Research Article

"I Was Raised in Addiction": Constructions of the Self and the Other in Discourses of Addiction and Recovery

Adams L. Sibley[1] ![ORCID], Christine A. Schalkoff[1], Emma L. Richard[2], Hannah M. Piscalko[2], Daniel L. Brook[2], Kathryn E. Lancaster[2], William C. Miller[2], and Vivian F. Go[1]

Abstract

The aim of this article is to address how conceptualizations of addiction shape the lived experiences of people who use drugs (PWUDs) during the current opioid epidemic. Using a discourse analytic approach, we examine interview transcripts from 27 PWUDs in rural Appalachian Ohio. We investigate the ways in which participants talk about their substance use, what these linguistic choices reveal about their conceptions of self and other PWUDs, and how participants' discursive caches might be constrained by or defined within broader social discourses. We highlight three subject positions enacted by participants during the interviews: *addict* as victim of circumstance, *addict* as good Samaritan, and *addict* as motivated for change. We argue participants leverage these positions to contrast themselves with a reified *addict*-other whose identity carries socially ascribed characteristics of being blameworthy, immoral, callous, and complicit. We implicate these processes in the perpetuation of intragroup stigma and discuss implications for intervention.

Keywords

discourse analysis; addiction; harm reduction; substance use disorders; opioids; stigma; rural health; Ohio; qualitative methods

Introduction

In the United States, 11.2% of people aged 12 and above report having used any illicit substance in the last month (Centers for Disease Control and Prevention, 2017). Of imminent concern is the rise in misuse of prescription and non-prescription opioids, which accounted for 47,600 deaths in 2017 (National Institute on Drug Abuse, 2019). The economic burden of the opioid epidemic may be as high as US$504 billion annually (Davenport et al., 2019; White House Council of Economic Advisers, 2017). Over the past two decades, the epidemic has sustained a growing discourse around its historical determinants, its human and social impacts, and the pursuit of sustainable interventions. It is a crisis now firmly embedded in the American zeitgeist, capturing the attention of not only public health officials and policy makers but the public more broadly (Blendon & Benson, 2018; Russell et al., 2019).

In light of this national epidemic and its impact across socioeconomic and geographic strata, and in the search for solutions in both prevention and treatment, there is renewed discussion in the public sphere about what actually constitutes addiction, that is, what it means to be addicted. Drug use and addiction are topics that have been explored for decades in the discourse literature (Bailey, 2005). Debate continues about how addiction should be conceptualized, and what implications these definitions serve—whether, for instance, addiction is a choice or outside the locus of individual control, whether it is a disease of the brain or a moral failure, whether drug use is taken up hedonistically or in response to psychological trauma, and whether addiction only occurs among

[1]The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA
[2]The Ohio State University, Columbus, Ohio, USA

Corresponding Author:
Adams L. Sibley, Gillings School of Global Public Health, The University of North Carolina at Chapel Hill, 302 Rosenau Hall, 135 Dauer Drive CB7440, Chapel Hill, NC 27599, USA.
Email: asibley@live.unc.edu

certain people under certain conditions or whether it can happen to anyone (J. B. Davies, 1997; Hammer et al., 2013; Keane, 2002; Pickard et al., 2015; Reinarman, 2005). Elsewhere, personal identity within addiction is queried, as in research on 12-step peer support programs, where members are encouraged to self-label as "addict," even in recovery; self-narrative is leveraged to explain past and negotiate present versions of the self (Frank, 2011; Rafalovich, 1999; Reinarman, 2005). These debates are not merely pedantic; discourse is fundamental to an individual's experience of addiction. Within the social constructionist framework, and by extension discourse theory, identity is not static but a culturally negotiated process of formation and transformation (De Fina et al., 2006). Whether *sent down* through institutional ideologies or *carried up* through the interactional contexts of everyday talk, discourse constrains (or enables, depending on one's view of agency) the possible selfhoods one can assume (Bamberg et al., 2011; Fairclough, 2015).

Identity (as a social process) has legitimate implications for health outcomes among people who use drugs (PWUDs). The addiction experience has been conceptualized as a pathway of identity loss and gain: As individuals transition into addiction, the positive markers of identity (e.g., being a good parent) begin to diminish and are eventually displaced by new identities (e.g., fitting in with peer drug users; Best et al., 2016; Dingle et al., 2015). The role of self-concept may be particularly salient in recovery: Individuals who value a recovery-oriented social identity over an addiction-oriented social identity fare better in addiction treatment (Buckingham et al., 2013). Providing resources that promote positive recovery self-concepts may likewise improve treatment initiation and adherence (Downey et al., 2000; Gourlay et al., 2005). As the concept of addiction is increasingly understood as a "person-in-a-particular-social-world disorder" (Flanagan, 2013, p. 3), it is critical to consider how these conceptualizations shape the lived experiences and identity processes of PWUDs.

Discourse and Addiction

We turn now to the topic of discourse—"a group of statements which provide a language for talking about—that is, a way of representing—a particular kind of knowledge about a topic" (Hall, 1992, p. 290). Discourses can be understood as the systematic ways that social reality is constructed by and reflected through language (Parker, 1992). Whether embodied in talk or written text, a particular discourse represents a finite array of possible statements that can be made about an object (e.g., addiction). Discursive formations are often taken for granted in society as obvious and natural, and as such are imbued with ontological authority (van Dijk, 1995). The socially

constitutive power of discourse lies in its tendency to legitimize certain lines of argumentation while delegitimizing others, to imbue discursive objects with putative attributes and qualities, and to construct and delimit possible ways of seeing and being in the world (Reisigl & Wodak, 2001; Willig, 2008). These constructions are made possible if we accept the notion (advanced by discursive psychologists in rejection of cognitivism) that there are no "consensual objects of thought" (Willig, 2008, p. 161)—that is, the notion that addiction, as a concept, is neither permanent nor mutually comprehensible. For individuals experiencing addiction (however understood), there are implications for both experience and identity. What traits are ascribed to those who use drugs illicitly? Where is the boundary between addiction and drug misuse (or between the "addict" and "non-addict"; Bailey, 2005)? What is to be made of the liminal space between addiction and recovery (Wagner et al., 2016)? How is discrimination against individuals with substance use issues justified? And who gets to decide?

In this article, we examine talk used by PWUDs in interviews about their lived experience of addiction, including drug use history, risk behaviors, and treatment attempts. We investigate the ways in which participants talk about their experiences with substance use, what these linguistic choices reveal about their conceptions of self and of other PWUDs, and how these conceptions might be constrained by or defined within broader social discourses. We demonstrate that language is a powerful resource for PWUDs in meaning making and identity construction, which are in turn constitutive of the social realities of addiction. Finally, we explore implications of these processes in the perpetuation of intragroup stigma, a phenomenon that potentially impedes solidarity among PWUDs.

Method

The data used in this article come from a larger study of the opioid epidemic in rural Appalachian Ohio. The study was part of a domestic multi-site project funded by the National Institute on Drug Abuse (Grant: #UG3/UH3DA044822; Principal Investigators [PIs]: Go and Miller). Ethical approval was granted by the Ohio State University's Behavioral and Social Sciences Institutional Review Board (#2017B0328).

Recruitment was initiated through partnerships with local health care organizations, including health departments and treatment facilities, which referred potential participants to our study. The study team also distributed flyers to areas where PWUDs might frequent, including social service organizations, homeless shelters, peer support and recovery groups, churches, and gas stations. Participants were also identified through

snowball sampling, in which respondents were asked to share information about the study with peers. Eligibility criteria included being 18 years of age or older, claiming residence in one of the study counties, and having a history of either illicit opioid use or any injection drug use.

This article is based on 27 in-depth interviews with PWUDs in three counties in Southern Ohio. Respondents included 14 men and 13 women ranging in age from 25 to 59. Fifteen respondents reported using any drug illicitly in the previous 30 days. The most commonly discussed substances included heroin, fentanyl, prescription opioids and benzodiazepines, methamphetamine/ice, cocaine, and diverted buprenorphine. Most respondents indicated injection as a preferred route of administration. Fewer than half of respondents discussed being in recovery at the time of the interview, ranging in length from a few days to about a year, including a minority who were prescribed medication for opioid use disorder (MOUD, typically buprenorphine or buprenorphine/naloxone) by a clinician. All participants were White, which is representative of the study region, where Whites compose 95% to 98% of the population at the county level.

Data Collection

In-depth interviews were conducted between April and August of 2018 by two graduate research assistants with extensive training in qualitative methods. Both interviewers were White females in their 20s. The semistructured interview guide was collaboratively designed by an interdisciplinary team of health researchers across eight grantee institutions and intended to elicit barriers to substance use treatment and uncover opportunities for intervention (Supplemental Material). After providing written informed consent, participants were asked to describe current and past drug use, risk behaviors, interactions with law enforcement and health care providers, and other experiences pertinent to their drug use (such as treatment attempts and infectious disease testing). Questions included prompts like "Tell me about the first time you used a drug aside from alcohol to get high—it could be pain pills, marijuana, or something else" and "Tell me about your most recent interaction with any doctor or other health care provider." Interviewers were encouraged to probe on participants' experiences as well as perceptions (e.g., "What led you to see a doctor or health care provider? How, if at all, did the topic of drug use come up? How did the conversation go?"). Interviews were conducted in private rooms in health departments and substance use treatment organizations, or, at the request of participants, in public locations like coffee shops. Each interview lasted, on average, about 1 hour. All participants received US$25 and a printed sheet of local harm reduction, treatment, and mental health

resources. The audio-recorded interviews were subsequently transcribed verbatim by the interviewers, producing a corpus of 301 single-spaced pages of text.

From a discourse analytic perspective, it is important to be cognizant of not only language but also the social context in which it is used (Paltridge, 2006). The data presented in this article include illustrative quotations from individuals with lived experiences of addiction but are excerpted from discrete and formalized dialogic exchanges between academic researchers and research participants. PWUDs may discuss addiction differently in a formal interview than they would in a peer support group, with family and friends, or among other PWUDs. Even in research settings, the discursive tenor may be different in a focus group of PWUDs, which encourages solidarity and elicits shared experiences, than in a one-on-one interview (see, for instance, Nieweglowski et al., 2018). The interpersonal context of the data collection, along with the structured questions that guided the interaction, likely circumscribed what participants felt impelled to share and how they chose to share it. This tension has previously been noted in qualitative studies involving PWUDs (Rance et al., 2017); however, discourse analysis (DA) is well suited for addressing the contradictions and complexities (i.e., within-text variability) of narrative accounts (Wetherell & Potter, 1988).

Data Analysis

DA includes a broad array of methodologies described across disciplines in the social sciences and humanities; what these approaches have in common is a systematic approach that treats language itself as the unit of analysis (Potter, 2004). Language is not taken for granted as a transparent medium for communication between social actors with mutual comprehension of the topic of communication but is understood to be value-laden, culturally prescribed, and used in particular ways to accomplish particular objectives (Wetherell & Potter, 1988). In studying the variations in language use between and within individuals, DA is useful for exploring how discourse constitutes (and is constituted by) the social reality of its participants.

We analyzed the data guided by methods described by Parker (1992) and adapted an orientation to the text articulated by Wood and Kroger (2000). Two primary research questions directed the analysis:

> **Research Question 1:** What discursive resources are used by participants to discuss their own addiction and the addiction of others?
> **Research Question 2:** How do participants' positions within addiction discourse influence their subjective experiences and circumscribe possible selfhoods/ways of being?

Preliminary coding focused on identifying subjects (actual or potential participants in discourse, for example, self, other PWUDs, law enforcement agents, health care providers) and objects (phenomena that are referred to and represented in discourse, for example, addiction, overdose, MOUD). Importantly, subjects within a discourse are also objects, insofar as they are assigned attributes (i.e., are constructed) in the discourse (Parker, 1990).

Subsequently, we designed thematic codes to capture potential interpretive repertoires, or the distinct grammatical and stylistic manner in which participants construct particular versions of addiction (Seymour-Smith, 2015; Wetherell, 1998; Wetherell & Potter, 1988). Interpretive repertoires are identifiable by recurring lexical and syntactic features of the text, including figures of speech, metaphors, analogies, disclaimers, extreme case formulations, narrative, and other rhetorical devices (Wetherell & Potter, 1988; Willig, 2008; Wood & Kroger, 2000). The use of a narrative code allowed us to collate the autobiographical elements of the transcripts and more efficiently parse the social and individual contexts of each participant's talk. In this way, interpretive repertoires were examined and compared both within and between transcripts (Maxwell & Miller, 2008). Identification and refinement of interpretive repertoires were facilitated through extensive memoing on the transcripts and excerpts.

The eventual analytic focus was on participants' representations of self and other, which we conceptualized as the subject positions made available to and occupied by participants within addiction discourse. Positioning is a concept developed by social psychologists to supplant the traditional notion of conversational roles (see Mead, 1934). Whereas roles are taken to be situationally static and inflexible (as in an interaction between a doctor and patient), positions are dynamic and fluid (B. Davies & Harré, 1990). Individuals may reflexively take up and move between multiple positions in a discursive interaction to serve certain purposes—for instance, to claim a desired identity—although individuals may not be aware of their positioning nor its effects: "One lives one's life in terms of one's ongoingly produced self, whoever might be responsible for its production" (B. Davies & Harré, 1990, p. 48). What follows is an account of subject positions within addiction discourse either enacted (by the self) or envisioned (for the other) by participants in the interview setting.

Although most participants identified as "addicts," a label used functionally to emphasize the helplessness of addiction (J. B. Davies, 1997), this article employs person-first language (e.g., "people who use drugs"). The use of identity-first language (e.g., "drug user") invokes attributions of responsibility for drug use and perpetuates stigmatizing attitudes, even among ostensibly compassionate groups like health professionals (Kelly & Westerhoff, 2010). Where the term "addict" is employed in this article, it is done so to mark the discursive object, not to label the persons to whom that object is attached. To clarify this distinction, *addict* will appear italicized.

Results

Throughout the interviews, participants constructed, enacted, and envisioned subject positions within discourses of addiction and recovery. Each subject position can be understood as existing diametrically with an opposite role, often occupied by an unidealized PWUD. While participants tended to explain, justify, or qualify their own struggles with drug use and its corollaries, as well as current and past attempts at treatment, they likewise positioned others—through hearsay, speculation, or case examples—as irresponsible, immoral, or complicit in addiction. In this way, participants were able to rationalize their own trajectories as plausible, even inevitable, against the backdrop of the delegitimized *addict*. In many cases, this dichotomy was implicit in the discursive techniques employed by participants. However, one participant explicated this distinction by naming and defining two categories of PWUDs, which he labeled "Type A" and "Type B":

> There is a difference between, in my mind, there are two classes of drug addicts. There are those who don't get it, will never get it, will be a drug addict their entire life, God bless them. [. . .] And, then, there are those people who just didn't have the right influences in the right times of their lives, which is the class that I am in. [. . .] The second class of addict that I find are people that just didn't know any better, started their life wrong. I have skipped all kinds of chapters in the book of life, ya know?

Below we present three subject positions used reflexively by participants to mark their own affiliation or location within discourses of addiction and recovery. The *addict as victim of circumstance* attributes one's substance use trajectory to familial abuse, economic trauma, or other external factors. The *addict as good Samaritan* portrays oneself as compassionate and morally capable in light of adversity. Finally, the *addict as motivated for change* avows one's determination to overcome addiction. Participants moved freely between these positions in the course of the interviews, taking up new roles within the discourse as the interview structure dictated or permitted. Within each position, evidence is provided for talk about the countervailing other, that is, the contrasting attitudes and behaviors which participants attribute to particular or general others to explain, justify, or validate their own positions.

The Addict as Victim of Circumstance

Participants employ narratives of victimhood to explain the geneses of their addictions and travails in treatment. Victimhood is most often explicated in terms of intergenerational familial drug use, personal experiences with trauma, encounters with unscrupulous others, and systemic discrimination.

A common strand in the data is the construction of addiction as a corollary of trauma. Most describe growing up in poverty, having parents or siblings who used illicit substances, or experiencing physical or emotional abuse in childhood. Addiction is discussed not as a practice that transpires unexpectedly but rather as a rite of passage, transmitted intergenerationally through family and friends. Participants often note that their drug use started as a coping mechanism to deal with a difficult home life or traumatic event, like the death of a loved one.

Participant 15, a construction worker who has 6 months of sobriety, attributes a lifetime of addiction to his harrowing upbringing. He started using alcohol and marijuana in early adolescence, later transitioning to heroin as a teenager. Participant 15 grew up in a large family in which drug use was seen as an acceptable, even obligatory, social practice. Ultimately, he suggests that the root of his addiction lies in abuse suffered at the hands of his father:

> Uh, forever, I said the reason I used drugs was 'cause my dad used to beat me up all the time until I was 13 years old and like that was how I would escape it.

The participant juxtaposes his struggles with addiction with a strong work ethic and self-reliance. He reminisces about taking care of his brothers and sisters and doing his best to stay out of trouble in spite of his parents, who were unwilling to chastise him for his deviant behaviors. He paints himself as a well-adjusted adult in light of these challenges, noting, "I have always kept a good job, I have always had nice things, provided for myself. I never had my parents taking care of me or nothing like that." Many participants similarly note that, even when they were at rock bottom, they made an effort to be responsible, whether that entailed taking care of their children, paying their utilities, or avoiding misconduct.

In contrast, Participant 15 questions the motives of other PWUDs, describing members of a drug culture unfamiliar to the one in which he grew up:

> I could probably walk a block any direction, I could find someone who is dealing methamphetamine or has it or is looking for it, you know? When I was growing up, say a young teenager, I had, never had someone came up to me and ask for drugs. That didn't happen. I could walk through

town and five people, hey, do you know where to get anything? What's wrong with people these days? I don't know if they just don't care.

Like Participant 15, most participants discuss the role of trauma in their addiction but are reticent to acknowledge the influence of a problematic upbringing on the behaviors of others. More often, they associate the drug use of generalized others with immorality or malfeasance. As one participant said,

> I was telling my granddaughter this the other night [I: Mhm] that we would go to bed and leave our front doors open, you know, to get cool air and stuff, and you can't do that now [I: Mhm]. I feel that the crime is because of the drug use [I: Mhm]. People are just stealing whatever to try and sell it to buy drugs [I: Mhm] and you, you just can't trust anything here now. It has really went down. (Participant 22)

Others describe their victimhood as being rooted in medical malpractice. Many participants share that the genesis of their addiction lies in legally prescribed pain medications, often started in the wake of a work-related injury. Those who shared this experience tend to ascribe blame to doctors, passivizing their own role in medical encounters to deflect accountability. Participant 11 started borrowing prescription opioids from a coworker in her 30s, later seeking out her own prescription to alleviate her chronic back pain. Within a few years, she transitioned to heroin, which she smoked with her husband until she entered treatment 2 years ago. Although she contends that her dependence escalated in the wake of her mother's death, Participant 11 attributes her misuse to a provider's thoughtless prescribing practices:

> I had a quack doctor and he just handing over opioids like it was candy, ya know? [I: Yeah]. He was giving me Valium, he was giving me Percocet, every single one. [. . .] Instead of doing anything to fix the problem with me physically [I: Mhm], it was easier to hand over opioids.

Even among those who take personal responsibility for their substance misuse, there is a sense that their lapse into addiction was facilitated or abetted by providers. One participant concedes, "I quit playing the blame game a long time ago—I put the dope in me" but qualifies his admission by stating, "I wouldn't have done it if [. . .] it wouldn't have been so easy to get."

For many, addiction entails a sense of powerlessness—the will to resist temptation lies largely outside of their locus of control. Participant 19 has been in and out of treatment for over a decade, at times voluntarily and at other times mandated through the justice system. Although he still occasionally uses opioids, he has a stable relationship with his girlfriend and a steady job in the health care

field. He illustrates his personal struggles with staying sober:

> And it's kinda—it's really difficult to recover here, [I: Yeah] for me. Um, yeah, I just um like I went to a convenience store, and uh just to get a Mountain Dew. Whatever. Minding my business. And uh I saw a woman, an old dealer there, and this was just a couple days after I had left controlled housing. Like, uh, transitional housing. So, I was no longer uh s-, s-, subject to three drug tests a week. [I: Mhm] I had like 17 months clean. So, like I saw my old dealer and about a million thoughts hit my head, a million excuses why, you know, I can get me a little bit and be cool. And I couldn't fight 'em off. And like that ended up being like a 36 hour or $700 binge. You know, I just—it's shit like that that reminds me that I'm powerless, and I can't do just a little bit.

As Participant 19 attempts to maintain sobriety, he must contend with external triggers like a familiar dealer and an inner dialogue that provides "a million excuses" for returning to drug use. This struggle is exemplified with the metaphor of "fighting off" his pervasive and subconscious temptations, a battle he admits he is "powerless" to win. Even in moments when he is "minding [his] business," unpredictable circumstances arise. Despite his best efforts, his relapses thus become almost inevitable in an environment replete with antagonistic forces. Many participants note this sense of inescapability, a notion that "there's really nothing that you can do to stop it. It's here. It's done" (Participant 11).

In contrast, Participant 19 discusses the state of the epidemic in light of a generation of PWUDs who he describes as complicit in their own addictions:

> I: Um, how have you noticed the area change in terms of drug use over time?
>
> P: Um, it just seems like um, just seems like people have gotten progressively more and more reckless as far as, uh, getting drugs. I mean, um, it seems like, uh, people no longer have, uh, much of a conscience [I: Okay] when it comes to finding ways and means to get more. Um, they uh less and less it seems like people are uh considering consequences of their actions. Um, it's dec—it's become in all definitions of the word, I think it's just become more and more progressively dangerous.

Whereas the participant's own drug use is driven by factors outside of his control, he talks about others as having agency in choosing between right and wrong: Those who seek out illicit substances are not "considering consequences of their actions." At the center of his contention is the notion of conscience, that one's actions are rooted in cognitive processes of morality, and that people are increasingly making choices that are immoral to the extent that drug use culture has become dangerous.

The Addict as Good Samaritan

Many participants highlight their willingness to help fellow PWUDs, especially in the context of overdose situations. In these cases, addiction does not interfere with participants' sense of right and wrong, although they are more skeptical about the motives of others.

Before entering treatment 9 months ago, Participant 16 injected heroin and methamphetamine on a daily basis. He has lost count of how many times he has overdosed in recent years, but he vividly recalls two experiences that required the intervention of paramedics, including one that landed him in prison for a year and a half. He grew up using drugs socially from his teen years and has witnessed many friends overdose in his young life. He illustrates that his typical response to an overdose is to slap the unconscious party or splash water in their face. When necessary, he is willing to call the authorities: "Uhm, I have called the squad once or twice."

In general, however, Participant 16 does not believe most PWUDs are willing to help others in such situations. He describes what he sees as a growing trend of overdose victims being abandoned by peer PWUDs:

> People are just getting kicked on the side of the road, dead bodies, ya know? You hear about it all the time. At first, you hear about it and you're like oh my god like, they're just throwing, they're literally just letting people die but the more you hear about it, the more numb you get to it.

Even in cases where intervention is available without fear of law enforcement reprisal, he is hesitant to accept that other PWUDs would make the beneficent choice. When asked whether he thinks people would be willing to carry naloxone (an overdose reversal medication) if it were made more accessible, he replies, "Absolutely, they would, ya know. I don't know about sharing it, but they would definitely have it accessible."

The trope of the overdose victim being dumped in the street by unconscientious acquaintances was repeated by over half of respondents. Participants paint the decision of whether to administer naloxone or call 911 as a moral and humanistic one. Those who have never witnessed an overdose convey with certainty that, in a hypothetical scenario, they would make the moral choice, even at risk of their own well-being:

> I mean a lot of people will leave you to lay and go on, ya know? And, you're dying. It's crazy, but they do it. I wouldn't, I would help someone. If it costs me whatever, I'd help them, yep, yep. That's just me though [I: Yep]. I have heard that some people have left people and they have died, I mean. They didn't get in trouble for it. (Participant 12)

Notably, participants tend to attribute these stories to hearsay, having heard about cases through the grapevine

or knowing a friend of a friend. The extent to which overdose victims are actually abandoned or whether the trope is constituent of mainstream addiction discourses is unclear.

Although most participants discuss aiding others in the context of overdose situations, some share their willingness to help fellow PWUDs more generally. Participant 23 started on prescription pills at 18 after a knee injury, which she concedes is "just an excuse." She has since transitioned to heroin, methamphetamine, and cocaine, which she uses to self-medicate her persistent boredom. She holds a regular job as a gas station attendant, a privilege she uses for the benefit of other PWUDs experiencing unemployment and homelessness:

> Just like, I got two. Two guys right now. They're both [living] on the hill. They're both homeless, but they know they can knock on my door anytime and I'll wash their clothes, I'll give them something to eat, I'll give them something to drink. [I: Mhm] And we struggle. Somedays we don't get a pop. Somedays we don't know what we're having for dinner. But they can knock on my door and I'll feed them anytime they want. And I don't know why I'm like that. My significant other gets mad at me. But I mean, that's how I was raised, so.

Unlike most other participants, Participant 23 uses the plural pronoun *we* to discuss experiences of addiction, inviting other PWUDs into her repertoire of victimhood (e.g., "You know, for our age of people um you know, people in their 20s and stuff like that, we just—everybody's bored. [I: Mhm] I mean, we're probably going to—it's, it's hard"). This is a recurrent theme in her interview, as she tends to convey a collective identity rather than individualize her experiences, perhaps appointing herself as a reasoned delegate for her marginalized peers. Nevertheless, her discursive style does not preclude her from classifying other PWUDs, as when she derides those who abandon overdose victims as uncaring: "People around here are evil [. . .] I don't, I don't see how, how another human being can do that."

The Addict as Motivated for Change

Participants with recent success in recovery usually mention a breaking point like "hitting rock bottom" or "hitting the end of my run" as the moment they committed to change. This moment could be triggered by a personal epiphany or by a seminal event, such as an overdose, the death of a loved one, or the loss of a custody battle. As one participant with a year on MOUD states, "Clichés are clichés because people say them all the time and they say them all the time 'cause they work, but uhm, like, I was just done" (Participant 17).

In discussing attempts at treatment and recovery, participants use terminology related to motivation to legitimize their own victories. In this way, addiction is constructed as something that must be overcome, and the onus is on the individual to summon the will to do so. Those with addiction are given agency in deciding whether or not they want to be addicted; success or failure is thus placed squarely at their feet. This notion is salient even among participants who acknowledge systemic challenges, including limited bed availability in inpatient treatment facilities:

> And, I mean, there's plaques on the wall around this place for people who died while on the waiting list. It's a tragedy, but you gotta, you gotta advocate for yourself [I: Right], ya know. If you are not willing to push forth, I mean, the whole thing about the whole waiting list thing is you're are supposed to call like every Monday. If you miss a call, it's on you. Obviously you didn't want to get in. (Participant 9)

Participant 5 has been sober for 3 months, motivated to maintain her recovery by the thought of being a strong mother for her three young children. She has an apartment and is working again, although she has been in and out of treatment for a decade, facing periods of homelessness, criminal justice involvement, abuse, and addiction. She confides that she is a survivor of rape, first as a young teenager and then again as an adult, at the hands of an ostensible friend who offered her housing when she was down on her luck. Asked about what stimulated her most recent treatment attempt, Participant 5 states that she was simply ready: "I had made the choice. I had made the decision. I was sick and tired of being sick and tired."

In contrast to her own earnest motives, she explains that others use treatment to prolong or excuse their addiction, especially in the case of MOUD, which includes the use of partial opioid agonists like buprenorphine to suppress withdrawal symptoms and reduce cravings. MOUD is a contentious subject among participants, many of whom argue that it is a crutch, that it does not truly constitute being clean, or that it has a high potential for abuse. Although she enjoyed a 5-year period of sobriety on Suboxone, Participant 5 is skeptical that others would use the drug for sincere reasons. She explains that she followed her expected regimen, "stayed clean and did what I was supposed to." In contrast, she believes others have more nefarious motives, imagining a resource-constrained environment where one's abuse of MOUD limits the recovery potential of others:

> There was people who were coming in there that were high and would steal and it's like oh you relapsed? Okay, you still get it, and you still get it, and you still get it because relapse is going to happen, and it is going to happen. But, whenever

it is happening all the time, then I think you should be cut off it [I: Hmm]. I think there should be so many chances that you get and then okay, you are done, you know? If you don't want to make a choice, and you don't want to live the right way and take it, why use it? Why waste time and take it away from someone who really needs it?"

Participants often describe other PWUDs as being complicit in their own addiction. Participant 26 explains that his former friends were unable to overcome addiction because they did not want to do so. He argues that "they're content with just chilling on the block, smoking some weed, drinking some 40s, and living that lifestyle, you know?" Even among those who acknowledge that addiction is a disease, treating the disease is argued to be volitional, and agency is once again bestowed upon the PWUD to make a change:

> If you want to change it, change it. At the same time, yes, it's a sickness, yes, it's a disease. But, what do people who have cancer do? They go see a doctor, you know what I mean? I mean, you gotta get off your ass and do something about it. Otherwise, you will stay stuck in misery. People just, will never change. (Participant 9)

Discussion

This article explored positioning in addiction discourse as enacted and envisioned by a sample of 27 PWUDs in Appalachian Ohio. Participants discursively constructed subject positions to explain or justify their trajectories within their own addiction narratives in contrast with the archetypal *addict*, who carries socially ascribed characteristics of being blameworthy, immoral, callous, and complicit. Participants passivized their drug use as arising from familial abuse, unscrupulous medical care, or economic trauma; emphasized their moral certitude in light of adversity; and substantiated their motivation to overcome addiction. Meanwhile, participants attributed to the imagined other traits of culpability, malfeasance, and complacency.

The tendency to present differential experiences of the *addict*-self and *addict*-other should not be reduced to volitional or deliberate attributions but must be examined within the constraints of broader social discourses. According to critical theorists, these macro-level discourses are not only socially constituted, they are also socially constitutive—They construct reality in a way that reinforces systems of power and ideology (Wodak & Fairclough, 1997; Yardley, 1997). PWUDs thus draw from popular, though reified, systems of knowledge and beliefs about addiction, and these systems become the discursive cache which PWUDs access in constructing representations of the self and other. In other words, the participants make use of interpretive repertoires—"the

culturally familiar and habitual lines of argument" (Wetherell, 1998, p. 400)—in organizing and embodying the positions we identified in the interviews.

Bailey (2005) notes that there are multiple popular addiction discourses which PWUDs may draw upon to make meaning of their experiences and to conceptualize the self. One such discourse is the so-called *myth of addiction*, a series of notions about the inevitability of certain effects of addictive substances (J. B. Davies, 1992). These effects include a predisposition to criminality and the erasure of morality and responsibility (R. Hammersley & Reid, 2002). Even in the increasingly popular medical discourse of addiction-as-disease, in spite of a prevailing sympathy for neurobiological predispositions, there is a connotation that the addicted individual, as such chronically afflicted, cannot be helped (Phelan et al., 2002). Although addiction is thus conceptualized as arising from an inexorable loss of control, the addicted are nonetheless imbued with undesirable attributes that are taken as permanent, if not individually precise. The social inertia of these discursive constructions impels PWUDs to reimagine the self in counterpoint to the other, as created in and perpetuated by popular addiction discourses, to counter the "self-evident descriptions of social reality that normally go without saying" (Fraser, 1992, p. 53).

The subject positions occupied by individuals experiencing addiction demarcate possible selfhoods and subjective experiences in the social world (Willig, 2008). Experience, as exercised by participants through narrative description, is used in discourse to validate claims about one's true identity. When the *addict* is constructed as worthless, they will take up with the worthy. When the inescapability of addiction's nefarious consequences is taken for granted in social discourse, the *addict* takes exception to the taken-for-grantedness. There is a compulsion for normality (Nettleton et al., 2013). But in subsuming normality, there is inevitably a construction of abnormality; the archetypal *addict*-other is corroborated, reinforcing the very discourse that most would wish to subvert. As Sampson (1993) states, ". . . in the representation lies the constitution of what we come to accept as the real" (p. 1222). The reified *addict* identity is thus confirmed, paradoxically, through participants' efforts to distance themselves from mythologized addiction behaviors and experiences.

Implications

While the literature is replete with examples of discourse reinforcing power imbalances between non-marginalized and marginalized groups, including PWUDs (Nettleton et al., 2013; Rolfe et al., 2009; Weinberg, 2000), there is a dearth of research examining discursively constituted

social dynamics *within* marginalized groups (cf. Rodner, 2005).

One clear implication of addiction discourse is stigmatization of PWUDs. In fact, individuals with substance use disorders are more heavily stigmatized even than those with mental illnesses, propagating stereotypes and impeding helping behaviors among non-addicts (Corrigan et al., 2009). Stereotypes and judgments arising from stigma remain important barriers to uptake of substance use treatment and persistence in recovery (Luoma, 2010).

Stigma is most often conceptualized as a process existing outside of the stigmatized (social stigma) or as internalized by the stigmatized (self-stigma) (Matthews et al., 2017). However, in his seminal discussion of the subject, Goffman (1963) evinced that stigma may exist *between* the stigmatized, as a means of positioning the self as less blameworthy than the other:

> The stigmatized individual exhibits a tendency to stratify his "own" according to the degree to which their stigma is apparent or visible. He can then take up in regard to those who are more evidently stigmatized than him the attitudes that the normals take toward him. (p. 107)

One participant in recovery reflected on her own tendency to judge fellow PWUDs, noting,

> I find myself doing it now. I have to remind myself that was me a year ago. Um, I will see someone at Wal-Mart and be like, oh my God, look at that meth head. And I'm like, *you're* a meth head, just because I don't use . . .

Intragroup stigma has been explored in a variety of contexts, including perceptions of skin tone among Black university students and HIV-related stigma among men who have sex with men (Courtenay-Quirk et al., 2006; Harvey et al., 2005). Intragroup stigma was recently examined in a qualitative study of female patients in a residential addiction treatment center—Notably, women with markedly different histories of drug use uniformly reported experiencing stigma, although they perceived the stigma to have arisen for different reasons: Those who used "hard" drugs (e.g., heroin) experienced shame for their supposed loss of womanhood, while those who used "soft" drugs (e.g., alcohol) felt their addictions were invalidated by their peers (Gunn & Canada, 2015).

In spite of these examples, intragroup stigma remains an understudied phenomenon. As has been noted, stigma management is a strenuous responsibility that is intensified by group polarization—as in cases of stratification among those with different addiction experiences—but can be mitigated when efforts are made to empower, rather than castigate, deviant identities (Anderson & Ripullo, 1996). Most of the stigma intervention literature has to date focused on improving resilience among the

stigmatized or shifting the behaviors and attitudes of those who stigmatize (Cook et al., 2014); what these approaches fail to account for is the possibility that these seemingly distinct constituents may be one in the same.

Hence, although intervention efforts should be focused at the structural levels where discourse is perpetuated, more research is also needed to explore opportunities for stigma reduction and solidarity-building among PWUDs. Contact is one recognized strategy for reducing stigmatizing attitudes through stereotype disconfirmation (Alexander & Link, 2003; Livingston et al., 2012; Reinke et al., 2004). Support groups, for instance, could be a venue not only to engender social support among PWUDs but also a forum for participants to build intragroup solidarity and confront the erroneous labels perpetuated in mainstream discourse. Importantly, there are few such opportunities for PWUDs who are not in active recovery; 12-step programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) typically require a desire for abstinence, and even participants on MOUD report stigma in these settings (Krawczyk et al., 2018). Syringe service programs and other harm reduction sites may represent safer venues to formally or informally engage PWUDs in group-based social support without the perceived pressure of treatment seeking. In these spaces, PWUDs might challenge the material reality of discursive constructions like the *Good Samaritan* (and its counterpoint). As Willig (1998) has argued, such an intervention should rely on participant-guided collective action approaches rather than professionally facilitated approaches, per se. That is, any attempt by health educators to reshape participants' discursive resources (and thus their subjective experience) is innately manipulative, however well-intentioned (Willig, 1998). PWUDs should thus be empowered to reflect upon, critique, and modify their own repertoires of addiction, rather than subscribe to repertoires provided by authority figures or ostensible health experts. Participatory frameworks like Photovoice, which promote agency and collective action among marginalized populations, may be of service here (Baker & Wang, 2006; Malherbe et al., 2016).

Limitations

The study sample was limited to PWUDs in rural Appalachian Ohio. As with any social phenomenon, discourse is culturally, temporally, and physically contextual (De Fina et al., 2006). The interpretive repertoires used by participants to convey experiences with addiction and recovery may not generalize to PWUDs in urban areas or in other rural places. In addition, while the sample was racially representative of the study region, our data nevertheless fail to capture the experiences of people of color

(POC). Gary (2005) has noted that POC experiencing mental illness are subject to a double stigma, facing prejudice due to both racial/ethnic identity and mental health status. Kulesza et al. (2016) likewise demonstrated stronger stigma-related implicit beliefs toward Latino/a people who inject drugs (PWIDs) than toward White PWIDs. It is likely that POC who use drugs must also navigate a "double discourse" of addiction and racism, which centers Whiteness as a normative source of power and privilege and devalues other racial identities (Giroux, 1997; Wetherell & Potter, 1993). Future research should explore how these two discourses interact and bear upon the addiction and recovery experiences of POC.

Another limitation of the study is that it was not originally designed for DA; our interpretation was ancillary to our original purpose of eliciting PWUD attitudes and experiences toward the explicit goal of intervention development. The data that result from qualitative research are necessarily influenced by the epistemological and methodological stances of the researchers, as well as the data collection procedures (e.g., interview guide design, interview style and probing, transcription techniques; Carter & Little, 2007). This calls into question the suitability of secondary analyses of qualitative data and specifically whether the proposed secondary methodology "fits" with the data (M. Hammersley, 2010). However, as van den Berg (2008) argues, there has traditionally been an overestimation of the influence of a priori methodological assumptions on the resulting data; after all, interviews are co-constructed in interaction, rendering the outcome "unpredictable because the results are partly dependent on the interviewee" (p. 184). In fact, DA may be particularly well suited for secondary analysis, as the researcher is more concerned with the discursive resources that emerge across the text rather than attempting to empirically validate participants' experiences or attitudes (Potter, 1996).

Conclusion

The aim of this study was to explore discursive resources used by PWUDs in discussing experiences with drug use. We describe three subject positions taken up by participants in the course of interviews that serve to delineate the *addict*-self from the *addict*-other. While the repertoires discussed in this article are likely not exhaustive of the strategies PWUDs use in social interaction, they highlight the kind of identity work that is intrinsic to the addiction experience. PWUDs must navigate, manage, and enact multiple selves in interaction, and in so doing contribute to the social reality of addiction itself. Specifically, we emphasize that the construction and inhabitation of subject positions like the *Good Samaritan* and *Victim of Circumstance* legitimize popular categorizations of the

"good" and "bad" *addict* reified in social discourse. This categorizing function of participants' talk is not necessarily strategic nor deliberate; discourse orients speakers toward certain linguistic commonplaces, and so whatever is uttered may come "naturally" to the speaker (Wetherell & Potter, 1988). Yet, regardless of intentionality, these discursive styles have practical consequences for PWUDs. Most importantly, we argue that intragroup stigma may be one by-product of a social discourse that constrains possible selfhoods available to those experiencing addiction or recovery. More research is needed to explore the role of intragroup stigma in PWUD experiences of addiction, how hierarchies of discreditedness are established among PWUDs, and feasible strategies to shift the multiple macro-level discourses that constitute the social reality of addiction and avail positions to PWUDs therein.

Finally, although PWUD experiences have previously been explored using discourse and narrative analyses, these studies have historically encountered only individuals in recovery (e.g., AA members, inpatient treatment participants; Malvini Redden et al., 2013; Nettleton et al., 2013; Taïeb et al., 2008). To our knowledge, this is the first such study to incorporate the talk of PWUDs in active use, a critical perspective given both the contextual basis of discourse and the performative nature of identity work. According to critical theorists, discourse is constitutive of institutional power and ideology, and few in the social order may be as powerless as those marginalized by their drug use (Fairclough, 2015; Wodak & Fairclough, 1997). Therefore, more work is needed to understand the addiction experience from perspectives of PWUDs in active use and especially using constructivist approaches (e.g., DA) that acknowledge and critique the multiple and subjective versions of social reality (Grbich, 2007).

ORCID iD

Adams L. Sibley [ID] https://orcid.org/0000-0001-5073-8677

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Author Biographies

Adams L. Sibley is a PhD student in Health Behavior and Injury & Violence Prevention Fellow at the University of North Carolina-Chapel Hill in Chapel Hill, NC, USA. His research interests include stigma reduction and improving community-based interventions for people who use drugs.

Christine A. Schalkoff is a PhD candidate in Health Behavior at the University of North Carolina-Chapel Hill. She studies substance use stigma in rural Appalachia.

Emma L. Richard is a research coordinator at NYU Langone in New York City. She was a Master of Public Health student at the University of North Carolina-Chapel Hill at the time this work was conducted.

Hannah M. Piscalko is currently a project coordinator in the Epidemiology Division at The Ohio State University College of Public Health in Columbus, OH, USA. She was a graduate student in Epidemiology at OSU at the time this work was conducted.

Daniel L. Brook is an MD/PhD candidate in Epidemiology in The Ohio State University Medical Scientist Training Program.

Kathryn E. Lancaster is an assistant professor of Epidemiology at The Ohio State University College of Public Health. In her research, she seeks to understand engagement in prevention and treatment of substance use and infectious diseases among vulnerable populations.

William C. Miller is a senior associate Dean for Research and Professor of Epidemiology at The Ohio State University College of Public Health. Dr. Miller's research addresses the intersection of substance use and infectious diseases.

Vivian F. Go is a professor in the Health Behavior Department at the University of North Carolina Gillings School of Global Public Health in Chapel Hill, NC, USA. Her research focuses on the design, implementation, and evaluation of HIV interventions among marginalized populations, particularly people who use drugs and men who have sex with men.