, you know, be a journalist, I think I told you that. Maybe a relationship, a relationship that I'll be happy in too. It's easier, you know, easier, drugs make it easier, in a relationship if you have the same views on drugs and drug use, someone whose habit of drug use is the same, the same drugs, then you can share. Yeah. You know, using drugs is not a bad existence. I could have it a lot worse than I do now. Lilian

I take drugs because I want to enjoy the effects. I've always found them a help. I like drugs and I'll keep on using them. I haven't got a problem with drugs. I'll just keep on using them as long as I want to. You know, opiates are actually really very safe, heroin's better for you, it's a less addictive drug. It's, um, ignorance that fucks people up. It's people going into things with out knowing what they're getting into, where they're headed. I knew exactly what I got into, where I'm headed. I'm the mad punk rocker, fucking rock and roll type, you know, in the local music scene, um; I'm a living legend. That's the way I am and that's the way I'll always be. Like I told you, originally one of the reasons I started taking drugs was as an escape, a refuge, now it's because I want to enjoy them. I've chosen the way I want to be and I like it and I'll keep on doing it. Anything else is basically meaningless. Hugh

At the moment I'm okay, I'm doing okay. At this point in my life I don't think too much about the future. I really don't have much of a future in terms of HIV. I moved back down here after my grandson was born because I wanted to be around and I started to get quite ill and wanted time for my kids to get to know me and me to know them because they were almost adults. I hang out with the HIV support group and I

go to the AIDS Foundation. It's really easy to get, um, narcotic drugs from there. If I'm having trouble with lots of pain, yeah, in terms of HIV, most doctors are, they don't know a lot about it but they're quite easy in terms of writing scripts. So yeah, for me, I'll just keep on taking my drugs until I die I suppose. I always look forward to taking them. I've always looked forward to the rush and the stone. I like the rush, can't deny that, still like it. Yeah, I'm at an okay point with it [drug use]. Two years down the track I might be dead. At this point in my life I'm just living it the best I can.

Eliza

I reckon I'll give up using drugs one day. My drug use has been a good experience because that which does not kill you makes you stronger. Drugs didn't kill me. I might have ODED a couple of times [laughs] but they haven't killed me. Mmmm. I'm comfortable with who I've turned out to be. I'm confident and I'm happy, mmmm. I understand that I still have excessive violent tendencies but I'm controlling them now. It's also nice to know that if I ever needed it, it's there. I'll never be a pacifist. It's just not in my genetics is it? Oh, yeah, it's [drug use] given me a bigger command over my own doings, the ability to accept responsibility for the things I do. I'm all the fucking better for it. Yeah, I'm going to give up sometime in the future but I may have the odd joint, take an odd trip, because I might be getting back into the ring, competing in the ring. If you go for an amateur title shot you get piss tested, you come with pot, or fucking whatever, coke, or whatever in your system, you loose your title. You just wouldn't go in the ring and get fucking sore legs or bruised legs for fucking nothing you know. So yeah, I'll be giving it up sometime in the in the not too distant future. **Toby**

I'm too frightened to get off it. What would I do? I'm so used to it, that it's too, just too terrible to think about being without it. I think if I wasn't seeing [boyfriend] I really don't think I would be doing so much. Yeah [laughs], I've really got to, I've got to stop using it, it's not much of a life really. I really don't think about anything any more than about two days away. I can't think what I might want to do in two months. Two days is far enough away. I can't even really think what I'll be doing in two days time other than be using drugs. I don't know. Sometimes I think I'm pretty comfortable where I'm at. I don't know what tomorrow holds so I don't know what the future holds. I can't even imagine having any kids in the future the way I am now.

Jenny

When I think about my life I think about how there's more to life now than using drugs. It's like my life has consisted of drugs, it revolves around drugs, and it's like, you know, drugs make me feel good for a huge part of it but at the end of the day they've ruined my life, you know, that day was a waste of time, that week was a waste of time, and month, to a year, to, you know. It's like when I think about it, I've just wasted, blown, hundreds and thousands of dollars by doing, just having a life that's gone boom, non existent, and yeah, it's all just been bullshit. So yeah, it's no wonder I get suicidal, you know, planning to kill myself because my life is wasted shit. I chose to use, and unfortunately because I did, my life, yeah, it's, life's never, ever, ever going to be what it was. Yeah. Now I'm getting more harm out of it than good, I'm getting to the point of being rock bottom, you know, I **need help**, if I want to keep on living I need help, I've got to get help but I don't know where. **Simon**

*It doesn't matter what happens to me in the future. As long as the kids don't get taken off me I'll be all right. I've managed this far to keep it all together. I just want something good for the kids, everything I didn't have. The kids are getting older so I have to be more careful about what I do. I don't think I'll ever be drug free. It'd mean changing too much. I don't think I've got the strength to make those changes. I'm just like heaps of others, caught up in all this shit and can't see my way out of it. Drugs really do rule my life. I guess the day'll come where I've gotta choose between drugs and my kids. I just hope it's not too soon. **Rosemary***

*Drugs are all I have. They're my whole past, they're what's happening for me now and they'll always be there in the future for as long as I'm alive. I can't imagine them not being there. I can't live without them. I need them to shut everything out. I need them to feel safe. I need to know that they're going to be there. I don't care about anything except getting out of it every day. I don't know what I'd do if I didn't have any. I haven't had to face that yet. I just haven't got anything else. **Tui***

I really need to open my eyes to what I'm doing to my life. It's just not fun anymore, hasn't been for a long time. I never thought of myself as an addict until recently. That's what I am. Look at me. I'm 35 years old and I'm a fucking criminal. I wasn't brought up to be like this. I know there's got to be something better. I've just lost five years of my life. I've experienced heaps and it's time I started to make something of my life, make a few hard decisions about where I want to go, if this is the road I want to travel or not. You know, if you'd said to me ten years ago that I'd pull an armed robbery I'd have laughed at you. That's not true now because that's what I've done. Drugs own me. I need to make some hard decisions and do something about all this.

Jared

*I'd fucking choose dying over no drugs any day. Can't get worse than that eh. You fucking whities always think, thinking about tomorrow, tomorrow, next week, next fucking year instead of fucking living today, enjoying today. Who fucking cares about next week? The only thing you need to fucking worry about next week is casing some fucking joint over to see what you can get without having to do a lag for it. Fucking dreaming about tomorrow's for losers. I'm not a fucking white trash loser. I'm gonna die a hero doing what I want to do. **Willie***

*Now I've found a way to feel normal I don't ever want it to stop. It's not that the drugs are a problem, it's having to find the money to get them. I just think every year I'm gonna have to grow a few paddocks of poppies and stock up for the winter. Like a squirrel. I really don't know what I'll end up doing. I think I'll probably die of an overdose, probably not a bad way to go. I haven't got any real plans for my life. I'll just live it out like I am now. I could decide to go cold turkey and stop but I don't want to handle the cold turkey. I've tried before. I guess this is my life, all it's ever going to be. **Jimbob***

Life can really get you down sometimes. Your whole life changes when you use drugs. Everything changes, friends, your life, everything. Sometimes it's good and other times it's not. I really enjoy some of it, like, ripping off the system [benefit fraud]. I don't really like being a working girl but it's easy money. That's the worse of living like this, is the money, finding the money. I've probably shot up over a million dollars

worth of drugs, all up my arm. Imagine what I could have done with that money. Basically though, my life sucks, even though some of it's okay. I do want to get off because I want to have a family one-day. I want my own house and it's not going to happen when the money's going in my arm. I don't know if I can change though, I don't know. **Lauren**

If I look back on my life, especially since the accident I realise what a waste it's been. Who would have believed this would happen to me. I didn't. I didn't think I'd ever be like this. It's like a bad trip really only it's not a trip; it's my life. I've really lowered my standards, like I don't even have any anymore. Even though I think about stopping I know at the back of my mind I'm not really thinking that at all. I don't feel proud of myself at all, I'm really quite disgusted sometimes. Drugs have made me block out all my feelings, like made me into this person I'm really not. It's like, it's like I want to sort of do something about it but I just don't know what to do. I don't know what I'll do about it. I'm still thinking about it. I just didn't think I'd be like this. **Timothy**

What stands out about these particular exemplars is the uniqueness of each participants' position as a human being amidst the commonalties of their experience of drug dependence, and the stand each of them take on the kind of Being they are, their choice of self, their potentiality-for-Being. For each of the participants in this study, living with a drug dependence required them to understand and bring together their past experiences into their present life to create new possibilities for themselves. In doing so, they brought into their awareness an acceptance of their finitude, a realisation that they alone are the source of significance for their life, and that they alone, through the actions and choices in which they engage themselves in everyday preoccupations, are solely responsible for what their lives add up to *in the end*. For the participants, their existence is, in each case, theirs to choose, they alone are products of their choices, they alone are responsible for whatever they make meaningful about their own individual and particular existence, that of the world, and that of others.

In each case, Dasein is mine to be in one way or another. Dasein has always made some sort of decision as to the way in which it is in each case mine (Heidegger, 1927/1962, p.43).

Review and summary

In this chapter, the discussion has focused on care in the ontological sense. Care, ontologically, is the kind of care that constitutes one's Being in the world, and is essential to one's existence. "Dasein, when understood ontologically is care."

(Heidegger, 1927/1962, p.84). For Heidegger, one's being is one of care (*sorge*). It is care that makes one's existence meaningful, that one's being in the world is made significant. To be in the world is to care, to be careful (*besorge*). One is a being for whom the kind of life to be lived matters. Through being in the world, being with others, and being with things, one is forced to deal with the world, with the situation within which one finds one's self. Thus, it is in this sense that things matter to one, that one cares.

In one's everyday being, care gets expressed in the many different ways in which one is concerned with, and concerned for, the entities of one's world, and by one's concern for others, one's solicitude. In the first part of this chapter, in the first theme, Taking care, being careful, care was discussed in regard to the way in which the participants' understood their own Being and their situation in the world. In the last part of the chapter, discussion has focused on the ways in which the participants are called to take a stand on the kind of Being they are, their choice of self. In taking a stand on the kind of Being they are, their choice of self, their being drug dependent and their drug lifestyle, the participants connected themselves into a different group of people and a different way of being. Thus, the stand which each took on their life defined their identity and determined their individuality, both authentically and inauthentically.

The discussion also focused on exploration of the participants' hopeful possibilities. For most of them, hope created a certainty, a belief that life is worth living at the present and in the future. As a common experience, in that the participants could anticipate possibilities through allowing their past to inform their present, hope was shown to be of importance in the living of their lives, on taking a stand on their choice of self. Through their choice of self the participants found themselves situated outside society's normative ways of being, a situation which gave rise to an awareness that they each need to be their own selves for it is in each being their own self that their uniqueness stands out amidst the commonalties of their lived experience of drug dependence.

This chapter concludes the presentation of the study findings and sets the groundwork for consideration of clinical implications of the study. If care is to be provided for

people dependent on drugs, then it is necessary to understand what it is to be drug dependent. By drawing on the lived experiences of drug users who have a drug dependence, it is possible to arrive at a more complete picture of the phenomenon of drug dependence and its essential features. In the following chapter the study findings are discussed and the implications for clinical practice are considered.

CHAPTER VIII

DISCUSSION AND CONCLUSIONS

The starting point of this thesis was the assertion that drug dependence is a relatively common yet poorly understood phenomenon, an assertion that has been upheld by the study findings. For the participants in this study, drug dependence presents as a series of experiences which profoundly affect each of them as well as those others who share in the experiences in one way or another. Despite the many theories and perspectives that exist to explain the varied and highly complex phenomenon of drug dependence, it remains a subjective human experience lived by the individual engaged in the experience. The understanding of it as a meaningful behavior embedded in our culture is limited by the prevailing objectification and reductionism in the current approaches and theories that abound in the field of drug dependence behaviors. In light of this, the aims of the present study were to undertake an inquiry into the nature of the lived experience of drug dependence, to uncover and make explicit through a hermeneutic process the shared practices and common meanings of drug dependence as perceived by the study participants, and through the interpretation and transformation of the participants' personal stories into a written account, gain insight and a deeper understanding of the phenomenon of drug dependence.

In this study, the choice of phenomenology was purposeful. As I wanted to understand the complexities of the participants' lived experiences of drug dependence, Heideggerian hermeneutical phenomenology presented itself as useful philosophical approach. In addition, phenomenology, as a philosophy and a methodology, has great applicability to drug dependence practice in that it offers a means of uncovering meanings embedded in the clients' descriptions of their everyday lived experiences of drug dependence. In phenomenological inquiry the starting point is with the subjective experiences of people who are able to freely express their own experiences regarding the phenomenon under investigation to the researcher. In this study 25 participants willingly narrated stories of their everyday lived experience of drug dependence including their thoughts and feelings associated with the experience. Without such willingness the study would not have been

possible. As such, it is these accounts, parts of which are presented in this thesis as illustrations of their lived experience, that make possible the background for the hermeneutical understanding from which the conclusions are drawn. Thus, the purpose of this chapter is to summarize and discuss findings of the study and to lead from discussion of the lived experience of drug dependence to the implications of the study for clinical practice and suggestions for further research.

In this study three significant major themes emerged in the experience of the participants: becoming and being drug dependent, being with others, and being with care. Aspects of these themes will be discussed in relation to Heidegger's (1927/1962) concept of *solicitude* – care for others – as it applies to clinical practice. Conclusions drawn from the present study will illustrate the importance of the health care professional confirming drug dependent people as valuable human beings in their interactions with them. It is then suggested that it is not enough to understand drug dependent people in terms of theories and models. Rather, it is important to understand drug dependent people's unique set of needs – both regarding the meaning of their experiences of seeking and receiving care and to trust and respect them in their ability to know their own situation. Such understandings and a caring attitude would result in greater richness and significance in the health professional – client relationship and hold the potentiality for more successful client outcomes.

Understanding the nature and experience of drug dependence

The phenomenon of drug dependence presented in this thesis emerged out of the participants' lived experience. Irrespective of the routes by which the participants traveled into drug dependence, drug dependence was a subjective life changing experience grasped as meaningful in terms of their Being-in-the-world, their identity, their sense of belonging, their feeling normal, their escape from reality or pain. It was in a background of human experience and personal vulnerabilities that the participants began their drug use, committed themselves to becoming drug dependent, became enmeshed in the lifestyle, experienced drug dependence as having personal meaning, in essence, constituted the world in which they lived from their own experiences and background whilst being constituted by the world in which they lived.

As a result of their becoming and being drug dependent, the participants experienced changes to their embodied Being, both physically and psychically, changes that brought about a sense of loss of their former selves, of their previous way of Being-in-the-world, changes in which they encountered and lived alongside others in a social world as outsiders - part of the *Them* group, those who did not meet society's expectations or norms. For the participants, it was a world in which they were forced to deal with the situation in which they found themselves, a situation in which they made choices, choices which revealed what mattered to them, that which they were concerned-for, concerned-with, and cared-for.

Thus, for the participants, becoming and being drug dependent was a lived experience defined not by theoretical models which set out to explain dependence behavior from a mechanistic/reductionistic perspective, but more so by their personal involvement in having embarked upon the drug dependence journey. For them, it was the nature of the journey and the situation in which it came about, both of which required resoluteness and active participation, which made it a life changing experience. It was from this context that a description of the nature and experience of drug dependence was brought to light.

The phenomenon of drug dependence

To understand drug dependence as a lived experience rather than as an objective observed experience, it is essential to get "to the things themselves" (Heidegger, 1927/1962, p.34) - one's pre-reflective experience of a phenomenon, in this study, drug dependence as it is experienced in the participants' everyday lives, what it is like, and how it has affected their lives. Thus, the experience of a phenomenon in the lived world of a participant is the starting point for a phenomenological description, which in turn, leads to a hermeneutical interpretation in which the researcher is concerned with uncovering meaning through reflection, and a written description of aspects of the lived experience, a description upon which one can reflect and say "so this is what it is like..." For a person with drug dependence, for instance, the objective observed experience is one of tolerance and withdrawals, different behaviors, and a different lifestyle. Yet the lived experience of drug dependence is one of embarking upon a journey, of feeling and being different in both body and

mind, of taking care of business, of going to inordinate lengths and taking impossible risks to get to the object of their desire. By returning to “the thing itself”, the participants’ lived experience of drug dependence, one comes to understand the nature and meaning of it as a complex meaningful human phenomenon and of the real and potential effects of drug dependence on peoples’ lives, both the participants’ and others who are alongside of.

Becoming and being drug dependent

The lived experience of drug dependence was a powerful life experience which could be likened to a journey, a roller coaster ride which once embarked upon was not only a struggle to stop, but also one that the participants would go to any lengths just to carry on for one more day, everyday. For the participants in this study becoming drug dependent took some time and effort. Realization of drug dependence came when the participants found that they needed drugs everyday rather than choosing to use drugs at will. Without drugs, the participants did not feel well enough, physically or psychically, to carry on their usual everyday activities. In feeling and being different, in body and mind, the participants came to recognize that their situation in the world had changed from what it was before they found themselves in the world as drug dependent. They were no longer leading relatively normal everyday lives, instead, they were completely involved in a lifestyle dominated by getting money, obtaining and consuming drugs, avoiding risks, and socializing with other drug users. For the participants, feeling and being different in body and mind, called for a reconceptualisation of their Being-in-the-world, an understanding of the loss of their former selves and a taking on of a new identity, that of *addict/junkie*, and a new script for acting: a drug lifestyle, drug using friendships, and the pursuit of drugs – all of which are censured in our society and involved experiences that were potentially risky, damaging, chaotic, and frightening.

Accordingly, in their life-world accounts of their experiences, the participants did not talk about gateway theories, the stages of change, or neurotransmitters as reflected in the drug dependence literature and clinical practice. Rather, they spoke of their anxiety, their fear, their uncertainty, their emotional pain, their difficulties, and their

need to feel normal. Because many of the participants' experiences of their drug dependence were particular to them individually, and because what they felt and experienced was a direct result of their becoming and being drug dependent, the participants had difficulty in narrating some of their stories in a way that they felt adequately explained their experience of becoming and being drug dependent and the meaning of those experiences. Some of the difficulty lay in their belief that only another person dependent on drugs can know what it is like to be drug dependent, to live that experience and know that that experience embodied the whole of one's Being. Additionally, for the participants, others – non drug users, those who have not experienced drug dependence, the highs and lows of the life, the despair and the optimism, the pleasure and the pain - do not have an insider's perspective which to identify with and therefore understand them.

In this study the participants were free to choose what to talk about from their own lived experience of being-in-the-world with drug dependence. Such narratives about their lived experience disclosed the complex interactions of the many factors that led them to becoming and being drug dependent as well as revealing that drug dependence resides in human experience. Accordingly, in the creation of the text, the participants' experiences of becoming and being drug dependent were transformed through the addition of the researcher's voice to their voices. By putting their experiences into words the participants made them available to the researcher who, through focusing on the essences of the participants' experiences, their interpreted realities, and translating her understanding into a narrative description, has made the participants' lived experiences visible to the reader in a textual form. As such, the reader is able to presence their self in the participants' situation to try and understand their unique experience, their world, without living it. The definitive transformation of the participants' experiences is validated in the recognition given by the reader of the text, the *phenomenological nod* (Munhall, 1994, p.189), the sense of... "Yes, I can see what that experience is like, I knew that but I've never put it into words before", even though the reader may not share the researcher's interpretation of the participants' lived experience of becoming and being drug dependent.

Being with others

Being in the world is a being with others and as such the study participants encountered and lived alongside others in a social world in which, through their drug dependence, they were perceived as being different, of not meeting society's expectations or norms concerning the use of psychoactive drugs. Because of the illegal nature of drug using, their connection into a different group of people and the drug lifestyle, the participants found themselves as marginalised members of society. In being marginals, the participants experienced much societal negativity and prejudice that impacted greatly upon their relationships with others in the world. Feared, rejected, and punished for being different, the participants, feeling threatened, vulnerable, and resentful, further withdrew from social interaction with non-drug users and moved more into a social climate conducive to using drugs and drug using friendships. With increased involvement in the drug lifestyle reinforced by greater identification with other drug users with whom the participants felt an understanding and acceptance, they experienced an increasing sense of alienation from the wider society, a hostility and devaluation which, in turn, not only further served to create a societal division between them and non-drug users but also intensified many of the feelings they experienced including those of not being listened to or understood. Such feelings hindered the participants' ability to trust and participate in treatment when requested or sought.

In this study, asking the participants to describe their lived experience of drug dependence meant maintaining an openness to the extent and type of biases that exist and to the many historical and theoretical understandings that are held in our society about drug dependence. One of the results of the many diverse understandings which are held about drug dependence in our society is the creation of a division, a non-normative category, a distinction between the *We* group and the *Them* group. Through their illegal drug use and their drug lifestyle, drug dependent people such as the participants have long been considered as different from the rest of society, the *We* group. In Chapter II of this thesis, an overview was given of the historical and theoretical trends and models in understanding drug dependence, many of them in which the human realm, one's subjective lived experience, is seen as secondary or generally neglected. Such narrow perspectives with regard to drug dependence further

helps in creating and reinforcing the societal division between drug dependent people and the rest of society, a division in which drug dependent people are not viewed as human beings with a drug dependence but as sinners, sick people, deviants. Being viewed in this way, for the participants, impacted significantly upon them and on their dealings with others in their everyday lives. As such, relationships with others were significant in that they both impacted upon the participants' drug use, and the participants' drug use impacted upon their relationships with others. In being with others, all of the participants experienced difficulties in some of their relationships. The tone and nature of these relationships and the attitudes communicated to the participants through their interactions with others helped to shape profoundly their perceptions of themselves as being deviant, of not belonging to mainstream society, of being outsiders, and of not being valued.

As illustrated in the narrative in Chapter VI, drug dependence not only has profound effects on the experiencing participant and the wider society but also on their families and friends. Although drugs protected the participants from the pain of their everyday realities, drugs also meant they lived a lesser retracted existence in which they cut out old friendships, associated mainly with others involved in drugs, lost the credibility and respect of others in the straight world, and infused societal condemnation and contempt.

Several of the participants told of the difficulties they experienced in their relationships with others, their withdrawal from social contact with non-drug users, the condemnation of those willing to sit in judgement on them, and the second rate care they received because of societal misunderstandings and fear of drugs and drug users. In our society where drug use and drug dependence is feared and seen to be a threat to societal values, it is not surprising that the participants sought out the company of other drug users with whom they could feel at ease with and develop a sense of belonging and acceptance through sharing and discussing the pleasures and problems of a similar lifestyle.

Although preferring to seek out relationships with others that shared in and understood the lifestyle, the participants also realized the importance of interacting with others in a social world. However, because of the intense social stigma and

prejudice toward drug dependent people, much of which is reinforced and sustained by sensational media coverage and public censure, and the illegal nature of their drug use and participation in criminal activities necessary to support their drug dependence, many of the participants kept their drug dependence hidden when interacting with others. For others to know of their drug dependence was for them to experience hostility, stigma, contempt and rejection. In realizing the importance of interacting with others, whether or not they kept their drug dependence secret, many of the participants worked at maintaining relationships with non-drug users, particularly family members who were supportive to them. In interacting with these others, many of the participants wanted, and hoped for, confirmation as significant human beings with valid experiences, not to be devalued because of their drug dependence. For the participants who needed so much to be understood and accepted by others as fellow human beings, their willingness to give to others through telling their stories was a moving factor in their decision to participate in this study as illustrated in the following exemplar:

*The reason I decided on this interview is, the reason I'm doing this... if it helps in some small way, when I look at my life, you know, if I've done anything in my whole life, um, to contribute, even in some small way, to make this world a better place for one single person, even in a small way, then me doing this interview may in some way, you never know, just one sentence I've made, said during this interview, you know, may make someone else think, might make someone change, you know, because, like I said, **there is nothing whatsoever, there is absolutely nothing glamorous about drug use.** It costs terribly. I know. I've had 27 years to develop this opinion and I've had it quite sometime, for some years, **there is nothing glamorous about drug use.....** The most important thing I have learned in life is to have deep compassion and understanding for the human condition, in all it's complexities, because if you ask me, there's no substitute for experience, that's why I'm doing this interview. **Tony***

For many of the participants, the effort and gesture to help others was clearly an important aspect of the participant's sense of self and a new experience of connecting with others, of wanting others to understand that they too were fellow human beings, albeit in a different situation, with wants and needs. As a result of listening to their stories I felt a profound respect for these participants who were willing to share their stories and their troubles. Through the telling of their stories the participants wanted to be accepted for who they were, acknowledged in a non-judgmental way, not be defined by their drug dependence, not be perceived as social misfits or deviants, but

as human beings who were experiencing problems with drugs. They, too, wanted to live a normal life, yet through their drug use and drug lifestyle, they accepted that they were different from others in society.

For many of the participants, it was through their being-with-others that they were able to come to know themselves and to project a world that was of importance and significance to each of them. In such a world the participants were forced to deal with the situation within which they found themselves, situations within which they made choices, choices which revealed what mattered to them, what they cared for.

Being with care

As a feature of Being-in-the-world, being with care encompassed the ways in which the participants took care, their everyday concerns and their everyday choices and actions that revealed what mattered to them. For the participants, being with care involved watching out for themselves, being vigilant in living a chaotic lifestyle and in matters of their health. An important part of watching out for their selves was the way in which their past experiences informed their present being as well as their future – a coming of what has been and a looking forward in terms of giving sense to their existence. Additionally, being with care encapsulated the way in which each of the participants was engaged in the world in an individual way, each taking a stand on their own Being through the choosing of their possibilities in an uncertain future. In taking a stand on the kind of Being they had in their unique situation of living with a drug dependence, the participants reflected on their choice of self, their Being-in-the-world. Through reflecting on self, the participants endeavored to find meaning and to understand the truths of their lives.

The participants had, through embarking upon their drug journey, become what they are, each shaping and having shaped their lives through their everyday choices, some reflective, some less so, each striving toward their own potentiality-for-being, each taking a stand by their choice of self. In choosing their self, the participants struggled with the everyday problems and concerns particular to their way of being-in-the-world, the situation in which each of them found themselves, and had to deal with, their thrownness into drug dependence. In living in their thrownness, their drug

dependence, the participants were each concerned with what mattered to them, their worries, difficulties, hopes and aspirations. In their care-for, concern-with, and concern-for that which mattered to them, the participants shared with others a common humanness in that it is part of the very nature of humans to care, to be concerned. It is this feature of human Being-in-the-world, that things matter, that Dasein's being is care, that the participants are, before all else, human beings, individuals, each with their own concerns, feelings, desires, and difficulties which they have to deal with. Because the participants are first and foremost human beings for whom things matter, it is to their human reality that we must first look before we can come to an understanding of drug dependence as a complex meaningful phenomenon, for drug dependence lies not in drugs, it resides in human experience. The meaning of human experience, Being-in-the-world, is to be found through the realization that to be is to care. It is in this way that care, as concern which is care for things, and solicitude which is care for other *daseins* (human beings) provides a guideline for this study into the lived experience of drug dependence. It is in this way that care, in the sense of concern and solicitude, proffers a hopeful and encouraging approach in which to understand and address drug dependence behavior.

Involvement in a caring relationship

In Heidegger's (1927/1962) analysis of Being-in-the-world, the concept of *care* (*Sorge*) is of central importance as discussed in Chapter VII. For Heidegger, care is the constitution of Dasein; one's Being-in-the-world and one's Being-with-others. As such, care encompasses concern for the things that matter to one and solicitude for other people. Following Heidegger's position that caring is a way of Being-in-the-world, caring, as care for others - solicitude, in the context of drug dependence, consists in understanding and recognizing the reality of the world of the drug dependent person, in creating and re-creating a future of possibilities for the drug dependent person, while helping them in letting go of possibilities that are no longer authentic. Encompassed within Heidegger's conceptualization of solicitude, as care for others, is a complexity of skills, an availability to understand, a presencing of one's self sensitively in the world of the drug dependent person, a *being there* or a *being with* another, an openness, a showing of genuine interest in the drug dependent

client as a person - a fellow human being, one who is troubled by specific difficulties rooted in their drug dependence.

As a form of caring in drug dependence practice, solicitude embraces a “factual social arrangement” (Heidegger, 1927/1962, p.122), a directive that serves to guide practice, a way of working and sharing existence with others. In his analysis, Heidegger noted two different forms of expressing solicitude for others. One is to “*leap in*” for the other, take over, and assume the responsibility for the actions of the other. Although this form of care produces reliance or dependence on the part of the one cared for, it is sometimes of necessity such as when the other has overdosed on drugs or is detoxing from drugs. The second is solicitude that “*leaps ahead*” of the other. This form of solicitude “pertains essentially to authentic care” (p.123), care which, through being with the other, sharing their existence and focusing on the other’s potentiality-for-Being, empowers and frees the other to choose to live to the full truth of their own Being. This form of care is the goal of the caring relationship in drug dependence practice – of not choosing for the drug dependent person, of giving alternatives for them to choose from personally in as far as they are capable of knowing them.

Basic to Heidegger’s concept of solicitude is recognition that Being-in-the-world is a Being-with-others, that existence in the world is shared with other people. Although we each live our lives in unique ways and our worlds are experienced differently, there are commonalties in our everyday existence that connect people in the world, the main commonality being that things matter to us. It is this commonality of everyday being-in-the-world, that things matter, that gives a sense of reality to caring practices and guides the development of an empathic understanding which is fundamental to the giving of the best type of care possible. It is this commonality that allows the health care professional caring for the drug dependent person to experience the uncertainties, contempt, rejection, vulnerabilities, hopes, and aspirations of their client. It is this commonality that allows the health care professional to truly listen to and hear the inner being of the drug dependent person, a voice seldom sought, heard, or understood.

According to Heidegger (1927/1962), an empathic understanding is possible “only on the basis of Being-with” (p. 125), of sharing existence with others. Although the lived experience of drug dependence as described by the participants is not generally shared by most others in society, it is in being concerned about the things that matter that we exist in a shared world and are available to understand and be with another, to have empathy - “the ability to perceive the meaning and feelings of another person and to communicate that feeling to the other” (Gagan, 1993, p.53). Caring then, as the kind of solicitude which “*leaps ahead*”, an empathic understanding, is for Heidegger (1927/1962) tied to our Being-with another in the world. It is a presencing of one’s self in the other’s situation to try to understand their unique experience, a capturing of feelings and thoughts, openness to the other’s point of view. It is an understanding of the other’s world as if one were inside it.

In drug dependence practice, entering into the drug dependent person’s world requires some “consideration and forbearance” (Heidegger, 1927/1962, p.123) on the part of the health care professional, effectively, a caring solicitous attitude within which the effect of drug dependence on the whole of the person’s life is acknowledged, and within which the drug dependent person is given a voice, their experience is listened to in an individualistic way, not diminished, nor distanced, nor dismissed, nor normalized. In solicitous drug dependence practice, a caring approach merges the concerns and goals of individuals into a partnership in which the drug dependent person is engaged in their own treatment planning. Jenny’s account of her experience of being in a residential treatment facility in which she was forced to participate in group activities against her wishes is an invaluable example of the necessity to provide interventions and treatments that are based on the immediate needs and goals of the individual person if they are to make lasting and deep-seated changes in their everyday lives, in living drug free. Being coerced into treatment before being ready, of having no choice with regard to the treatment process, and experiencing the negative and ill-judged reactions of health care professionals led Jenny to believe that she was not seen as a person who was suffering and fearful, but as a drug addict who was expected to surrender herself to a higher power. Jenny had stated that she wanted help and had some expectations for this help but was left feeling let down and consequently relapsed back into her drug use.

In the context of solicitous care, the health care professional faces the challenge of accepting drug dependent individuals as people who may not yet be ready to make profound changes in their lifestyles or who may not want to achieve lasting abstinence, but may just need to reduce their drug dependence in order to manage their lives in a more positive manner. For people like Jenny, this acceptance is not always apparent. Consequently, opportunities to engage the drug dependent person in a change process are lost. In the event of help being sought, a caring solicitous approach on the part of the health care professional is of critical importance in giving the drug dependent person the impetus to get off drugs. Helping the drug dependent person is not easy. As stated by several of the participants, they do not want to stop using drugs but what they hope for is that they will want to stop. Caught in the paradox of their own feelings for drugs they do not want to be drug dependant and experience the consequences but, because they want and need drugs, they fail to find the determination to leave them alone. In this situation, a caring and solicitous approach requires that the health care professional meet the drug dependent person with an open mind, listen to their uncertainty, accept and respect them and the meaning of their experiences, and communicate hope to them whilst understanding their own experiences in practice.

In drug dependence practice, it is undoubtedly of value to the drug dependent person's physical and psychological care, when seeking help, for the health care professional to know personally the experience of drug dependence or to find some common ground analogically in terms of understanding drug dependent people's needs and responding to them. However, in the absence of not being similar to, or sharing in similar experiences of those who have a drug dependence, it becomes more important for the health care professional to truly listen to and maintain an openness to the drug dependent person's experiences and to take care not to cease listening to them in the belief that the drug dependent person's experience can, or may be understood analogically or vicariously.

Through focusing on the drug dependent person's world, the health care professional would therefore be able to respond more effectively to their needs and concerns, to assist them in reaching their goals and to engage and retain them in treatment processes that help bring about changes that are more lasting. Additionally, the health

care professional, through focusing on their world, would have a greater understanding of the difficulties this client group face in engaging in a change process, and of the importance of readiness and motivation in achieving profound lifestyle changes. Acknowledgement of the reasons for seeking help and identification of the fears experienced by drug dependent people about treatment and change can improve the provision of care and provide support when required. By listening carefully to the drug dependent person's perspective and experience, the health care professional can learn about drug dependence and the way in which it can be managed. As such, barriers to engaging in treatment as perceived by drug dependent people, such as expectations for immediate change and fear of losing autonomy through program rules, can be overcome and help seeking behavior can be encouraged.

Sensitivity to the obstacles and the fears that drug dependent people may experience in seeking help, providing support in overcoming such obstacles, and allowing for expression of concerns are useful ways of helping this client group break away from their drug lifestyles and to work for a positive outcome. In an area where relapses and non-completion of treatment are very likely occurrences such considerations are of great importance. Of great importance also in drug dependence practice is the ambience of prejudice, fear, and misunderstanding that surrounds the lives of people who are drug dependent. Not only do they create a societal division, they also create many barriers to keep drug dependent people out of treatment.

Consequently, there is a very real need for the health care professional in working with this client group to provide a supportive, positive, and trusting milieu distinct from outside influences and the societal negativity toward drug users that hinders the drug dependent person's ability to not only participate in treatment but also to trust. In the provision of quality care, developing a level of trust is achieved through the health care professional accepting and valuing drug dependent people as valuable human beings who can care for themselves, who can take responsibility for their drug dependence, and who can work towards being drug free when ready. A further aspect of developing a trusting relationship is the acceptance of each drug dependent person's uniqueness amidst their commonalties. For the participants in this study, becoming and being drug dependent was a commonality they all shared, yet each one

of them differed individually in the way in which they were engaged-in-the-world, in taking a stand on their own being through their actions and choices, and in their everyday hopes and aspirations. Likewise, just as each participant differed in their abilities, values, and intentions, they all had in common a wealth of past experiences that informed their present being to bring about new possibilities for themselves.

As such, the health care professional needs to be aware of the drug dependent person's history and the influence that past experiences in their lives have had on who they are and how they can move forward to the future, to that which they hope for themselves. Among the hopes that the participants held were the possibility of being drug free, of having better relationships with others, of not having to commit crime to get their drugs, of having an endless supply of drugs, of having someone care about them, of having a job, or of having less chaos in their lives. Although such hopes and aspirations may mean very little to the health care professional as to probable future possibilities for the individual concerned, to disregard them would be to negate the meaningfulness of what matters to them, what is of concern. In living with a drug dependence, each of the participants talked about their everyday concerns, the things that mattered to them, the ways in which they watched out for themselves, and their involvement in the world. Although the participants all shared in similar experiences, each of them was engaged in the world in their own individual way, each holding their own concerns. For them, everyday life consisted of much chaos, many risks and uncertainties, more so than for most without a drug dependence. Accordingly, the stories told by the study participants are such that they convey the need for drug dependence practice to be based on an understanding of the drug dependent person's world as it is perceived by them, along with the knowledge of both the meanings that they attach to their experience, their hopes and aspirations, and of the things that are of concern to them, that which matters. Hopes and aspirations are a baseline of life, a belief that life is worth living at the present and in the future regardless of past difficulties or despairs. Accordingly, it is critical for the health care professional to grasp what it is that the drug dependent person hopes for, is concerned about, in order to act therapeutically and engage them in a change process. Drug dependence practice, when based on solicitude, involves much more than people's drug dependence. It is concerned with helping people move toward envisioned possibilities in their everyday encounters with the world, nourishing constructive

actions and relationships, focusing on immediate needs as perceived by the client, and focusing on building on their strengths.

For the participants, aspects of their drug dependence led them to reflect on their Being-in-the-world, the nature of their existence, an existence that developed unequivocally from their past experiences, from the situation in which each one of them found themselves thrown. In reflecting on their own existence it is probable that the drug dependent person may need not only to talk about their experiences, their uncertainties, their difficulties, their anxieties, and their aspirations and have what they say listened to, but also be confirmed for what they are or even what they can become. When such a situation presents itself, the challenge in drug dependence practice is for the health care professional to meet the drug dependent client with an open mind, recognize their existence, accept and respect them as people and communicate hope to them.

Correspondingly, the adoption of a formal theory or perspective about drug dependence behavior that is divorced from practice can create confusion, conflict, and other problems. Despite the advancement of a profuse progression of theories and explanations about drug dependence over the past century, no single theory or model exclusively informs drug dependence practice or is adequate or sufficient to explain the multi-dimensional nature of drug dependence. In fact, many hinder our ability to understand the complex phenomenon of drug dependence. Contributing to any such problems and bewilderment is the lack of agreement as to the etiology of drug dependence, the numerous perspectives and models for the treatment of drug dependence, and the confusion and uncertainty that accompanies the explanatory concepts and definitions in the drug dependence field. Reliance on, preference for a particular theoretical model or specific treatment approach, or misapplication of a model in which the drug dependent person's situation and potential for change is incorrectly interpreted can lead to an ineffectiveness in the provision of care for this group of people. Furthermore, an inability on the part of the health care professional or other to consider, acknowledge, or try alternative theories, along with the numerous definitions or conceptualizations, can increase the possibility of losing sight of the individual person and their subjective experiences.

Essentially, the use of separate theories to explain drug dependence, the anomalous definitions and diagnoses of drug dependence and the varied choice of treatment strategies are largely determined by the underlying perspective held by the health care professional or other. As such, it is this underlying perspective that may predispose the health care professional to look at the drug dependent person and their problems in limited ways, or alternatively, to think that they understand the meaning of the drug dependent person's experiences, the reasons behind their drug dependence, their needs and their problems, when in fact they do not. Basically, a solicitous attitude in drug dependence practice means setting aside reductionistic interpretations, suspending prejudices and biased views of drug dependence behavior, and attending to the drug dependent person's lived experience, what they feel about themselves, feel about others, and feel about the events happening in their lives.

In their stories, several of the participants described experiences which were either discounted or not accepted by the health care professional on the basis of not fitting into existing theories or models, or not meeting the health care professional's assumptions about the nature of drug dependence. For example, Eliza reported a doctor not believing her drug dependence developed from heroin without her not having used any other illegal drug. Such a belief is based on the gateway drug use theory (Kandel, 1982, 1989) which posits that drug dependence follows a predictable developmental progression beginning with alcohol and tobacco then progressing to cannabis before the harder drugs. When Eliza first sought treatment, her experience of developing a dependence on heroin was not deemed valid as it was not considered to have followed the normal course of events according to the underlying perspective held by the doctor. Consequently, Eliza felt that she lacked value as an individual person and that her existence, her self-experience, was being denied.

For this reason, it is not sufficient for health care professionals or others to understand the drug dependent person's situation in terms of theories or models, or assumptions held about their problems, before making choices regarding their care or what can be done to help fix or ameliorate the problems with which they present. In taking a limited view of the drug dependent person's problems and how they experience their situation through adherence to a particular theory, the health care professional fails to respond effectively to the drug dependent person's perceived needs, to engage them in

the treatment process, and to recognize them as valuable human beings with possibilities. Similarly, the lack of consistency and the ambiguity in defining the key terms and concepts also contributes to such factors on behalf of the health care professional in terms of recognizing the potential for positive outcomes, or in the event of negative outcomes, the extent to which drug dependence affects every aspect of the drug dependent person's life.

Although there can be no drug dependence practice without theory or explanatory concepts and definitions to guide the health care professional or other, acknowledgement of, or respect for the drug dependent person's opinions or point of view about their own life situation rather than a disconfirmation of their experiences would communicate some hope, some "light at the end of the tunnel", some potentiality-for-Being-in-the-world, if not now, then some time yet to be. In having a greater focus on symptoms, diagnosis, or categorization into particular groups (for instance, sinners, sick people, or victims) and discounting the drug dependent person's experiences and the difficulties in their lives, is to further resituate them as not fitting into society's normative categories of acceptability and as not valuing them as part of the normal social world.

Interestingly, although a plethora of perspectives currently exist with regard to drug dependence and drug dependence treatment there is a consistent tendency for many people - health professionals, psychologists, lawyers, members of the lay public, and others, to hold a combination of moralistic and medical beliefs that underlie their behaviors toward drug dependent people. Such beliefs actually serve to create images of drug dependent people as people who are different from the rest of society, who do not belong, who are not to be trusted, *persona non grata*. Such beliefs also influence the clinical orientation of the health care provider. Similarly, there are also long standing beliefs that all drug dependent people want to be cured, that the health care professional knows what is best for them, and that the prevailing theories are clinically more useful than the subjective experience of the drug dependent person. The essence of these beliefs is that the health care professional is the expert and has superior knowledge and understanding of the experience of drug dependence whilst the drug dependent person living the actual experience does not. As such, the health care professional can retain a detached objectivity within which they are preoccupied

with explaining the person's drug dependence through these theories and models. In not being engaged in the drug dependent person's experience, in taking an objective stance, the health care professional sends the message that they do not respect the drug dependent person's integrity and that their ways of experiencing their situation are not valid.

In the main, the prevailing theories and explanations about drug dependence, pre-existing judgements, biases present in the field, past influences, and ways of thinking all work to distort and distance the health care professional and client relationship and hinder the delivery of the best possible standard of care because neither the health care professional nor the drug dependent person really understands the other. From the drug dependent person's perspective, distance between themselves and the health care professional is created and maintained through societal stereotypes, conflicting and negative views, inappropriate treatment, failure to recognize individual differences, not being listened to, having their existence and self experience denied, not being accepted as people, not being confirmed for what they are and what they can become. Ideally, for the drug dependent person, a good caring relationship is when they feel their needs are being attended to, they feel cared for, they feel their opinions and points of view are listened to, they are met with an open mind, when they are accepted and respected as fellow human beings, and when hope is communicated to them. However, for the drug dependent person, the mistrust, lack of respect, lack of confirmation and non-acceptance as a person serves not only to undermine their expectations of therapeutic care when sought but also possibly serves to increase their drug using behavior, their identification as a drug user, adherence to a drug lifestyle and further drive them into hiding. Consequently, a major shortcoming in providing care for drug dependent people appears to be an inability to respond effectively to their needs and maintain a safe and trusting caring relationship. Nonetheless, there are times in a caring relationship between the healthcare professional and drug dependent person when mistrust and uncertainty are called for, such as when the drug dependent person has overdosed, has suicidal tendencies, is taking drugs in a totally disorganized and chaotic way, or is at risk of harming others. Thus, at times, a detached professional objectivity can be considered valuable to the care of the drug dependent person, a "*leaping in*" and taking charge, assuming responsibility until the person is able to do it for themselves. Oftentimes, such

situations are full of contradictions and anomalies and as a result demand skillfulness and knowledge on behalf of the health care professional. Consequently, the stance taken between professional objectivity in the above likely situations and a phenomenological involvement in the world of the drug dependent person can be very narrow at times in that caring, as related to *being with* – solicitude, promotes closeness whilst objectivity advances a distancing in understanding the person's lived experience.

In this context it is imperative that drug dependence practice is competent, knowledgeable, and specific. Correspondingly, the challenge of drug dependence practice is concerned with not only being professional, embracing theory that informs practice, but also with offering a veritable expertise without losing sight of the individual person as a valuable human being. As drug dependence practice is based on establishing a relationship with the drug dependent person, a therapeutic approach based on a framework of care can be significant in helping drug dependent people in ways to which they can relate and that they can appreciate. As such, the main advantages of adopting an approach based on ontological care are that it recognizes the realm of human meaning and that it is not prey to the limitations of traditional reductionistic interpretations which restrict the possibility of understanding the lived experience of drug dependence.

Appealing to the importance of an ontological caring in drug dependence practice, a caring based on what the person cares about, what matters to them, does not in any way discount current theories or practice. Rather, in a field marked by controversy, conflict, confusion, and fervent emotion, it points to the need to question and evaluate the underlying assumptions of the models and theoretical foundations from which one practices. Essentially, because many theories of drug dependence focus entirely on a particular determinant, such as genetics, social factors, or moral depravity, and ignore not only the many interactive factors that affect each individual differently but also the fact that drug dependence is a product of the social structure within which the individual acts, they are not always of use in the adoption of a caring stance. As such, ontological caring in drug dependence practice simply can not be imposed upon conflicting and polarized theoretical perspectives with the hope that it will be therapeutically effective. While it does not greatly matter which theory the health

care professional is attracted to or uses, the underlying assumptions of a chosen theoretical perspective will affect how the health care professional practices. Accordingly, whilst there can be no practice without theory, what matters is how the health care professional grasps the drug dependent person's own conception of their situation, what it is that person is most concerned about, the meaning of the person's concern. Through grasping the drug dependent person's own conceptions of their situation, the health care professional is better able to appraise their problems, their strengths and weaknesses, along with the potential for positive and negative outcomes of any care provided.

Because of the highly complex nature of drug dependence, it is imperative that the care of people with drug dependence is provided by competent, experienced, and trained health care professionals from a range of disciplines. In the context of drug dependence practice and of providing ontological caring practice, competence involves the necessary professional knowledge and skills. However, just as no one theory or model comprehensively informs drug dependence practice, no one discipline can completely cover all aspects of drug dependence. Similarly, no one individual entering drug dependence practice can attain enough training and experience to take care of all aspects of drug dependence. Hence, in drug dependence practice, care, as solicitude, requires not only an understanding of the drug dependent person's lived experience but also an understanding of drug dependence from a variety of disciplines, theories and perspectives. Essentially, it is not enough to understand drug dependent people in terms of theories or models, they must also be understood with solicitude "*guided by considerateness and forbearance*" (Heidegger, 1927/1962. P.123).

In being solicitous, the health care professional engages in the existential world of the drug dependent person. By engaging in their world the health care professional is able to gain a deeper understanding of the experience of drug dependence from their points of view. In gaining a better understanding of their lived experience the health care professional is better able to help the drug dependent person to move forward in time and realise their possibilities – what they hope to be, what they are able to become, and what their lives add up to in the end. Thusly, caring, as solicitude, is a

fundamental concept reflecting genuine concern for another. For many, caring offers a passageway to hope. Such caring is paramount to drug dependence practice.

Limitations and strengths of the study

In the design, methods used, and presentation of this study, some important limitations are recognized. As such, their acknowledgement may be of assistance to the reader in comprehending more clearly the scope of this study. As outlined in the introductory chapter this study is qualitative in nature, the methodology used being that of Heideggerian hermeneutical phenomenology. Such a phenomenological approach offers a combined method that describes a phenomenon, in this study, that of drug dependence, as well as allowing for interpretation enabling the lived experience from text to be uncovered and brought to the light of day (Heidegger, 1927/1962; Van Manen, 1990). However, as with all qualitative research, the hermeneutical phenomenological interpretation used in the present study is only one of several possible interpretations for the participants' stories. As Van Manen (1990, p.31) points out, "...A phenomenological description is always *one* interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially *richer* or *deeper* description." Accordingly, with each interpretation, the researcher is the "instrument through which data is collected" (Rew, Bechtel & Sapp, 1993, p.300), worked through and analyzed. As such, data collection and analysis are inescapably affected by the researcher's own life-world, beliefs, pre-understandings, perspectives, personal biases, and techniques of using words to represent experience. Respectively, in the research process of this study, I have made no attempt to conceal my pre-understandings, assumptions, and biases, rather, in recognizing and acknowledging them, any impact upon the subjective understanding is lessened.

In this study the participants were free to choose what to talk about from their own lived experienced of being-in-the-world with drug dependence. Such narratives about their lived experience disclosed the complex interactions of the many factors that led them to becoming and being drug dependent as well as revealing that drug dependence resides in human experience. Accordingly, in the creation of the text, the participants' experiences have been transformed through the addition of the

researcher's voice to their voices. By putting their experience into words the participants made it available to the researcher who then through focusing on the essences of the participants' experiences, their interpreted realities, and translating her understanding into a narrative description, has made the participants' lived experience visible to the reader in a textual form. The definitive transformation of the participants' experiences is validated in the recognition given by the reader of the text, the *phenomenological nod* (Munhall, 1994, p.189), the sense of... "yes, I can see what that experience is like, I knew that but I've never put it into words before", even though the reader may not share the researcher's interpretation of the participants' lived experience of drug dependence.

Thusly, in a phenomenological study it is the task of the researcher to "*bring to speech*" (Van Manen, 1990, p.32) that which has been uncovered in the research process - the participants' experiences, interpretations and meanings of their lived experience. As such, this thesis is a fulfillment of that task, a product of the interaction between the researcher and 25 participants with a drug dependence, a collection of personal stories from which themes emerged using the participants' own words within which to organize the data, an interpretative undertaking to weave together the understandings that have been uncovered from the stories through *writing and rewriting* (Van Manen, 1990, p.32), and a textual description of the participants' lived experience of drug dependence made available to the reader.

In telling the participants' stories in the way that best captures what it is like for them, in a way that lets meaning shine through, I have endeavored to be faithful to the participants' narratives, remaining as close as possible to their own language and stories in the creation of the text. But, because of the subjective nature of phenomenology, it is possible that relevant data has been overlooked as a result of my technique or personal bias. Additionally, because each phenomenological study is unique as meaning is interpreted through one individual's worldview, findings again may not be transferable. Further, such a study is fundamentally limited by words to represent experience, yet words are all there is. "*It is in and through words that the shining through (the invisible) becomes visible*" (van Manen, 1990, p.130). Another researcher might choose different metaphoric examples and identify different themes to explicate the participants' lived experience, however, both would contribute to

greater understanding of the phenomenon of drug dependence. As such, the present interpretation is only one of several possibilities.

For the participants, the main criteria for inclusion in this study were the lived experience of drug dependence and the ability and desire to articulate their experience. As a result of these inclusion factors the participants came to the study having already reflected on their experience of drug dependence through knowing that they would be required to describe their experience. Accordingly, there may possibly have been omissions in their stories particularly if parts of their experiences were considered too painful, shameful, compromising or jeopardizing. However, it is the belief of the researcher that because of the established rapport with the drug using community through voluntary work at the local needle exchange, an atmosphere of trust, safety, and acceptance led to the participants being forthcoming with true accounts of their experience. A major limitation of this study is that generalizations cannot be made to the entire population of drug dependent people due to the small, unrepresentative nature of the sample and the phenomenological approach. Those who volunteered to participate may differ from those who were unwilling to participate and any such differences are unknown. Without random selection of participants it is impossible to know in what way their experiences are representative of all drug dependent people and, as such, use of the findings is cautioned. Despite the small sample, the willingness and extent of data collected is significant and the findings have nonetheless given important insights into the experiences of drug dependent people.

A further limitation of the study is the time and resource constraints inherent in conducting a Ph.D. study. As a consequence of such constraints it is necessary to make pragmatic decisions with regard to participant numbers, data collection, and the other various phases of inquiry, in particular, reflection, interpretation, and writing. Because of the nature of phenomenological research – the openendedness of attempting to understand the complex world of human experience from the point of view of those living the experience, none of the specifics of the research process can be formulated in advance. More pertinently, in this study, some of the openendedness in the research process had to be waived in order to meet time and resource constraints. For example, it would have been of interest to know more about how

drug craving is experienced, what relapse means when the drug user is determined to give up using drugs, what finally getting off drugs means to the drug user, and what the social roles amongst drug users mean. Due to time constraints, it was beyond the bounds of possibility to carry on with the study to continue data collection with the participants to encompass such issues.

Although some important limitations have been recognized in the present study there are also strengths. Firstly, phenomenological descriptions of specific situations, such as *being drug dependent*, reveal what the situation is like, the complexities of the participants' lives, and the social and cultural realities in which the participants live. The findings of this study are closer to life than the variables and constructs of quantitative research. Although quantitative research methods are an excellent research tool to identify risk behaviors, develop models for drug use patterns and collect trend data, they lack the depth of information derived from qualitative methods. Additionally, the constructs formulated are often difficult to translate back into everyday life. Unlike quantitative studies, phenomenological studies of everyday lived experience such as that of drug dependence allow service providers to see tangible points of intervention into the lives of those who live with a drug dependence, for example, readiness for counseling, pharmacotherapy and/or residential treatment.

A second major strength of a phenomenological study such as this is that it attempts to retain the integrity of the phenomenon under study – drug dependence as it is lived. The goal of the study is to describe the essential constituents of the phenomenon preserving the ways in which they imply one another, the relational way in which they are structured, not as separate entities impacting on one another, but as a whole of interrelations among the constituent elements of the phenomenon. Essentially, this structural description says *what* the phenomenon is. It is an account that stands on its own and enables understanding of a life world phenomenon, the structure of the experience of drug dependence as it is experienced in everyday life, and ways to step into that world.

A definite strength of this method is also its sensitivity to the subtle nuances of the participants' perceptions and interpretations. Through the use of open-ended

questions, the participants were able to communicate more elusive thoughts of their lived experience than what would have been possible had close-ended questions been used. Additionally, as unforeseen feelings and perceptions were uncovered, the line of questioning could be quickly changed using cues offered by the participant to capture such discoveries and further assist them with disclosing the lived experience. For the researcher, an advantage of the method used in this study is that it provides for gaining insight into the self, in particular, an increased awareness of one's own place in the world in relation to the participants'. As such, an increased awareness empowers one to act with greater understanding when encountering the phenomenon of drug dependence in the future.

Furthermore, phenomenological methods such as the one used in this study can be profitably used together with quantitative methods (triangulation) in the study of the same phenomenon (Wilson & Hutchinson, 1991). Although differing on several grounds such as data collection, analysis, and theoretical perspective, the information obtained through combining a phenomenological method with a quantitative method may assist in providing a more complementary explanation or picture of the phenomenon under inquiry. For example, administering multiple urine tests can determine what drugs a participant used within a certain time period but not why they used them, the social or cultural context within which they were used or the subsequent feelings/effects they experienced. As such, phenomenological research can explore the relation between the type of drugs used as measured by urine testing, the influence of the participants' cultural and social environment on their drug taking and the feelings they experienced, that is, once a trend had been identified via quantitative methods, the circumstances from which that trend was derived can be explored phenomenologically to gain an understanding of the meanings, perceptions, beliefs, values, and behaviours of the participants in relation to their drug dependence. With triangulation, not only may the limitations of the phenomenological method be compensated for by the strengths of a quantitative method, there may also be improvement in the truthfulness and soundness of findings. According to Fielding & Fielding (1986), the use of both qualitative and quantitative methods for measuring or capturing a phenomenon of interest is useful in identifying the direction of and estimating the extent of bias, validating or verifying results and providing complementary and complete information about the phenomenon under inquiry.

Implications for drug dependence practice

In interactions with clients who use drugs and are drug dependent, health care professionals need to take into consideration a number of insights provided by this study. Above all, the findings of this research study highlight the importance of health care professionals confirming drug dependent people as valuable human beings in their interactions with them. Such confirmation must be recognition of the drug dependent person as a client whose viewpoints and narratives deserve to be met with interest and respect and whose experiences are listened to and acknowledged as being real for them.

Essentially, it is not enough for the health care professional to understand drug dependent people in terms of the many different theoretical perspectives that exist. Although they guide the health care professional in providing care to drug dependent people and are important to know, drug dependence is a dynamic phenomenon that may be better understood using a different perspective that allows a fuller understanding of this human experience. For the health care professional, phenomenologically informed practice offers an approach to caring that better serves the client who is drug dependent. Thus, it is of greater importance that the health care professional listen to and understand the drug dependent person's needs both regarding the meaning of their experiences when seeking care and to trust in their ability to know they are an authority on their experience, that they are responsible for their choices and actions and that they have the capability to recreate a future of possibilities with the support of others. As essential parts of true professional caring, being acknowledged as an individual, a person of value, and being listened to and treated with respect can be, in the drug dependent person's perception, the most important aspects of treatment when sought.

Basically, being drug dependent is a highly subjective experience. The way drug dependent people view themselves and others differs from non-drug dependent people, and so health care professionals need to understand how they experience and appraise their situation in the world. Furthermore, the lived experience of drug dependence involves existential changes that are often uncertain and overwhelming

for the individual. An important challenge for health care professionals caring for drug dependent people is to help the individual adapt to a new situation, that of not being drug dependent, and to find a healthy identity based on trust in their own judgement and in their own perceptions. In order to do this it is crucial that the health care professional listen to the drug dependent person and use their subjective experience as a basis for individually planned interventions. As such, the findings of this study can be of help to health care professionals in the effort to understand and care for drug dependent people on their journey.

The findings of this study also highlight the importance in drug dependence practice that any treatment sought by the drug dependent person be not only appropriate but also accessible and readily available. For the drug dependent person inappropriate treatment (for example, the imposition of a drug free goal), lack of choice in treatment (for example, residential treatment facilities that adhere to a unitary treatment model), and negative stereotyping by both health care professionals and others (for example, adherents of the moral perspective who believe that drug addicts are weakwilled, irresponsible and immoral) were interpreted as a reflection on society's contempt and hostility toward them, thus affecting their decision to seek help and stay in treatment.

As such, any treatment interventions by health care professionals should be designed to meet the drug dependent person's needs. An understanding of the meanings that drug dependent persons attach to their behavior and interactions can provide the framework for any such treatment interventions. The core of the drug dependent person's response to treatment is based on their connection with the health care professional, a connection established through reciprocal sharing and revealing of self within a context of caring, respect and acceptance. For the health care professional, such a connection facilitates communication of what matters to the drug dependent person, creates conditions that connect the drug dependent person to uncover what is important in their lives, and enhances possibilities of providing solicitous care that will provide the drug dependent person to engage in treatment.

Finally, because the study provides some descriptions of the lived experience of drug dependence, it can be a reading material for health care professionals working alongside people who are drug dependent to gain a better understanding of their

predicament and also students in order to better prepare them for their role as professionals in the drug dependence field. In order to provide solicitous care and support that is meaningful to the drug dependent person, health care professionals must be aware of what the drug dependent person is going through and that they themselves form part of the relational world of *we* and *them*, a world in which the drug dependent person struggles with a range of problems related specifically to their drug dependence and problems that develop from the reactions of others towards them. Accordingly, the descriptions and interpretations of the study enable the health care professional as reader to consciously reflect on the drug dependent person's world and to develop a broader knowledge and understanding of the meaning of what it is like to be drug dependent.

As a method, hermeneutical phenomenology offers a different understanding about drug dependence. Through this approach, the meaning associated with drug dependence is not only uncovered, brought to light, but is maintained within the context in which it was generated. Such an understanding can bridge the gap between the way the health care professional thinks about drug dependence and the way it is experienced by those who live it. By being willing to try to understand the person's experience of drug dependence, recognize their hopes and fears, that which matters, and to acknowledge the way in which they find themselves alongside others, health care professionals are in a position to make a difference in their lives, to provide solicitous drug dependence practice. Challenges such as confirming drug dependent persons as valuable human beings and understanding their needs through listening to them make drug dependence practice meaningful and integral to professional solicitous care.

Suggestions for further research

The aim of this Heideggerian hermeneutical phenomenological study was to uncover meanings embedded in descriptions of the everyday lived experience of drug dependence and to bring to speech that which has been uncovered (Van Manen, 1990). Given that there is a paucity of research about the meaning of people's lived experience of being drug dependent, this study represents advancement to the knowledge and understanding of this complex human phenomenon. Although

representing a step forward in research into drug dependence, there is a real need for further research that encourages the voicing of drug dependent people's experiences and emphasizes understanding the meaning of the drug dependence experience from their perspective, in effect, the subjective experience of drug dependence.

For example, it would have been of interest to know more about how drug craving is experienced, what relapse means when the drug user is determined to give up using drugs, what finally getting off drugs means to the drug user, and what the social roles amongst drug users mean. Due to time constraints, it was beyond the bounds of possibility to carry on with the study to continue data collection with the participants to encompass such issues. Another such need is for research that examines why many people are not motivated or ready to seek help for their drug dependence, and if they do, why they do not seek it sooner or why they do not stay in treatment after seeking help.

Such studies can be valuable in gaining not only a clearer understanding of the techniques needed for attracting drug dependent people into treatment and in improving the existing provision of care but also in meeting their needs in a treatment setting and addressing motivation, ambivalence, and readiness for change. There is also a need for research into why some people are able to get off drugs through their own efforts without outside clinical intervention. Such findings could be of immense benefit in assisting others to become drug free through the use of various coping strategies such as avoidance, self-reinforcement, and hope.

In addition, drug dependence research would benefit by examining the lived experience of both licit and illicit drug dependence in different groups such as the aged, children, parents, Maori, other minority ethnic groups, pregnant women, and health professionals. In focusing on the subjective experiences of drug dependence in these groups, patterns would be uncovered that may help us better understand the importance of self image and identity in becoming and being drug dependent, and to target prevention, intervention, and treatment strategies to such populations.

Future research also needs to address such questions as: what does the terms *addict/junkie* mean and do they mean different things to different people? do drug

dependence theories help drug dependent people make sense of their experience?; what is the meaning of family and peer influences on the genesis of drug use?; what is the health care professionals experience of drug dependent people?; what is the drug dependent person's perception of their own drug dependence and their desire to rise above it or stay in it?; and, what is the meaning of drug seeking behavior? In addition to the above specific questions related to drug dependence which deserve further research, work is needed to explore interventions, models of treatment, and services which drug dependent people find helpful in becoming and being drug free. Such research might be of assistance in generating standards and guidelines for treatment and to use in the evaluation and monitoring of treatment programs. Furthermore, research that focuses on examining expert drug dependence practice is needed, particularly as it is perceived by drug dependent people, their families, and others involved in the field. In the New Zealand drug dependence field there is a dearth of research which looks at the knowledge and skills necessary for health care professionals and vocational workers treating and dealing with people who have drug problems or which evaluates education and training programs for those who work in the field.

Finally, there is a need for research that looks at the phenomenon of care from the perspectives of both the health care professional and the drug dependent person. In this study, care encompasses both concerns for the things that are important to one and solicitude – a concern for others. Care is the significance which being in the world has for human beings and as such is of importance in drug dependence practice. If drug dependence practice is to be based on that which matters, that which is of importance to one in their life, what one cares about; then those choosing to help people with a drug dependence to deal with their world, with the situation in which they find themselves, need to not only know about caring and solicitude but also to live the experience of them.

Conclusion

This study set out to investigate what it is like to live with drug dependence, to be-in-the-world in this way. It confirmed that drug dependence is a complex and all encompassing phenomenon, a phenomenon which is the result of many interactive

factors that vary in salience from one person to another, a phenomenon which resides in human experience, not in drugs. Because drug dependence lies embedded in human experience and is a complex and established part of human *Being*, a methodology that would allow a multidimensional approach that could most effectively give an insider's view of what it is like to live with a drug dependence was required. In addition, the methodology needed to focus on the person with drug dependence wholistically and be deeply embedded in the world of their everyday life (Van Manen, 1990).

Accordingly, the choice of phenomenology arose because as a method, it allows the embedded meaning in everyday lived experience to be uncovered in such a way that it can be made explicit. As a method, phenomenology also had the ability to provide insight into the health care professional – client relationship and to possibly help uncover ways of caring that are specific to the experiencing person, both of which, when combined with a deeper more meaningful understanding of the individual's lived experience of drug dependence, are essential for the provision and delivery of the best possible standard of care in drug dependence practice.

From the many possible phenomenological approaches to uncovering and describing the meaning of a lived experience, Heideggerian hermeneutics, a phenomenological approach based on the philosophical world-view of Martin Heidegger (1927/1962) was chosen. Heideggerian philosophical perspective views the essence of being – *Dasien*, as embedded in everyday experience, the meaning of which is revealed through hermeneutical interpretation – the practice of phenomenological reflection and writing to understand a person's life-world (Heidegger, 1927/1962; Van Manen, 1990). Thus, as a philosophical framework within which to interpret and retell the participants' accounts of their lived experience of drug dependence, Heideggerian phenomenology proved worthwhile. In addition, through using the phenomenological hermeneutics of Heidegger (1927/1962), in listening to, transcribing, analyzing, interpreting, reflecting, organizing, writing and rewriting the participants' everyday lived experiences of drug dependence, their very humanness, their being-in-the-world, is appreciated and valued. As such, the use of Heideggerian hermeneutical phenomenology has provided a rich understanding into the lived experience of the

person with a drug dependence as well as yield valuable insights into the fundamental nature of drug dependence.

In this study, the presented data provide a rich narrative that elucidates what it is like to live in the world with drug dependence. For the participants, drug dependence is a powerful life experience which can be compared to a journey, an arduous journey into the unknown, a journey laden with chaos and uncertainty, a journey of watching out and looking forward, a journey which has exerted profound physical, psychological, and social effects upon the whole of their Being-in-the-world. When the participants commenced their journey into drug dependence, their past circumstances, their present situation, and their future expectations were part of what they carried with them. Once aboard the drug bandwagon each of the participants were thrown into a different way of Being, a being comprised of changed embodiment – feeling different both physically and psychically; of being alongside others in a different way – meeting with resentment, condemnation, and prejudice; and of dealing with the world, with the situations within which they found themselves – everyday actions and choices about that which mattered, was of concern, a being with care.

Interwoven in the participants' accounts of their lived experience of drug dependence are offerings of new ways for others to come to a more meaningful understanding of their life-world and of the ways in which health care professionals can engage more fully with the concerns of the drug dependant individual in order to provide care and support that is meaningful for them. In telling their stories the participants not only spoke of what it was like to be in the world with a drug dependence – the situation in which each of them found themselves thrown into, but also what it was like to be a human being in the world, a world into which we are all thrown and share, a world within which things matter, are of concern. Through the voicing of their lived experience of drug dependence, their human beingness in the world, the participants have provided a greater understanding of the meaning and importance of becoming and being drug dependent and of what it is like to be in the world in this way. Such understanding not only draws attention to the importance of relating to drug dependent people in a humanized manner but also opens up new possibilities for informing drug dependence practice and addressing the needs of these people.

In this chapter, the findings of the study have been considered with a particular focus on Heidegger's (1927/1962) concept of solicitude as care for others. It was asserted that solicitude, as care, could provide a basis for clinical practice that is based on understanding the experience of the drug dependent person. In drug dependence practice therapeutic interventions and treatments which are effective and appropriate in meeting the drug dependent person's needs and difficulties depend on adequate understanding of human experiences of drug dependence, and the meanings such experiences have for those involved. As illustrated in this study in relation to drug dependence, Heideggerian hermeneutic phenomenology is of benefit in deepening our understanding of lived human experience through understanding the meaning of the experience from the individual's perspective, and involvement in helping to create the possibility of change.

This study arose out of being challenged that I "don't know what it's like" by a drug dependent person in clinical practice. It was my belief that it was possible to understand what it is like to live with a drug dependence from a client's perspective and that understanding would not only create a better appreciation of the experience but also enable me to help the client find and use their strength in making their future choices. In conclusion, qualitative research of this nature can do much to explicate the meaning of drug dependence and improve the quality of the drug dependent person's care.

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APPENDIX I

GLOSSARY OF TERMS

Glossary of commonly used street slang referring to drugs, drug use, and other terms associated with the drug scene/culture. Many colloquial names of drugs and drug related words are region specific and time specific, for example, what people in Wellington call Blues may be different to what people in Auckland call Blues. New terms are continuously being introduced by users to hide the nature of their activities or simply to use a more colourful and graphic imagery

Bud – cannabis flower head

Bennies -amphetamines, benzedrine pills

Benzos - benzodiazepines

Bust - To arrest, or be arrested by police

Buy - To purchase drugs

Buzz - Moderate high, stone from a drug without hallucinations

Cabbage - Cannabis leaf

Clean - Free from suspicion, not having drugs in one's possession, not using drugs any longer, cannabis with leaves, seeds, sticks removed

Coke - Cocaine

Cold turkey - Abrupt withdrawal from drugs that have produced physical dependence

Cook - To heat a mixture of drugs ready for injection

Crap - Low quality drugs of any type but usually cannabis

Crash - To come down after using drugs, to go to bed or to sleep

Cut - To dilute a drug with another substance to make more quantity

Dak - Cannabis

Datura - Jimson weed, has psychoactive properties

Deal - To buy, supply or sell drugs (also dealer, dealing)

Do, or Doing - Refers to the state in which someone is using a drug ('doing' acid)

Done - Methadone hydrochloride

Doobie - Cannabis joint

Dope - Any psychoactive drug, particularly cannabis

Dope fiend - Term applied to themselves by those who are dependent on drugs

Druggies - Regular drug users, dependent drug user

Dynamite – high grade heroin

Ecstasy -MDMA-3, 4 -methylenedioxy methamphetamine. One of the hallucinogens, also called eckies, E's, XTC, M&M's

Fit - Syringe and needle, outfit for injecting drugs

Fix, To - To inject a drug intravenously

Footballs - Amphetamines

Footies - Temazepam, a benzodiazepine. Generic, Euphynos,

Freak - Person who prefers a particular drug or behaviour (speed freak); or person whose lifestyle, behaviour, appearance, or ideas determine that the person is different from mainstream society

Geeze – get high

Gear - Any drug, especially cannabis or drugs for injecting

Get off - To experience a change in consciousness as a result of drug use

Get on - To use drugs for the first time

Grass - Cannabis

H - Heroin

Hard stuff - Usually opioids/heroin/homebake

Hep - Hepatitis

Hit - To inject intravenously

Homebake -Synthetic drug produced from analgesics containing codeine to resemble morphine/heroin

Hooked - Physically dependent on drugs

High – stoned, out of it

Habit – drug dependence

Heavies – aggressive people

Into - Using drugs

Jack(ing) - Drawing blood into a syringe/injecting

Joint - Cannabis cigarette

Junkie - American term that originated in the 1930's when addicts were prescribed heroin but had to pay for scripts so they collected scrap metal and junk to sell to merchants. One who is physically dependent on hard drugs

KG - A kilogram

IV – intravenous drug use

Kilo - a kilogram of drugs, usually cannabis

LSD - D-lysergic acid diethylamide tartrate 25, acid

Marzine - Cyclizine, an antiemetic, usually mixed with morphine sulphate and injected

Misties - Morphine sulphate tablets

Morph - Morphine

MST'S - Morphine sulphate tablets

Maryjane – marijuana

Mushies – mushrooms

Mash out – get stoned, out of it

Nark - Informer, also a drug squad detective

Nod, Nodding, on the Nod - Drowsy, dreamy, dozy state following injection of an opioid drug characterised by head lolling forward and then slowly jerking up and down

Off it - out of it, stoned, high, fucked

On - Using drugs

On tick - credit when purchasing drugs

Opiate - any non synthetic opioid including morphine, heroin and codeine. Opium and its derivatives

Opioid - the generic term applied to substances derived from the opium poppy, their synthetic counterparts, and compounds synthesised in the body

Opium - the resinous liquid obtained from the seed heads of the opium poppy

Outfit - injecting equipment

Pick - Needle

Poppies - Opium poppy (*Papaver somniferum*)

Pot - Cannabis

Primo - Good quality cannabis

Rivvies - Clonazepam, a benzodiazepine. Generic, Rivotril

Rollies - Rohynol

Rush - Initial onset or feelings of euphoria after taking a drug

Score - Buy drugs
Script - Drug prescription
Shitfaced - Stoned, high, fucked
Shoot up - Inject drugs
Smack - Heroin
Smashed - Stoned, out of it, high, fucked up
Snort - sniffing drugs
Spaced out - High, stoned, ripped, fucked
Speed - Methamphetamine
Spot, spotting - Method of smoking cannabis, usually a spot placed on a knife, heated over a flame or element and smoke sucked up through a straw or paper tube
Stoned - High, ripped, flying, out of it
Straight - Not using drugs; not intoxicated with drugs; not under the influence of drugs
OD - overdose
Sessioning – talking about drugs, drug use
Stoned – drug effects
Strung out - Physically dependent on a drug
Taste - Injecting drugs
Temmies - Temgesic
Toke - A puff of a joint
Trip - To take hallucinogenic drugs; the actual experience one has using hallucinogenic drugs; acid
Using - To take drugs
Wasted - Stoned, high, out of it, fucked, very intoxicated
Weed - Cannabis
Works - Equipment for injecting drugs



**MASSEY
UNIVERSITY**

Private Bag 11222
Palmerston North
New Zealand
Telephone 0-6-356 9099

APPENDIX II

Facsimile

6 November 1997

Margaret Anne Adams WILLIAMS
Department: Psychology

Dear Margaret,

Re: Human Ethics Application: HEC97/139

A Phenomenological approach to understanding the social and psychological meaning of drug taking.

Thank you for attending the meeting of the Human Ethics Committee held on Friday 24 October, with your supervisor Mr Kerry Chamberlain. The Committee appreciated your clarification of a number of issues raised. The following points need to be attended to in relation to your application.

The title of the research project should be amended to:

A Users Perceptions of Their Own Drug Use

Format the first paragraph of the Information Sheet as an introduction of the researcher, the reason for the research, the telephone contact numbers of the researcher and your supervisor.

Amend the fourth paragraph of the Information Sheet to read:

Acknowledgment of the personal significance and meaning of using drugs may assist in the development of effective treatment and prevention programs.

Amend the heading - **What would you have to do:**

The Committee outlined their concern that all steps were taken for the protection of the researcher. All material and tapes collected in relation to the research must be stored in a manner whereby the researcher and participants are both protected. No identifying names or addresses should be used.

Advise participants that they may have the option to have the audio tapes returned to them or destroyed. This should also appear in the Consent Form.

Also include clause: (in the Information Sheet and Consent Form)

I agree/do not agree to the interview being taped.

I understand that I have the right to ask for the tape recorder to be turned off at any time.

The Committee asked you to consider how you will deal with learning about any serious criminal activities during the course of her research.

Reimbursement:

After considerable discussion regarding the reimbursement of expenses for those taking part in this research, the Committee concluded that participants, if they wished, should be given the choice to accept reimbursement of up to \$20 to cover actual expenses incurred by their participation in the research project.

Subject to the above amendments and inclusions being received, the ethics of the application are approved.

Any departure from the approved protocol will require the researcher to return this project to the Human Ethics Committee for further consideration and approval.

Yours sincerely



PP Professor Philip Dewe
Chairperson
Human Ethics Committees

cc: Supervisor: Kerry Chamberlain



**MASSEY
UNIVERSITY**

Private Bag 11222
Palmerston North
New Zealand
Telephone +64-6-356 9099
Facsimile +64-6-350 5608

**FACULTY OF
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**DEPARTMENT OF
HUMAN
RESOURCE
MANAGEMENT**

1st December 1997

**Margaret Williams
Department of Psychology
MASSEY UNIVERSITY**

Dear Margaret

Re: **Human Ethics Application HEC 97/139**
*A Phenomenological Approach to Understanding the Social and Psychological
Meaning of Drug Taking.*

Thank you for your letter of 21st November and the information sheet and consent form.

The amendments you have made now meet the requirements of the Human Ethics
Committee and the ethics of your project are approved.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Philip Dewe', written over a large, loopy initial 'P'.

**Professor Philip Dewe
Chairperson
Human Ethics Committee**

c.c. Kerry Chamberlain and Chris Stephens
Department of Psychology

DO YOU USE DRUGS?

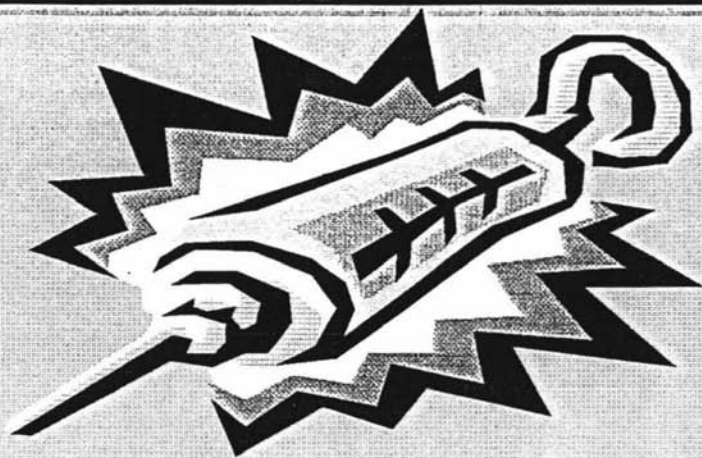
The study will look at the drug using experience - which only the user is capable of conveying. Being part of this study will involve an interview where you can talk about your experiences, beliefs, attitudes and expectations with regard to your drug use. Users themselves are the most important source of information. There is a \$20 payment for any expenses incurred.



WOULD YOU LIKE TO BE PART OF A STUDY?

**Contact Margaret
at the IV Union 06 3571059
on Monday nights
or phone her at
and leave a contact number.**

DO YOU USE DRUGS?



WOULD YOU LIKE TO BE PART OF A STUDY?

The study will look at the user's own perceptions and meaning of drug use. It will involve an interview where you can talk about your beliefs, attitudes, and expectations with regard to your drug use. There is a payment of \$20 for expenses.

See Margaret

***AT THE IV UNION ON MONDAY NIGHT OR LEAVE
YOUR NAME AND/OR CONTACT NUMBER AT THE IV
UNION***



**MASSEY
UNIVERSITY**

Private Bag 11222
Palmerston North
New Zealand
Telephone +64-6-356 9099
Facsimile +64-6-350 5673

**FACULTY OF
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APPENDIX IV

A USERS PERCEPTIONS OF THEIR OWN DRUG USE

INFORMATION SHEET

WHO AM I?

My name is Margaret Williams. I am a post graduate psychology student undertaking research for a Doctor of Philosophy Degree at Massey University and would like to invite you to participate in a study of people who use illicit drugs. From this study I hope to learn about your experiences and your thoughts and feelings related to your drug use. For the duration of the research I will have two supervisors, Kerry Chamberlain and Chris Stephens, who, along with me, can be contacted if you require any further information or have any questions, by telephoning us at 06 366 9099 (Psychology Department, Massey University).

WHAT THE STUDY IS ABOUT

The purpose of this study is to explore and to understand the social and psychological meaning of drug taking by investigating drug user's perceptions of their own drug use, more specifically, the drug user's own ideas about the reasons for their having gotten involved with drugs, their continuing drug use, the meaning that the use of drugs has for the, and their ability/inability, resistance, or wishes to overcome or change their drug use.

Throughout the investigation, the broader context in which drug use behavior takes place will be taken into account, that is, the implications of the drug user's own perceptions of their drug use and their beliefs, attitudes, and expectations with regard to their drug use.

Acknowledgement of the personal significance and meaning of using drugs may assist in the development of more effective prevention, intervention, and treatment programs.

WHAT WOULD YOU HAVE TO DO?

Participation in this study would involve an in-depth interview employing open ended questions in which you would be asked to describe your experiences of drug taking, and to share your thoughts, perceptions, and feelings about these experiences. The interview would be audiotaped in full and there would be no time limit placed on the length of the interview.

The audiotapes will be transcribed using identification numbers or pseudonyms. No identifying information will appear in the transcriptions. On completion of the transcribing all tapes will be destroyed or if requested, be given to you.

ARE YOU ELIGIBLE?

To participate in this study you must be both willing and able to discuss your drug using experiences, be between the ages of 16 - 55 years, and have used an illicit drug at least once a day on at least 8 days during the previous two weeks.

WHAT CAN I EXPECT FROM THE RESEARCHER?

If you participate in this study you have the right to:

- Refuse to answer any particular question at any time
- To withdraw from the study at any time.
- Ask any further questions about the study that occur to you during or after your participation.
- Provide information on the understanding that it is completely confidential to the researcher. Identification codes will be made for each participant and kept in a locked filing cabinet. Audiotapes will be transcribed using the identification codes and also stored in the cabinet. No identifying information will appear on the transcripts or in any published report.
- Be given a summary of the findings on completion of the study.

Once again, if you require any further information on the study, or wish to contact me for any reason, you can write to me c/- The Psychology Department, Massey University, or contact my supervisors, Kerry Chamberlain and Chris Stephens, at the same address, or telephone them at 06 356 9099.

If you choose to participate, I look forward to interviewing you. Thank you.

Margaret Williams



**MASSEY
UNIVERSITY**

Private Bag 11222
Palmerston North
New Zealand
Telephone +64-6-356 9099
Facsimile +64-6-350 5673

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APPENDIX V

A USERS PERCEPTIONS OF THEIR OWN DRUG USE

CONSENT FORM

I have read the information sheet and have had the details of the study explained to me and I understand what is required of me as a participant.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular question.

I agree to provide information to the researcher on the understanding that it is completely confidential.

I agree/do not agree to the interview being audiotaped.

I understand that I have the right to ask for the tape recorder to be turned off at any time during the interview.

I agree to the researcher using quotations in the final report on the understanding that I will not be able to be identified.

I understand that I have the option of having the audiotape of the interview given to me on completion of transcribing or of being destroyed by the researcher.

I wish to participate in this study under the conditions set out on the information sheet.

SIGNED:

NAME:

DATE:



**MASSEY
UNIVERSITY**

Private Bag 11222
Palmerston North
New Zealand
Telephone +64-6-356 9099
Facsimile +64-6-350 5673

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APPENDIX VI

Confidentiality Agreement

The confidentiality of the participants in *A Phenomenological Approach to Understanding the Social and Psychological Meaning of Drug Taking* is protected by the Code of Ethical Conduct for Research and Teaching Involving Human Subjects as endorsed by Massey University Council.

As a person transcribing audiotapes, I have been made aware of, and understand the Code and acknowledge that in processing any information from the above study, that I am bound by the above Code regarding confidentiality and will not disclose any information pertaining to the participants.

Date:

Signed:

Name: