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Cocaine Confessions

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Abstract

This autoethnography adds my story to the scholarly literature on adolescent drug use. I examine how and why I used cocaine as an adolescent. However, to understand drug use, one must carefully unpack the psychosocial, cultural, environmental, and historical factors that influence this behaviour. Therefore, I explore each of these factors and their influence on my experiences with cocaine. Also, with any personal story about drugs, it is crucial to provide honest and thoughtful narratives about how drug use can affect someone's life. This approach can help address the misconceptions and stigmas associated with this behaviour. As such, I genuinely and painstakingly share how cocaine affected my life and how I perceived it to affect the lives of my peers. I consumed cocaine for a variety of reasons: I was curious about the drug, it helped me temporarily escape my life problems and find short-term relief from my distress and emotional pain, I had a desire to experience euphoria, drug use was a means of socializing and cocaine became the most coveted substance among my peers, using cocaine helped me gain and maintain status within my peer groups, and I used and continued to use cocaine because I likely developed a substance use disorder. My experiences with cocaine were truly a collective experience, as I never consumed this drug alone. Cocaine significantly shifted our peer group dynamics and strongly influenced our interactions with each other unlike any other drug at that point. In terms of impact, cocaine had a negative overall effect on my physical, psychological, and social development. Most notably, this drug interfered with my ability to create and sustain healthy relationships, and I believe that cocaine contributed to the development of my mental illness. This study has the potential to help young people, parents, educators, policymakers, health care providers, those in recovery, and others better understand the intricacies and more contextual factors that influence and are involved in adolescent drug use. This paper offers an olive branch to those willing to see

things from a different perspective and possibly change their existing beliefs about adolescent drug use.

Keywords: Addiction, Autoethnography, Cocaine, Drugs, Substance Use Disorders

Summary for Lay Audience

In this paper, I share my personal experiences of drug use as a teenager. I discuss how and why I used drugs during this time. However, to understand drug use, it is important to consider the many different factors that push people towards this behaviour. I review each of these factors and explain how they pushed me towards using cocaine. It is important for stories about drug use to be honest and meaningful, so people who are unfamiliar with this behaviour get a better understanding about the personal lives, developmental experiences, and living conditions of those who use drugs. Hopefully, these stories prevent others from being judgmental towards those who use drugs, especially those who are addicted and homeless. In this paper, I describe how cocaine affected my life and how I felt it affected my friends. I used cocaine for many different reasons: I wanted to know how the drug would make me feel, I was embarrassed, unhappy, and sad throughout much of my teenage years, and using drugs helped me forget about my problems for a while, I wanted to feel as happy as possible, all my friends used drugs and cocaine became our favourite drug, using cocaine helped me earn and keep the respect of my friends, and I used and continued to use cocaine because I likely developed an addiction to drugs. I never used cocaine by myself, as I was always with my friends. Using this drug together on a regular basis really changed our attitudes, behaviours, and feelings towards each other. Drug use hurt my growth as a teenager. Using cocaine damaged my relationships with friends and family, and I believe using this drug is one of the reasons why I developed mental illness. This paper may help a lot of people better understand the fine details and realities of drug use and help them realize that there are many different factors that push people towards drugs. This paper is a gift to those willing to learn more about drug use and possibly change their views about teenagers that use drugs.

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Introduction

One thing that all adults have in common is that we all experienced a unique period in our lives known as adolescence. This period includes tremendous change, growth, potential, adventure, and hope for the future. However, this period also includes challenges, heartbreaks, misadventures, and setbacks. For me, adolescence involved more of the latter. My dreams of playing professional hockey ended abruptly. My parents separated, and my family life dissolved. I engaged in unlawful behaviours such as stealing, vandalizing, trespassing, driving without a license, and fighting. I struggled academically and was expelled from high school for truancy. I became sexually active, had romantic relationships, and experienced romantic heartbreak for the first time. However, what stands out most about my adolescence was my submersion into the subculture of drugs. Using drugs began in my late childhood with smoking tobacco and drinking alcohol, but this behaviour quickly progressed once I became a teenager. Before the age of eighteen, I had consumed tobacco, alcohol, cannabis, psilocybin (magic mushrooms), lysergic acid diethylamide (LSD), phencyclidine (PCP), and ketamine (special K). Yet, the one drug that had the greatest impact on my development during this time was cocaine. But consuming this powerful drug was not an individual activity. It was an activity that involved my closest peers, and it significantly changed the way we behaved and interacted with each other. With the use of autoethnography, this paper highlights and systematically analyzes this period of my life and my experiences with cocaine. It adds a new wrinkle to the scholarly literature on adolescent drug use.

Before moving on, it is important to define and describe adolescence and substance use, so there is no confusion about these terms going forward.

Adolescence

According to Siegel (2013), all cultures acknowledge the years that fall between childhood and adulthood as a distinct period of life. However, the exact age range for this interval, commonly referred to as adolescence, is inconsistently defined in the literature. For example, Siegel (2013) argues that adolescence occurs roughly between the ages of 12 and 24. Bagwell and Schmidt (2011) claim that there are three stages of adolescence: early (approx. 10-14), middle (approx. 15-17), and late (approx. 18 and older). The WHO (n.d.a.) contends that although age is a convenient way to define adolescence, it is only one characteristic that delineates this development period. Yet, the WHO (n.d.b.) defines adolescence as the years between the ages of 10-19. Despite the disputed chronology, the common thread found in the literature concerning this developmental period is that significant changes certainly occur. Essentially, adolescence signals the transition from childhood into adulthood and includes physical, social, and psychological development (Bagwell & Schmidt, 2013; Csikszentmihalyi, 2020; Sanders, 2013; Siegel, 2013; WHO, n.d.b.).

Substance Use

Psychoactive substance use is not a new phenomenon, as humans have consumed drugs recreationally for thousands of years (Leyton & Stewart, 2014). However, the use of drugs has increased significantly over the last fifty years, and this increase has continued into the second decade of the new millennium (Pagliaro & Pagliaro, 2012). Many North Americans have traditionally considered this behaviour a rite of passage to adulthood (Pagliaro & Pagliaro, 2012). Regardless of age, culture, education, ethnicity, gender, race, religion, sexual orientation, or socioeconomic status, children and adolescents throughout North America may be exposed to and may actively consume a variety of drugs in various ways, which can adversely affect their safety, health, and well-being (Pagliaro & Pagliaro, 2012). An adolescent’s consumption and exposure to drugs may also negatively affect the

safety, health, and well-being of their families, friends, schoolmates, neighbourhoods, and larger communities (Pagliaro & Pagliaro, 2012). Moreover, "…the younger a child initiates alcohol and other drug use, the higher risk for serious health consequences and adult substance abuse" (Belcher & Shinitzky, 1998, p. 952). Despite the wealth of literature and studies that attempt to explain, theorize, and understand drug use, Pagliaro and Pagliaro (2012) argue that "…the question as to why children and adolescents use, or do not use the drugs and substances of abuse remains largely unanswered" (p. 117).

This autoethnography adds my story to the scholarly debate on why some children and adolescents use drugs. In particular, I examine how and why I used cocaine as an adolescent. However, to understand drug use, one must carefully unpack the psychosocial, cultural, environmental, and historical factors that influence this behaviour. Therefore, I explore each of these factors and their influence on my experiences with cocaine. Also, with any personal story about drugs, it is crucial to provide honest and thoughtful narratives about how drug use can affect someone's life. This approach can help address the misconceptions and stigmas associated with this behaviour. For this reason, I genuinely and painstakingly share how cocaine affected my life and how I perceived it to affect the lives of my peers.

Research Questions

Based on the aim of my study, I developed the following research questions: Why did I use cocaine as an adolescent? What were my experiences with cocaine during this developmental period? How did my cocaine use impact my development?

Overview

This paper begins with a general review of cocaine, including some historical facts, its pharmacology, its presence in popular culture, and its prevalence of use among adolescents. Then, I present a summary of autoethnography, which is the methodology I used to guide my data collection and analysis. Afterwards, I provide a snapshot of my adolescence

and share my lived experiences with cocaine (and other drugs) by presenting some specific excerpts from my autoethnographic writing exercises. These excerpts are paired with research findings from the literature, which includes various theoretical views on drug use. At the end of this paper, I provide direct answers to my research questions, highlight my key findings, discuss their possible implications, and then address the limitations of this study.

Methods

Paradigmatic Position

It is important for qualitative researchers to locate themselves paradigmatically to ensure congruence within their investigation. A paradigm is defined as a worldview or basic belief system, which dictates a researcher's study design, data collection, and data analysis (Guba & Lincoln, 1994). There are a variety of paradigms to choose from within the social sciences; however, the four most common paradigms are positivism, post-positivism, constructivism/interpretivism, and critical theory (Brown & Dueñas, 2020). In the paragraphs below, I locate myself paradigmatically and highlight my ontological and epistemological positions within this worldview.

Constructivism/Interpretivism

This paradigm values understanding the nuances of lived experience from the insider's point of view (Hart & Gregor, 2005). In other words, the goal of research guided by this paradigm is to understand the lived experiences directly from those who have lived them (Hart & Gregor, 2005). According to Carpenter and Suto (2008), human behaviour is important, and the aim of constructivist/interpretivist research is to decipher how people interpret or make meaning of social phenomenon.

Epistemology

This term describes the philosophical study of the origin, nature, and limits of human knowledge (Stroll & Martinich, 2021). Epistemology is concerned primarily with knowledge claims (Lyons, 2017). For Snape and Spencer, a constructivist/interpretivist paradigm posits that the researcher and social world impact one another and that research findings are shaped by the researcher's perspectives and values (Pitard, 2017). I acknowledge that the social world I live in (and will continue to live in) influences my perspectives and

values. However, I recognize that my perspectives and values evolve as my social world changes over time.

Ontology

The constructivist/interpretivist paradigm values relativism, which presumes that multiple and sometimes conflicting realities exist as opposed to one true reality (Carpenter & Suto, 2008). These multiple and sometimes conflicting realities are socially constructed by and between individuals (Brown & Dueñas, 2020). As a qualitative researcher, I agree with the relativist contention, and concur that one's reality is socially constructed.

Qualitative Research

Qualitative research is a method of inquiry that produces descriptive data (e.g., behavioural observations or personal accounts) of experiences, allowing researchers to examine how individuals perceive the world from different points of view (American Psychological Association, n.d.). Moreover, qualitative research is an umbrella phrase that includes a variety of research methodologies such as grounded theory, phenomenology, interpretive description, and ethnography ("Qualitative or Quantitative Research?" n.d.). These methodologies focus on understanding research from an idealistic or humanistic perspective (Pathak et al., 2013). This approach to research involves using and collecting various empirical materials such as case studies, personal experiences, introspections, life stories, interviews, artifacts, cultural texts and productions, as well as observational, historical, interactional, and visual texts (Denzin & Lincoln, 2005). These materials allow researchers to describe routines, difficult moments, and meanings in people's lives (Denzin & Lincoln, 2005). Qualitative research is a valuable method of providing rich descriptions of complex phenomena, tracking unexpected or unique events, highlighting the experiences and interpretations of these events by actors who possess differing roles and stakes, and giving voice to those whose views are seldom heard (Sofaer, 1999). For these reasons, a qualitative

approach was selected for my study. The remainder of this chapter includes a summary of the specific qualitative methodology used in my study, a description of my data collection and data analysis strategies, the ethical considerations, as well as the dissemination and implications of my research findings.

Methodology

Autoethnography is a qualitative methodology that offers complex, nuanced, and specific knowledge about particular lives, experiences, and relationships (Adams et al., 2015). This approach to research aims to describe and systematically analyse personal experiences to facilitate an understanding of cultural experiences (Ellis et al., 2011). In particular, autoethnography is an autobiographical genre of research and writing that displays multiple layers of consciousness, connecting the personal to the cultural (Bochner & Ellis, 2016). However, autoethnography is not simply descriptive or performative storytelling; instead, it follows the anthropological and social scientific approach to inquiry (Chang, 2008). "Autoethnographic stories are artistic and analytic demonstrations of how we come to know, name, and interpret personal and cultural experience. With autoethnography, we use our experience to engage ourselves, others, culture(s), politics, and social research" (Adams et al., 2015, p. 1). In autoethnography, the researcher's own experience is the central focus from which a new understanding of the culture under investigation is revealed (Starr, 2010). Autoethnography provides a holistic view that encompasses the research, writing, and dissemination of findings as a bridge between the personal and the cultural, political, and social aspects of life (Starr, 2010). An autoethnographer retroactively and selectively writes about their lived experiences that stem from being a part of a culture or possessing a particular cultural identity (Ellis et al., 2011).

Autoethnographic writing aims to produce evocative and aesthetically thick descriptions of personal and interpersonal experience (Ellis et al., 2011). The researcher can

accomplish this aim by first discerning patterns of cultural experience through interviews, field notes, and artifacts and then describing these patterns using aspects of storytelling, such as character and plot development (Ellis et al., 2011). The autoethnographer attempts to make their lived experiences meaningful and cultural experiences engaging and, by producing accessible texts, they may be able to reach a larger and more diverse audience, which can create personal and social change (Ellis et al., 2011). This methodology helps us reconsider how we think, how we conduct research, our relationships, and how we live (Jones et al., 2016). These stories represent "…a narrative of coming to an experience and a moment in time when excluding or obscuring the personal in research felt uncomfortable, even untenable" (Jones et al., 2016, p. 21).

Data Collection

My data collection was closely guided by the framework established by Chang (2008) in *Autoethnography as Method*. I used two autoethnographic writing exercises to capture my lived experiences of using cocaine (and other drugs) as an adolescent. These writing exercises are based on what Chang (2008) refers to as *chronicling the past* and *inventorying self. Chronicling* is a valuable strategy through which you generate a sequential order to the pieces of information collected from memory (Chang, 2008). The autoethnographer can create an *autobiographical timeline* via a chronological list of lived experiences or memorable events to assist with *chronicling the past* (Chang, 2008). This writing exercise highlights the evolution of the autoethnographer's personal life (Chang, 2008). As such, I created a list of my most memorable lived experiences of using cocaine (and other drugs). This list included experiences such as my initiation to cocaine, maintenance of cocaine use, progression to *crack*, addiction to cannabis, as well as my last experience with cocaine.

Inventorying self is a helpful strategy to avoid a total sense of randomness in the data collection process (Chang, 2008). The autoethnographer can create a list of themes and then organize and evaluate them to assist with *inventorying self* (Chang, 2008). This writing exercise sets in motion some preliminary analysis and interpretation since the autoethnographer will select and deselect certain pieces of information and rank them in a hierarchy of importance (Chang, 2008). As such, I created a list of themes surrounding my experiences with cocaine. This list highlighted the psychosocial, cultural, environmental, and historical factors associated with those experiences. For example, I discussed several important interpersonal relationships and interactions that I had during my adolescence. I organized these themes into a narrative that fit into my *autobiographical timeline*. I evaluated these themes through extensive reflexive writing exercises (e.g., journaling). As a result, I was able to determine the importance of each theme by understanding the impact they had, not only on my experiences with cocaine but my development as an adolescent.

Data Analysis

My data analysis was also closely guided by Chang's (2008) framework. Cultural data analysis and interpretation are essential to autoethnography because these processes transform autobiographical data into sensible and culturally meaningful text (Chang, 2008). Instead of simply describing lived experiences, the author tries to explain how fragments of memories may be blended to explain their cultural beliefs and relationship with others in society (Chang, 2008). Adams et al. (2015) recommend using a *story-approach* by writing in a way that emotionally engages both the writer and the reader. Adams et al. emphasize participating in editing and rewriting to create a meaningful and coherent narrative. This process helps the autoethnographer understand their *story* (Adams et al., 2015).

To meet the aim of my study, answer my research questions, and ensure that I remained faithful to autoethnography, I engaged in two analytical strategies. Firstly, I

carefully crafted my *story* based on selected passages from my autoethnographic writing exercises. Having a well-crafted *story* helped me comprehend my lived experiences and assisted with data analysis. Secondly, I partook in cultural data analysis and interpretation by analysing my lived experiences with cocaine (and other drugs) through psychosocial and developmental lenses.

Ethical Considerations

Conducting research, writing about, and representing lives carries a significant ethical burden regardless of the methods and methodologies applied (Sikes, 2015). For autoethnographers, ethical issues and questions concerning truth and truths are often more challenging and obvious because telling our own stories usually implicates others (Sikes, 2015). As Thompson-Lee (2017) points out, "…it is almost impossible to tell one's story without referring to others" (p. 56). Even if an autoethnographic study does not require a formal review process, the autoethnographer should consider a code of confidentiality during each step of inquiry (Chang, 2008). The autoethnographer may use pseudonyms for some or all and create composite figures based on factual details to obscure their identities to protect the privacy of the individuals who appear in an autoethnography (Chang, 2008). The individuals who appear in my autoethnography were assigned pseudonyms or replaced with composite figures. I also avoided including any personal identifiers such as nicknames, race/ethnicity, age, other physical descriptions, specific geographic locations, specific employment histories, and any other potentially identifiable pieces of information.

Dissemination of Research Findings

I plan to disseminate my research findings in a variety of ways. Firstly, I have prepared this manuscript to publish in Western University's School of Graduate and Postdoctoral Studies Thesis and Dissertation Repository. I also plan to submit a truncated version of my manuscript to various open-access publication outlets in the disciplines of

health and social sciences. Furthermore, I plan to present my research findings at several professional conferences related to the fields of substance use and mental health. Lastly, I hope to share my study in non-academic mediums such as podcasts and radio interviews.

Implications of Research Findings

My autoethnography not only immerses readers into my experiences with cocaine (and other drugs), but it also provides a timely and culturally relevant perspective into the phenomenon of adolescent drug use. Based on the aim of this study, my research findings shed light on how and why I used cocaine during adolescence and how this behaviour impacted my development. These findings add value to the existing body of scholarly literature on adolescent drug use and provide the non-academic community deeper insight into this phenomenon. As such, the publication of my research findings can inform scholars, health care providers, addiction counsellors, teachers, parents and families, social workers, law enforcement, policymakers, youth, and people who use drugs.

Cocaine

But it was just a dream for the teen who was a fiend
Started smokin' woolies at sixteen
And runnin' up in gates, and doin' hits for high stakes
Makin' my way on fire escapes
No questions I would speed, for cracks and weed
The combination made my eyes bleed
- *Wu-Tang Clan (1993)*

Fast Facts

Cocaine is a powerful stimulant and is considered highly addictive; it produces strong feelings of pleasure, increases alertness, and decreases the consumer's appetite and need for sleep (Government of Canada, n.d.a; Hart et al., 2016). Cocaine is a fine, white powder that is derived from the leaves of the coca bush (*Erythroxylum coca* and *Erythroxylum novogranatense*) found in South America (Boucher, 1991; Government of Canada, n.d.a). Cocaine is classified as Schedule I in Canada's Controlled Drugs and Substances Act, which means this drug has a high risk for psychological and physiological dependence (CCSA, 2019.; DATAC, 2017; Government of Canada, n.d.a). Furthermore, in Canada the possession of cocaine can result in seven years of imprisonment, while production and trafficking of cocaine can result in life imprisonment (CCSA, 2019).

Historical Facts

The chewing of coca leaves for their stimulating effects and medicinal purposes was practised for thousands of years by the Indigenous peoples of Central and South America (Stolberg, 2011). "…Andean peasants and miners traditionally have consumed coca by sucking on wads of leaves, keeping them in their cheeks for hours at a time" (Boucher, 1991, p. 72). In 1880, von Anrep published about the pharmacological effects of cocaine nearly 20 years after a chemist named Albert Niemann first isolated cocaine from coca leaves during his doctoral research (Das, 1993; Gerald, 2013). In 1884, a young Viennese physician named Sigmund Freud, who later became known as the founder of psychoanalysis, published *Über Coca*, which was regarded as a thorough medical analysis of powder cocaine (Markel, 2011).

Freud used himself as his experimental subject for several months by consuming significant amounts of cocaine and recording the drug's physiological effects and potential therapeutic applications (Markel, 2011). Freud's publications on cocaine were well received; however, it was his colleague Carl Koller, an intern ophthalmologist, that gained worldwide recognition for introducing cocaine as a local anaesthesia for eye surgery (Markel, 2011; Richard, 2003). "By the time Freud published his first praise of coca, cocaine, along with milder forms of coca, was already available to Americans in drug stores, grocery stores, saloons, and from mail-order medicine vendors" (Das, 1993, p. 297). By the 1880s affordable coca products such as a coca wine called Coca-Cola, which contained small amounts of cocaine, was also available (Das, 1993). In the US, cocaine has been a controlled substance since the enactment of the Harrison Narcotics Act of 1914 (Palamar et al., 2015). Near the turn of the 20th century, cocaine became associated in the American public mind with crime sprees, particularly by Black men (Courtwright, 1992). However, those who consumed cocaine did not become criminals until urban police in the New South created moral panic over the casual consumption of cocaine among urban Blacks, blaming everything from urban riots to rape on the drug's influence (Cohen, 2006). In 1911, Canada legislated a restriction on the importation, manufacture, sale, and possession of cocaine (CAMH, 2010).

Pharmacology

Route of Administration

Cocaine hydrochloride (powder cocaine) can be taken orally, snorted (insufflation), or absorbed through a genital or rectal application (Abadinsky, 2018; Hart et al., 2016). Cocaine hydrochloride can also be converted into a solid (*freebase*), so it can be smoked or dissolved and injected intravenously (Abadinsky, 2018; Hart et al., 2016). *Crack* is a less expensive, crystalline form of cocaine which is created by mixing powder cocaine with baking soda and water (CAMH, n.d.; Goode, 2015; Hart et al., 2016). C*rack* can be smoked

or dissolved in weak acids such as ascorbic acid, lemon juice, lime juice, or vinegar and injected intravenously (CCSA, n.d.; Government of Canada, n.d.a; Waninger et al., 2008). *Crack* became available in the 1980s and its consumption became widespread in the United States by 1985 (Goode, 2015; Hart et al., 2016).

Modes of Action

When cocaine (any form) is smoked, snorted, or injected it rapidly enters the bloodstream and permeates into the brain (Nestler, 2005). Cocaine achieves its primary immediate psychological effect by creating an accumulation of dopamine in the brain (Nestler, 2005). Dopamine is a neurotransmitter that controls several vital functions such as the control of movement, and reward-related behaviours (Broome et al., 2020). The brain's dopamine system is stimulated by other reinforcing activities such as sex and eating (NIDA, 2020a). Essentially, cocaine interferes with dopamine communication inside the brain by binding to dopamine transporters and preventing the removal of dopamine from the synapse, which is the small space between two nerve cells (NIDA, 2020a). This process is responsible for creating the immediate feelings of euphoria from cocaine (NIDA, 2020a).

Effects

Cocaine is a central nervous system stimulant and therefore makes consumers of this drug feel energetic, alert, talkative, sociable, and euphoric (CAMH, 2010). Those who consume cocaine also "…feel more aware of their senses: sound, touch, sight and sexuality seem heightened. Hunger and the need for sleep are reduced" (CAMH, 2010, p. 2). In general, stimulants are known as sympathomimetic drugs because they increase heart rate, blood pressure, sweat, and respiratory rate, as well as cause pupil dilation (Maisto et al., 2019). When cocaine is smoked or injected, its effects are more intense and can be experienced within seconds but dissipate within five to ten minutes (CCSA, 2019). When cocaine is snorted, its effects typically peak between fifteen to twenty minutes but wane

within sixty to ninety minutes (Abadinsky, 2018). However, the effects of cocaine depend on several other factors including the tolerance of the consumer, purity of the drug, and the amount consumed (Abadinsky, 2018).

CG Kid is a hip-hop artist and recovery advocate who describes himself as a *poly-addict.* Over the years, he has shared stories about his experiences with drugs, as well as his life in recovery. In a YouTube video, *CG Kid* (2017) candidly described the effects of his cocaine consumption in the following way:

> Whenever I snorted cocaine, the first line was good. It made my face go completely numb… I would get like, where I'd wanna talk a mile-a-minute. I would get really excited, euphoria, like a real adrenaline kick in, and it was just like this, sparklers of confidence goin' off in my head instantly as soon as I snorted it, and uh yeah I loved that part…so it goes from like this really euphoric thing at like maybe 10pm… then at like 5am..., you're just, *I want more blow*, and you cannot go to sleep, you're restless as fuck, and all you can think about is getting more (0:48 – 3:08).

In some cases, consuming cocaine may precipitate a panic attack (Levinthal, 2016). Furthermore, as cocaine levels diminish from the consumer's bloodstream, their mood changes dramatically and the consumer becomes irritable, despondent, and depressed (Levinthal, 2016). When cocaine is consumed in large doses, it is possible for a psychotic state known as a *stimulant psychosis* to occur (Maisto et al., 2019). The most common symptom of a *stimulant psychosis* is paranoid delusions; however, the consumer may also display symptoms such as rocking, hair pulling, chain smoking, and *fiddling with things* (Maisto et al., 2019). Furthermore, when cocaine is consumed chronically, several additional problems may arise such as irritability, depression, paranoia, as well as tolerance and dependence to the drug (Levinthal, 2016; Maisto et al., 2019). Lastly, there is always a risk of

overdose death if cocaine is consumed in large quantities or if the drug has been contaminated, particularly with fentanyl and its analogues (CCSA n.d.; Maisto et al., 2019).

Popular Culture

Cocaine has been given many names including *coke, blow, candy, rock, C, jack, jimmy, nose candy, whitecoat, snow,* and *crack* (Government of Canada, n.d.a; Kuhn et al., 2014; NIDA, 2020b). Over the years, cocaine has been featured in popular culture, especially in the entertainment industry. Blockbuster films such as *Scarface*, *Blow*, and more recently the *Wolf of Wall Street* feature many scenes involving cocaine's production, distribution, and excessive consumption. In the 1990s, certified diamond and gold hip-hop albums such as *Notorious B.I.G.'s Life After Death, Raekwon's Only Built for Cuban Linx*, and *Capone-N-Noreaga's War Report* feature several lyrics about consuming cocaine, as well as manufacturing and *dealing crack.* Demi Lovato is an award-winning musical artist who has been outspoken about mental health, including the artist's experiences and struggles with cocaine. In Demi's self-titled documentary called *Simply Complicated,* Demi openly spoke about consuming cocaine for the first time:

> My first time doing coke, I was 17 working on Disney Channel, and I was with a couple of friends, and they introduced me to it. I was scared because my mom always told me that your heart could just burst if you do it, but I did it anyways and I loved it. I felt out of control with the coke the first time that I did it (Lovato, 2017, 5:34).

Prevalence of Cocaine Consumption Among Adolescents

Approximately 2% of Canadians consumed some form of cocaine during 2017 (CCSA, n.d.). For younger Canadians between the ages of 15-19, rates of past year cocaine use have remained consistent from 2013 (1.5%) to 2017 (1.6%) (CCSA, 2019). However, Pagliaro and Pagliaro (2012) reported a lifetime consumption of cocaine at 6.2% for

Canadians between the ages of 15-24. CCSA (2019) highlights this rise in cocaine consumption among young adults in their report by saying "…unlike the younger age group, past year use of cocaine for youth ages 20-24 has significantly increased from 3.3% in 2013 to 6.2% in 2017" (p. 2).

In the United States, findings from the 2018 National Survey on Drug Use and Health revealed that an estimated 5.5 million people aged 12 or older consumed cocaine within the past year (SAMHSA, 2019). Also, an estimated 112,000 adolescents between the ages of 12-17 reported past year consumption of cocaine, including approximately 4,000 consumers of *crack* (SAMHSA, 2019). The data analysis from this same study indicated that the 2018 estimates of cocaine consumption among adolescents were comparable to the estimates recorded between 2013 – 2017 but were lower than the estimates from 2002 – 2012. Lastly, this survey's results showed that the 2018 estimates of crack consumption among adolescents were lower than the estimates from 2002 – 2011 but were close to the estimates in most years between 2012 – 2017. Like the Canadian statistics presented earlier, cocaine use is more prevalent among young Americans between the ages of 18-25 with an estimated 2 million people reporting cocaine use in the past year, including 87,000 who used *crack* (SAMHSA, 2019).

The Boys

Me and my crew, me and my crew we be chillin and
Front on this and get dissed, motherfucker
Me and my crew, me and my crew we be chillin and
Front on this and get dissed…
- *Mobb Deep (1991)*

It was the summer of 2001. I was 16 years old and had just completed Grade 11. That summer I spent most of my time with a new peer group and switched high schools, so I could join them in the fall. This peer group, whom I will refer to as *the boys,* was a large group consisting of males around my age. There were some females who associated with *the boys*, but they did not socialize with the group as often as the males. From my vantage point, most of *the boys* came from a middle-class background, but a few of them seemed to be situated into the lower or upper classes. Most of *the boys* were unemployed and uninvolved in any extracurricular activities, so there was plenty of time for social gatherings. Most of *the boys* had parents that were either separated, divorced, or in some cases, never married. As well, most of *the boys* had trouble academically, which meant poor grades, frequent suspensions, and expulsion for many. *The boys* were loyal and enjoyed partying and getting intoxicated together on a regular basis. However, socializing with *the boys* was also unpleasant and distressful at times. Interactions among *the boys* were frequently aggressive and hostile. For example, “fuck you,” “fuck off,” “mother fucker,” and “shut the fuck up,” were some of the most common phrases of tossed around.

Disapproval among *the boys* occurred when someone violated the unwritten rules of the group. The list of unwritten rules is extensive, but here are some of the most egregious offences: unpaid debts or theft among *the boys*; withholding information (e.g., party location); exclusion (e.g., *selling out*); prioritizing education or extracurricular activities over socializing with *the boys*; withdrawing from socializing with *the boys* without a valid excuse (e.g., work); courting one of *the boys’* former girlfriends without approval from whoever

dated her previously; courting one of *the boys'* current girlfriends; courting a female or befriending someone that had not been validated by *the boys*; unwilling to: take risks (e.g., jaywalking in traffic), break the rules, by-laws (e.g., littering), or even some laws (e.g., speeding); being overtly respectful to authority figures (e.g., teachers); behaving or showing any signs of bisexuality or homosexuality; *biting* (copying) one of *the boys'* fashion or style without approval from *the boys*; wearing clothes that were perceived as out of style or feminine; doing activities that were perceived as weak or "gay" (e.g., wearing a bicycle helmet); unwilling to fight or defend oneself or one of *the boys* during an altercation (verbal or physical); and betrayal (being a *rat*). It was clear to me that these unwritten rules had been established for some time, and it was my responsibility to learn and demonstrate them quickly.

Regardless of violating any of the unwritten rules listed above, being unwilling to consume drugs, or to encourage abstinence or sobriety was probably the most intolerable infraction of the rules and would most certainly result in permanent exclusion and harsh ridicule from *the boys*. Furthermore, to gain acceptance and respect among *the boys*, each member must know and demonstrate the proper etiquette of accessing, handling, sharing, preparing, and consuming drugs. I had plenty of experiences with drugs (e.g., *weed*) before I joined *the boys*, so there was not much of a learning curve regarding these particular rules.

Primary Reflection

> When I began writing this chapter, I included a small piece about joining *the boys*, which occurred around the same time I was introduced to powder cocaine. I didn't think too much about it at first, but each time I revisited this section of the chapter, I began to recall more details about my interactions with, as well as the dynamics of *the boys*. At first, I really enjoyed spending time with *the boys*. The cast of characters in this group created for some entertaining and unpredictable moments.

There was also a strong sense of brotherhood among *the boys*, so gaining their acceptance felt good and offered some protection. However, the personal and social costs for associating with *the boys* were far greater than the personal and social rewards that I accumulated during that period of my life. Peer influence and peer pressure were prominent and ever-present among *the boys*. Furthermore, *the boys* were frequently at odds with each other over unwritten rule violations, such *selling out* or having unpaid debts. Although I was one of the younger *boys*, I regularly felt a sense of responsibility for the others. For example, if someone was getting violent, I tried to redirect their anger to prevent a physical altercation. There were also many occasions where I felt ashamed and embarrassed by *the boys'* conduct, especially in public places. *The boys* were lowbrow, gritty, and unabashed, which was frequently displayed by our use of foul language and rowdy behaviour. We had our own dialect and used creative slang on a regular basis. Our style, fashion, and behaviours were greatly influenced by the hip-hop culture of the 1990s. I was strongly influenced by *the boys* at that time, but I tried to maintain some shred of independence. In many ways, I felt like I was putting on a performance to gain acceptance from *the boys*. However, I was careful not to get a criminal record and I was calculated in my risks, while some of *the boys* seemed to throw caution to the wind far too often. "I don't give a fuck," was a common phrase among *the boys*. I'm not claiming innocence. I certainly engaged in plenty of unsavoury behaviours, but I typically drew the line where some of the others would not. Let's get to the brass tacks: my drug consumption did not occur in a vacuum, so I believe it is vital to include details about my social environment to better understand my behaviours at that time.

Theory of Drug Subcultures

In 1973, Johnson proposed the theory of drug subcultures (drug subculture theory) in an effort to explain alcohol and cannabis consumption (Pagliaro & Pagliaro, 2012). Johnson explains:

> Drug subculture theory is designed to explain group behaviour. Individual behaviour is defined as a function of following the subculture's values, conduct, norms, roles, and argot. The greater a person's commitment to a drug-using group and to subcultural values, conduct norms, roles, rituals, and argot, the greater the predictability of behaviour of that individual (as cited in Pagliaro & Pagliaro, 2012, p. 152)

According to Johnson, the most important value for a drug-using subculture is the intention to get *high*, and the most important conduct norm is whether a member has intentionally consumed, or desires to consume a particular drug to get *high* (Pagliaro & Pagliaro, 2012). With respect to children and adolescents, youth culture governs their behaviour, as well as their friendship groups and their norms of conduct, which include loyalty; maintenance of group association; social interaction in the group within locations where adult supervision is absent; and competition for status and prestige which creates new behaviours (Pagliaro & Pagliaro, 2012). For Dunlap (2017), the theory of drug subcultures can apply to illegal drug consumption across a range of socioeconomic groups. Within these drug using subcultures, the norms regarding consumption, social interactions, and activities are generally unwritten and unspoken (Dunlap, 2017). "Behaviour patterns, ways of thinking and social interaction allows users to function within the drug subculture and social context. The social context encourages individuals to engage in various behaviours attached to the drug subculture, both set and setting" (Dunlap, 2017, p. 2).

Subcultural Evolution and Drug Use

In 2005, Golub et al. proposed a theory called subcultural evolution and drug use. According to their theory, drug use is often more than simply consuming drugs to experience their physical and psychological effects (Golub et al., 2005). Rather, "…social activities, use by friends, popular images, references in music, myths, availability, potential legal consequences, and youthful rebellion can impart a greater significance to the behaviour. In this manner, drug use occurs within a cultural context" (Golub et al., 2005, p. 1).

Secondary Reflection

My peers played a significant role throughout my childhood and adolescence, especially with regard to my experiences with drugs. Without my peers, I can only guess that my experiences with drugs would have been very limited. Whenever I had my first experience with a new drug (e.g., cocaine), there was always another peer present. In every case, my peer(s) had prior experiences with the drug, so they served as my guide. There was rarely a time when I consumed a new drug for the first time with a peer who had not previously consumed that drug. I "lost my virginity" or "popped my cherry" on several occasions with peers who were more experienced with using drugs than I was. My peers were eager to share stories about their experiences with drugs. They modelled drug use, explained the etiquette of drug use, and in many cases were my primary source of information about drugs. Essentially, my peers (and I) promoted and encouraged drug use. Consuming drugs was prevalent. It facilitated bonding and created enjoyment. Consuming drugs also helped us cope with distress, frustration, and anger.

My Introduction to Powder Cocaine

Yeah, you got satin shoes
Yeah, you got plastic boots
Ya'll got cocaine eyes
Yeah, you got speed-freak jive, now
Can't you hear me knockin'… on your window
- *Rolling Stones (1971)*

We partied a lot in the summer of 2001. I was no longer playing competitive hockey, did not have a part-time job, did not attend summer school, and had very few responsibilities. Several of *the boys* were in a similar situation. Therefore, we had most of the summer to get *high*, party, loaf, and pursue romantic relationships. We spent our summer afternoons smoking cannabis, listening to hip-hop, playing video games and sports, and watching movies such as *Scarface*, *Casino*, *Blow*, and *Goodfellas*. Our evenings were spent partying and getting intoxicated until the sun rose the next morning. It always felt strange arriving at my family home during those early mornings. Some of my neighbours would be leaving for work, as I would be inching my way to my front door. I enjoyed that summer and was glad that I gained acceptance from *the boys*. *The boys* were similar to my previous peer group, whom I will refer to as *the church boys*. Both groups enjoyed consuming drugs and spending time together, so I did not have much difficulty adjusting to *the boys'* party lifestyle. However, late that summer there was one event that changed my life forever; I was introduced to powder cocaine.

Primary Reflection

I was *high* a lot during my adolescence, and the summer of 2001 was no exception. I spent more time *high* than I did not under the influence of drugs. What kind of life is that? Being *high* most of the time certainly could not have helped my biopsychosocial development. I wish I would have spent my summers getting in better physical shape, playing competitive sports, and working a part-time job at something I enjoyed. Perhaps umpiring baseball? I can understand that I wanted to

socialize, party, and enjoy my time, but I had no balance during the summer seasons, especially in 2001. My focus was to get *high* every day. There's another important point to be made here; the summer of 2001 was the first summer after my parents had separated. My father and one of my sisters moved out of our family home the previous fall, which significantly fractured my relationship with both of them. My father started dating someone not long after my parents separated, and our communication and interaction became infrequent. My mother also starting dating someone not long after my parents separated. She spent a lot of time away from our family home that summer. She picked up a part-time job on weekends, which was in addition to her full-time job during the week. As a result, there was very little adult supervision in my life at that time. My eldest sister and her boyfriend lived in my family home at that time. They frequently attempted to provide guidance and include me in their non-drug-consuming activities (e.g., gardening). However, I usually declined their invitations and defied their requests to discontinue or even minimize my unruly behaviour around the house.

The Dissolution of the Family and Drug Use Among Youth

According to Leyton and Stewart (2014), there are several features of parenting that are not considered maltreatment that may still affect a child's risk for drug use. For example, a non-intact family is associated with a child's risk for drug use (Leyton & Stewart, 2014). Non-intact families are often financially and occupationally disadvantaged, which means that these families are more likely to be dysfunctional compared to intact families (Leyton & Stewart, 2014). Furthermore, the ages of the children at the time of their family's dissolution are important; children and adolescents under the age of 16 appear to be more affected by the collapse of their family (Leyton & Stewart, 2014). Likewise, according to Robertson et al. (2003), research has shown that for children, the key risk periods for drug use occur during

major transitions in their lives, including parental divorce. Parental divorce is a transitional period when children experience a heightened vulnerability for problem behaviours (Robertson et al., 2003).

Ledoux et al. (2002), led a study on family structure, parent-child relationships, and drug use among adolescents from France and the United Kingdom (UK). The study sample included 1,174 boys and 1,110 girls from France, as well as 1,280 boys and 1,361 girls from the UK. The results showed that family variables were related to adolescent drug use. For example, in both sample groups, adolescents from non-intact families, those who were unsatisfied with their relationships with their mother and father, as well as those who had less parental supervision, were more likely to be heavy drug consumers compared to the other study participants.

Waldron et al. (2014) completed a study examining early drug use as a result of parental separation during childhood, as well as parental alcohol and cannabis dependence. This study collected data from the parents of 1,318 adolescents. The parents of these adolescents were monozygotic or dizygotic twins from Australia. Quantitative analysis was used to predict the adolescents' age at first and regular consumption of cigarettes, as well as their first consumption of cannabis, following parental separation. Furthermore, the analysis assessed both parent and co-twin drug dependence. The results of this study indicated that with few exceptions, the risks associated with parental alcohol versus cannabis dependence were equivalent, which suggests a strong genetic transmission of risk. Furthermore, when controlling for parental drug dependence, parental separation was a strong predictor for all drug use variables for adolescents, especially through age 13.

Secondary Reflection

The writing was on the wall. My parents argued on a regular basis. There was a lot of yelling, foul language, criticism, name calling, sarcasm, and belittling between

my parents. My mother was fiery, boisterous, and emphatic, whereas my father was calm, quiet, and sarcastic. My mother was typically on the offense, so my dad was usually on the defence. I overheard arguments between my parents that I can still recall vividly. As such, I became aware of my parents' private, interpersonal, financial, and romantic problems. Oftentimes, their arguments concluded with my mother slamming the front door and shouting, "I'm never coming back!" Then my sisters and I would watch my mother speed away in the car with a lit cigarette, only to return in a couple of hours. When my mother returned, she would busy herself with some household chores and listen to *Sade*'s *No Ordinary Love:* "I gave you all the love I got. I gave you more than I could give. Gave you love. I gave you all that I have inside... and you took my love" (Sade, 2020, August 9). On rare occasions, my father would raise his voice toward my mother; it intimidated me. I was unfamiliar with this side of my father. If he was not going to work on those tumultuous days or evenings, he would drink beer (sometimes whiskey), watch television, and keep his distance from my mother. After most arguments, they would stonewall each other until the next confrontation, or until an interaction was forced (e.g., "Who is driving Eric to hockey practice?"). I loathed being at home when the tension was high between my parents. Before I began my career as a drug user, I would escape into video games, television, movies, sugar, and music. However, I usually could not drown out the sound of my mother yelling at my father. I felt incredibly embarrassed when I knew their arguments could be overheard by our neighbours (e.g., during the summer when the windows were open or when they would argue on the front porch, driveway, or backyard). "I don't give a fuck if anyone can hear!" my mom would sometimes shout. That statement always made me cringe. My parents were clearly not in love and basically cohabited until my father and sister moved out of the house

just after I turned 16. I never saw them wear their wedding bands, celebrate an anniversary, show physical or verbal affection, or demonstrate any behaviours that indicated they cared about each other. They stopped sleeping in the same bed when I was a child. My father either slept on the beat-up couch in our living room or in my bedroom on the nights that I co-slept with my mother. “We’re going to stay together for you guys.” That was the message my sisters and I received from our parents as I entered adolescence. Our house was a miserable place to be most of the time. The negative energy and animosity between my parents were palpable inside of our home. You could cut the tension with a Ginsu. As such, my sisters and I avoided inviting our peers over and I spent a lot of time outside of our family home, especially as I entered adolescence. Near the end of my father’s time living in our home, he and I began to have our differences. He was critical of Bobby (pseudonym) and concerned that I was egregiously breaking curfew on a regular basis. “Be home by 9:30,” he’d say sternly before I’d leave the house on those evenings. “Ok,” I’d half-heartedly reply. Then I’d stroll in at 10:00 or 10:30 and he’d be sitting in the corner seat of the sofa with the lamp lit and the television turned off. He’d have a scowl on his face with his right hand against his cheek, his index finger resting on his temple, and his thumb on his jawline (like a backwards letter L). He was pissed off for several reasons, but as I got older and learned more about my father, I began to speculate why he was so upset with me during those interactions. I think he saw a lot of his younger self in me. Behaviours that he once engaged in as an adolescent. The difference was, as an adult who had a family, full-time job, and many responsibilities, he knew the consequences of those behaviours, while I was young, naïve, and ignorant. At that point, my relationship with my father began to strain. I disrespected him and disobeyed his rules regularly. “I don’t like Bobby. He’s

sneaky!" my father said. Yet, I continued to hang out with Bobby every day. My father's suspicions were accurate. Bobby and I were always into trouble: egging houses, smoking cigarettes, occasionally drinking alcohol, stealing candy from convenient stores, breaking curfew, and pulling pranks. Bobby was loyal, brave, funny, and loved getting reactions from the unsuspecting victims of our pranks. We were *as thick as thieves*. We both came from a working-class family, had plenty of mutual interests, and were around the same age. I wasn't going to ditch Bobby because my father didn't approve of him. No way! The bottom line is, when my parents separated and my family became divided, my behavioural issues escalated, especially my consumption of drugs. I had very little adult supervision, more leisure time, very little responsibility, and a compulsion to get *high*. I tried to avoid dealing with my emotions about the dissolution of my family. As such, my consumption of drugs served as my primary coping mechanism. I just wanted to escape from my family troubles, hang out with my peers, and have a good time. *The boys* became my world. I spent more time with them than I did with my family or doing anything productive or positive.

One Sunny Afternoon

Before I was introduced to powder cocaine, I had many experiences with a variety of drugs. My pathway of drug use was sequential and developed in the following way: tobacco, alcohol, cannabis (including hashish, oil, and edibles), psilocybin (*magic mushrooms)*, powder cocaine (and then *crack*), ketamine (special K), phencyclidine (PCP), lysergic acid (LSD), and gamma-hydroxybutyrate (GHB). By the summer of 2001, I became interested in experimenting with other drugs, but not yet had any opportunities to do so. At that time, *the boys* and *the church boys* were regularly consuming tobacco, alcohol, cannabis, and occasionally *magic mushrooms* (when they were available). However, powder cocaine had

not yet entered either of my peer groups. But on one sunny afternoon, my peer Chester (pseudonym) pulled out a small plastic bag of powder cocaine. There it was on a wooden table in front of me. An intriguing, white, powdery substance. At that point, I had no idea how much powder cocaine (or *crack*) cost or how to consume the drug. Charles, who was also there that afternoon was eager to try Chester's powder cocaine. Charles sold cannabis on a regular basis and seemed to always have cash on him. So, when Chester asked, *"do you want a line?"* Charles handed Chester twenty dollars and they both snorted some *rails* (lines of powder cocaine) using a rolled-up banknote. They immediately appeared to be stimulated and were eager to consume more. Unlike my previous experiences with alcohol and cannabis, Chester and Charles were unwilling to share their drugs with me. I made it obvious to Chester that I was interested in his cocaine, but he made it clear that he was not going to give me a free sample. Then Chester looked at me and said, *"give me your hat and I'll give you a rail."* I quickly handed over my hat and snorted my first *rail*. I felt the stimulating *high* immediately and desired more, so I went home and rounded up some of my favourite and most stylish pieces of urban fashion and returned to the scene. Chester selected the items he wanted in exchange for more *rails*. I enjoyed the rest of the afternoon *high* on cocaine.

Primary Reflection

I have no doubt that my previous experiences with other drugs made the decision to try powder cocaine much easier. I felt prepared and curious to experiment with *hard* drugs even before Chester arrived that day. I wanted to know what kind of effects these *hard* drugs would have on me. I also felt like I was missing out on an enjoyable experience when I saw Chester and Charles enjoying their *high*. They both had this look of satisfaction on their face. It's a look of satisfaction that most drug users are familiar with. I felt mature, rebellious, and cool when I consumed powder cocaine. When I first started spending time with *the church boys*, they often teased

me about my intolerance for alcohol and cannabis, and I struggled to keep pace with their consumption of these drugs. Eventually I built up a tolerance for smoking cannabis and that's when I felt that I truly earned their respect. A part of me felt like I still had something to prove to *the church boys*. In my mind, if I experimented with *hard* drugs such as cocaine before any of *the church boys* did, then I would be seen as brave, cool, and gain higher status among the group. I'm ashamed that I thought this way as an adolescent, but upon deeper reflection I can understand why I did.

The Gateway Hypothesis

The gateway hypothesis was first introduced in 1975 by Hamburg, Kraemer, and Jahnke, as well as Kandel (Kandel, 2002). The gateway hypothesis proposes that there is a progressive and hierarchical sequence of stages with respect to drug use (Kandel, 2002). This sequence begins with legal drugs such as tobacco or alcohol, then proceeds to cannabis [now legal in Canada] and to other drugs such as cocaine, methamphetamine, and heroin (Government of Canada, n.d.b.; Kandal, 2002). In other words, the consumption of various drugs is not random, instead the individual follows a trajectory (Kandel, 2002). Therefore, an individual who consumes one type of drug is at risk of progressing to another; however, this progression is not obligatory or universal, nor do all individuals progress through each drug (Kandel, 2002).

Tarter et al. (2006) examined the gateway hypothesis by determining if tobacco and alcohol consumption were risk factors for cannabis use. This study included 224 male participants between 10 and 12 years of age (at baseline). These participants were then re-evaluated at ages 12-14, 16, 19, and 22. The participants were categorized into three groups. Group 1 (n=99), consisted of participants who consumed alcohol and/or tobacco between baseline and the re-evaluation assessment at age 22 without having ever consumed cannabis. Group 2 (n=97) consisted of participants who transitioned to cannabis following their

consumption of alcohol and/or tobacco, which therefore demonstrates the gateway hypothesis. Group 3 (n=28), consisted of participants who began with cannabis and then transitioned to alcohol and/or tobacco, which therefore demonstrated the reverse of the gateway hypothesis. These groups were compared across 35 variables measuring psychological, family, peer, school, and neighbourhood characteristics. As well, the gateway hypothesis and alternative sequences (e.g., common liability model) in predicting substance use disorders (SUDs) were compared.

The results of this study revealed that 22.4% of the participants who consumed cannabis did not exhibit the gateway hypothesis, which demonstrates that there were other pathways of drug consumption among the sample. However, among the participants that did exhibit the gateway hypothesis, only delinquency was more strongly related to illegal drug use compared to legal drug consumption. Specific risk factors associated with the gateway hypothesis were not identified. Moreover, the other pathways of drug use had the same accuracy for predicting SUDs as the gateway hypothesis. As such, the authors concluded that it was the proneness to deviancy and drug availability in the neighbourhood that promoted cannabis use, which supports both the gateway hypothesis as well as other pathways of drug consumption and SUDs.

Bretteville-Jensen et al. (2008) analysed data from a representative sample of 21-30-year-olds from Oslo, Norway to examine the gateway hypothesis of both legal and illegal drugs and the subsequent consumption of cannabis, methamphetamine, and cocaine. The results of this study revealed that for those who consumed drugs, they began with alcohol prior to cannabis, and then proceeded to amphetamine and cocaine. In total, approximately 12% of the sample reported consuming amphetamines, cocaine, ecstasy, and heroin; 10.9% reported using cannabis before that, but only 1.5% reported consuming any one of these drugs without consuming cannabis first. Moreover, among the 503 amphetamine consumers

in the sample, 77% reported consuming cannabis first and 14% started consuming both drugs within a year of each other.

Secondary Reflection

The gateway hypothesis is reflected in my experiences, as my drug consumption certainly followed a trajectory. I can quite confidentially say that the gateway hypothesis was demonstrated by just about everyone in both of my peer groups. However, the degree of drug consumption between *the boys* and *the church boys* was different. *The boys* experimented with *hard* drugs at an earlier age than *the church boys*. Some of my peers consumed more drugs than others, especially those that had the financial means and access to drugs. Those who were able to generate steady incomes were more likely to consume a variety of drugs on a regular basis. Steady incomes were generated from a variety of sources: legal employment, drug *dealing*, theft, accessing a savings account created by their parents, mooching from family, government assistance, etc. Among *the church boys*, those who had the strongest relationship with Timothy (pseudonym) were more likely to consume cannabis. Timothy was not only one of the *church boys*, but he was also a drug dealer (exclusive to cannabis) which earned him high status within this peer group. Among *the boys*, those who had the strongest relationship with Gee (pseudonym) were more likely to consume a variety of drugs on a regular basis. Gee was not only one of *the boys*, but he was also a drug *dealer* (including *hard* drugs), which earned him high status within this peer group.

Powder Cocaine and The Boys

The cartel Argentina coke with the nina,
Up in the hotel, smokin' on sensemilla
Trina got the fish scale between her
The way the bitch shook her ass, yo, the dogs never seen her
- *Nas (1996)*

Powder cocaine touched down into my new social circle like a tornado in the fall of 2001. Almost all *the boys* were quickly being sucked into its vortex. Now our Friday and Saturday evenings were dedicated to snorting powder cocaine. Keep in mind that tobacco, alcohol, and cannabis were also being consumed regularly; however, powder cocaine became the main attraction. Yet, cannabis was still my *drug of choice* (preferred drug), so I always smoked cannabis during social gatherings with *the boys*. However, most of *the boys* seemed to tolerate mixing a variety of drugs and appeared to enjoy the combined effects. Not me, though. I was a *lightweight* (low tolerance for drug consumption). If I drank alcohol and then smoked cannabis (or vice-versa), I would get the *spins* (dizzy), feel nauseous, and then eventually vomit. After I would vomit, I would feel *straight* (not intoxicated), which was typically a relief. However, vomiting was a sign of intolerance, which was a sign of weakness to *the boys* (and *the church* boys), so vomiting was always met with mockery and ridicule.

On Sunday afternoons, some of *the boys* would get together to smoke cannabis and play basketball. I preferred these relaxed gatherings over the frenzied powder cocaine-fuelled Friday and Saturday evenings. I felt more in control of my decision-making when I was exclusively smoking cannabis. But those Friday and Saturday evenings were gung-ho with the powder cocaine, and I always felt a sense of unpredictability when we were *high*. However, these Friday and Saturday evenings always played out the same way. The *boys* would get together, purchase drugs, find a spot to hang out for the night, and then consume our drugs until the wee hours of the morning. We hung out at whoever's house did not have parental supervision. Some of *the boys'* parents were away on weekends, which gave us

access to a variety of comfortable spots to consume drugs. As such, we did not have to worry about getting caught or kicked out. I avoided using my house as much as possible because *the boys* were careless and often damaged things. Furthermore, being the host was an added responsibility, which was always a buzzkill for me.

Primary Reflection

Looking back, these powder cocaine-fuelled evenings were pathetic, hollow, and redundant. It was the same damn thing every weekend. Moreover, these gatherings lacked female presence, which was frustrating for me because I was still significantly interested in having a girlfriend. We couldn't take the party elsewhere (especially in the winter) because we typically had nowhere to go. *The boys* were never invited to parties (no surprise), so we'd crash them if we discovered their whereabouts. None of us were of legal age to be patrons at the bars, pubs, strip clubs, and nightclubs, and only a couple of us had *fakes* (false identification documents) so those venues weren't feasible for *the boys*. In the fall and winter months, we'd usually hunker down in someone's basement for the evening. We'd get intoxicated all night with Hockey Night in Canada playing on a television in the background. We'd chain smoke cigarettes, shoot the breeze, listen to hip-hop, *kick frees* (freestyle rap), and get rowdy. This would continue all night and into the wee hours of the morning. Rinse and repeat. However, these cocaine-fuelled weekends took a toll on my mental health. This toll intensified into my late adolescence as my consumption of drugs increased. I experienced bouts of sadness and despair on the days after consuming powder cocaine (and other drugs). This mental state was unfamiliar since I was typically an emotionally stable person. Perhaps these were the roots of the depression that I still experience as an adult?

Cocaine Use and Depression

Cocaine withdrawal may occur following the cessation of its use (Sofuoglu et al., 2005). As mentioned, cocaine has various effects on many important neurochemicals in the brain (Morton, 1999). In addition to creating an accumulation of dopamine, the consumption of cocaine immediately increases levels of norepinephrine and serotonin, which are two neurotransmitters responsible for alertness, increases in heart rate and blood pressure, as well as the fight-or-flight response (Morton, 1999; Nestler, 2005). In particular, serotonin is partly responsible for regulating appetite, mood, and sleep (Morton, 1999). After the repeated use of cocaine and the subsequent immediate release of the aforementioned neurotransmitters, an overall depletion of these same neurotransmitters gradually occurs (Morton, 1999). Therefore, a person's compulsive use of cocaine may be an attempt to maintain these neurotransmitters at homeostatic levels (Morton, 1999). Likewise, cocaine withdrawal can include a combination of symptoms including fatigue, vivid and unpleasant dreams, insomnia or hypersomnia, increased appetite, as well as psychomotor impedance or agitation (Sofuoglu et al., 2005). Like all other classes of SUDs, cocaine abuse and dependence are linked to an increased risk for depression (Rounsaville, 2004). According to Brown et al. (1998), research has shown that depressive disorders were the most diagnosed comorbid condition among those who abused cocaine.

Although there is evidence demonstrating a relationship between cocaine abuse or dependence and depression, the direction and dynamics of that relationship has been debated in the literature. For example, Pagliaro et al. (1992) found that some people with severe pre-existing depression may unconsciously consume greater amounts of cocaine to treat this condition. As such, Pagliaro et al. (1992) suggests that clinicians treating patients with comorbid depression should consider the possibility that their patient's depression may be a cause rather than the result of their cocaine consumption. Schmitz et al. (2000) compared patients with depression and cocaine dependence (CD, N=50) with patients who were only

cocaine dependent (CO, N=101). Schmitz et al. (2000) measured pre-treatment psychiatric symptomatology, substance use, and psychosocial functioning for these two sample groups. The results of this study demonstrated that the CD group had greater distress and poorer psychiatric functioning compared to the CO group. Moreover, the CD group had a higher prevalence of antisocial personality disorder, reported stronger cravings for cocaine, lower self-efficacy to abstain from drug use, as well as lower perceived social support.

Cocaine Use and Suicide

According to Roglio et al. (2020), SUDs, such as cocaine and alcohol use disorders are among the most significant predictors of suicide. In the US, the consumption of cocaine has been associated with a history of suicide among the general population, but especially for individuals who were cocaine dependent (Darke & Kaye, 2004). For example, one study showed that 39% of cocaine-dependent patients enrolled in treatment had suicidal histories (Darke & Kaye, 2004). In Brazil, a large-scale study with a representative sample revealed that the rates of attempted suicide and deaths by suicide among those who consumed *crack* cocaine to be 40.0% and 20.8%, respectively. In contrast, these rates were significantly lower among the general population, which were 9.9% and 5.4%, respectively (Roglio et al., 2020).

Roy (2001) conducted a study examining the characteristics of cocaine-dependent patients who had attempted suicide. In this study, cocaine-dependent patients who had a history of attempted suicide (N=84) were compared to a group of cocaine dependent patients who had no history of attempted suicide (N=130). These two groups were compared on clinical, personality, psychiatric, and physical variables. The results of this study showed that significantly more patients with a history of attempted suicide were female and had a family history of suicidal behaviour. Furthermore, this group reported significantly more childhood trauma, and were more introverted, neurotic, and hostile. Lastly, this group had greater comorbidity with alcohol/or opioid dependence, major depression, and physical disorders. As

such, Roy (2001) concluded that cocaine-dependent individuals may be at a greater risk for suicide when they experience problems associated with cocaine dependence, such as comorbidities and other stressors.

Secondary Reflection

I must declare that I have never considered or contemplated suicide, despite being clinically diagnosed and professionally treated for depression and anxiety for more than 15 years. My mind has just never wandered in that direction, I guess. I can't say for certain that my use of cocaine and other drugs caused my depression and anxiety, but I suspect that they contributed significantly. I've always been curious about my depression and anxiety, especially from a neurological perspective. Am I dopamine deficient? Did I permanently damage the reward circuits in my brain? Did my consumption of drugs cause a long-term imbalance of serotonin? I'll likely never find answers to these questions, but I do know that I'll probably have to live with depression and anxiety for the rest of my life. However, I remain confident that my mental illness is largely substance induced. In other words, had I not consumed the types and quantities of drugs that I did during my adolescence, I believe that I would not have developed mental illness. On a different note, the closest experience I can get to feeling *high* these days is by consuming significant amounts of caffeine. Cocaine and caffeine are both classified as central nervous system stimulants, so their modes of action involve some of the same neurotransmitters (e.g., dopamine, norepinephrine) (Hart et al., 2019). What doesn't surprise me is the fact that I have consumed significant amounts of caffeine over the last decade and a half to the point of dependence. If I do not consume caffeine, I experience psychological (e.g., depressed mood) and physiological withdrawal (e.g., migraines). I can certainly say that I experienced similar types of withdrawal on the days that followed my powder

cocaine binges. My mood swung back and forth like a pendulum on those days. The mornings (in most cases, afternoons) after powder cocaine binges were gloomy and dreadful. I lacked motivation and felt a sense of shame. “I’m never doing that again.” Without fail, I was back snorting *rails* the following weekend.

The Champagne of Street Drugs

If you want to hang out,
You've got to take her out, cocaine
If you want to get down,
Get down to the ground, cocaine
She don't lie
She don't lie
She don't lie, cocaine
- *Eric Clapton (1975)*

I quickly learned about the financial cost of consuming powder cocaine, and it became clear to me that this was a drug that I would not be able to afford on a regular basis. I did not have enough money to purchase both powder cocaine and cannabis. I still preferred smoking cannabis and typically had $40 for spending money divided between Friday and Saturday evenings. On a typical Friday or Saturday evening, I would spend $20 on cannabis, which would buy me two grams. Two grams of cannabis was enough to satisfy me for the evening, but I still wanted to consume powder cocaine. I did not want feel left out. I wanted to experience the best of both worlds, so to speak. However, with *the boys,* the entry cost to *"get in on the coke,"* was $20, so as you can see, I had some difficult decisions to make in those days. At that time, a half of a gram of cocaine cost $40, so splitting a half gram was usually the only option for me. However, spending my entire bankroll on cocaine would leave me without cannabis and would only buy me approximately one hour of cocaine *high.* I usually figured out a way to consume both drugs by trading *hits* (the act of inhaling) of my *joints* (cannabis cigarettes) for some *rails.* Some of *the boys* became generous with their *coke* when they were *high,* so I made sure to stay in close proximity when the *rails* were being prepared. I was a mooch when *the boys* were consuming cocaine, which seemed to decrease my status within this peer group.

Primary Reflection

I really enjoyed consuming powder cocaine at first, but I just could not financially afford to consume this drug. It was too expensive, and I did not have a large enough

source of steady income. I was unwilling to find legal employment or engage in the types of schemes that would provide me with the funds necessary to purchase powder cocaine every Friday and Saturday evening. I was jealous and bitter that some of *the boys* were able to afford this drug on a regular basis. I was especially bitter towards Chad (pseudonym) because I knew he was using his (seemingly wealthy) parents' money to purchase powder cocaine on a regular basis. Chad was an interesting character. I liked him a lot, and we bonded well. However, he seemed to really struggle with his confidence and was never truly embraced by *the boys*. He just stuck out like a sore thumb. He'd violate some of the unwritten rules on a regular basis. In particular, Chad was accused of being gay. I think this was mostly because of his excessively friendly nature. He was gentle, kind, funny, generous, loyal (to some of *the boys*), and sensitive. Chad was also rather touchy-feely with some of *the boys* when he was intoxicated, which raised suspicions about his sexuality. He also did not have a solid grasp on the hip-hop style, fashion, and dialect that the boys demonstrated and valued. But on those Friday and Saturday evenings, he seemed to gain status within our peer group. His presence was temporarily valued, particularly by *the boys* who benefited from his generosity with his *coke*. He always had money for drugs and would often select some of *the boys* to treat for the evening. This selection process meant that some of *the boys* were excluded, which was a violation of the unwritten rules. During the weekdays when I had very little money, Chad would cover my drug purchases. He'd share his cannabis with me and usually another one of *the boys*. He'd also provide transportation without asking for gas money and would also treat us to meals, beverages, and snacks. Keep in mind, these purchases were made with his parents' money and all *the boys* were aware of that. *The boys* frequently disparaged him

behind his back for *being* (behaving) gay and uncool, especially *the boys* that did not benefit from his generosity. On the other hand, there was John (pseudonym). John was another one of *the boys*. Where Chad struggled, John thrived. John was confident and had a solid grasp of our hip-hop style, fashion, and dialect. John was abrasive, rude, vulgar, funny, loyal, and manipulative. At one point, John earned a thousand dollars every two weeks through unskilled legal employment. He'd get paid every other Friday and then burn through his entire pay cheque within 48 hours. He'd spend most of his paycheque on cocaine, cannabis, alcohol, tobacco, and a variety of other drugs. On some paydays, he'd hand over a significant portion of his paycheque to Gee immediately, as he had already accumulated a debt of *drug spots* (drug loans) before his paycheque arrived. On most Friday and Saturday evenings, John would share some of his *coke* with me. He would also treat me to McDonald's and a *joint* on some Sunday afternoons. As a result of his loyalty and generosity, I viewed him as one of my closest peers at that time. However, John's presence and influence were overwhelmingly harmful to my development.

Socioeconomic Status, Demographics, and Cocaine Use

According to Patrick et al. (2012), there is little consensus regarding the relationship between socioeconomic status (SES) and the consumption of drugs. For example, there is some evidence that lower SES is associated with an increase in alcohol, tobacco, and cocaine consumption among white adolescents (Humensky, 2010; Lewis et al., 2017). In contrast, there is growing evidence that adolescents with higher SES may also be at risk for developing SUDs (Humensky, 2010). "For adolescents with high SES, having greater financial resources may indicate that the relative cost of substance use, that is the opportunity cost of substance use relative to other consumption, may be lower than for adolescents with lower SES" (Humensky, 2010, p. 2).

Gerra et al. (2020), examined the relationship between SES and illicit drug consumption among adolescents by focusing on three different patterns of consumption (episodic, experimental, and frequent). The researchers of this study also made use of two indicators to improve the measurement of individual SES characteristics in their sample. Data was obtained from the European School Survey Project on Alcohol and other Drugs (ESPAD), which has collected comparable data among 15-to-16-year-old students to monitor trends in drug consumption and other risk behaviours across Europe since 1995. The study sample included 24,136 males and 26,300 females from 28 countries including Greece, Italy, and Netherlands. The results of this study showed the consumption of cocaine as follows: episodic (0.53%), experimental (1.13%), and frequent (0.22%). Low familial SES was significantly associated with episodic and experimental consumption of cocaine but was not significantly associated with frequent cocaine consumption. Low parental education was significantly associated with experimental and frequent cocaine consumption but was not significantly associated with episodic cocaine consumption. In their discussion, Gerra et al. (2020) suggest that "…low SES in our study was found to be associated with experimental and episodic use of cocaine, but not with frequent use. This may be attributed to the high price of cocaine, making it not affordable for youth" (p. 13). The authors of this study suggest that drug policies should be combined with actions aimed at removing all barriers to social inclusion that are imputable to the SES backgrounds of adolescents.

Palamar and Ompad (2014) conducted a study to determine the demographic and socioeconomic correlates of adolescent cocaine and *crack* consumption. Data from the Monitoring the Future (MTF) survey was used to meet this study's objectives. MTF is an annual cross-sectional survey of high school seniors from approximately 130 public and private schools throughout 48 states in the US. This study sample included 65,717 students who were seniors between the years of 2005 and 2011. The results of this study revealed

4,064 students (6.2%) reported lifetime consumption of powder cocaine, 1,630 students (2.5%) reported lifetime use of *crack*, and 4,511 students (6.9%) consumed either drug. The results of this study also showed that many demographic and socioeconomic variables were similarly correlated with lifetime consumption of both powder cocaine and *crack*. For example, an income of greater than $50/week from a job increased the odds for powder cocaine and *crack* consumption. An income of greater than $50/week from sources other than a job more than doubled the odds of powder cocaine and *crack* consumption. Furthermore, high religiosity, high parental education, identifying as Black, and residing with one or two parents reduced the odds for powder cocaine and *crack* consumption. The results also uncovered that those students identifying as Hispanic were at higher odds for *crack* consumption, and females were at lower odds of consuming powder cocaine. Among the consumers of cocaine, residing with one or two parents lowered the odds for consuming both forms of this drug. Lastly, more religious students, as well as those identifying as Hispanic were at higher odds for *crack* consumption only. With respect to the impact of financial resources on the consumption of cocaine, Palamar and Ompad (2014) offer the following: "…cocaine use also tends to increase after an individual receives his or her paycheque (i.e., "the check effect") and cocaine users are more likely to purchase it and increase consumption when money is easily available" (2014, p. 7). The authors of this study suggest that programs aimed at preventing the initiation and adverse consequences of powder cocaine and *crack* consumption should consider the overlapping, yet different risk profiles associated with these behaviours.

Secondary Reflection

> As mentioned, most of *the boys* appeared to come from a middle-class background, which meant that most of us didn't have families that were struggling financially. At least it seemed that way to me. Regardless of legal employment, *the boys* always

managed to generate money for drugs. However, with powder cocaine, the stakes were higher. Purchasing a sufficient supply of powder cocaine for those evenings cost *the boys* hundreds of dollars. Keep in mind these hundreds of dollars didn't include the funds spent on tobacco, alcohol, cannabis, food, or any other expenditures. A lot of cash (and occasionally other valuable commodities) was being exchanged for drugs in those days, and sometimes acquiring our supply of powder cocaine required making road trips to distant cities. It became obvious that Gee was the greatest beneficiary of *the boys'* fondness for powder cocaine. Gee was *balling* (wealthy) once he began *dealing* (selling) *hard* drugs such as cocaine. He drove a sports car, drank expensive alcohol, dressed in new clothing, wore jewellery, ate at expensive restaurants, always held wads of cash, and often carried around a *fat* (large) stash of cannabis, cocaine, and other drugs. At one point or another, all *the boys* fell into a drug debt with Gee. Those unpaid debts were a serious issue for Gee in those days. If he *pinched* (caught) you with cash while you were in his debt, there would be some sort of altercation. As such, several of *the boys* (including me) would avoid his presence for as long as possible. He was like a tax collector in those situations. "Pay up, motherfucker! I know you have money." In my mind, he *hustled* (worked) his way to obtain the alpha status of our group.

Hollywoods

Yo, for years I been buyin' my coke from the same cat
Jheri curl nigga, Dominican nigga who look Black…
- *Capone-N-Noreaga (1997)*

In my experience, spending time with drug dealers and doing them favours typically resulted in some sort of payment or benefit. On rare occasions, I would spend a few hours with Gee to assist with some *activities*. I did not mind serving in this role because I knew that I would get *high* for free in the process. Typically, the payment was *free smoke* (free cannabis), but sometimes just spending time with Gee resulted in a more substantial reward. On one occasion, Gee said, "you can hit the *coke*, as long as we do Hollywoods." I was excited about his proposal but was unsure of what he meant by *Hollywoods*. "I'm down! What's a Hollywood, though?" I asked. "One gram per line," Gee asserted. I gladly agreed and then he, John, and I snorted powder cocaine all night. I cannot begin to guess how much powder cocaine we consumed that evening, but it got to a point where I could no longer snort cocaine. My nostrils were congested with the drug. I had to *tap out* (give up). One thing that I remember most about that night was realizing that I had forgotten about the playoff hockey game that I was supposed to compete in that evening. I was no longer playing competitive hockey, but I still enjoyed playing recreational hockey with some of *the church boys*. I later learned that my team had won the playoff series and that Timothy had played exceptionally well. I immediately regretted agreeing to *Hollywoods* and felt like I missed out on a better experience. However, my biggest takeaway from that evening, is how dangerously close one of us must have come to an overdose.

Primary Reflection

It appears that I used *hard* drugs such as powder cocaine during a much safer era. I can't help but think of how many of *the boys* would have been accidentally poisoned, hospitalized, overdosed, or passed away from a contaminated street drug

> supply, such as the one that exists today. I (and I believe all *the boys*) just wanted to have a good time. Fortunately, none of us had any serious acute health issues while consuming powder cocaine together back in the early 2000s. I never witnessed someone overdose, but I also never saw anyone inject drugs, which likely limited the possibility of witnessing an overdose, at least in that era. These days, consuming *hard* drugs is much more dangerous, as there is a greater risk for accidental overdose and death. I wonder how *the boys'* consumption of *hard* drugs would have been impacted by something like the current *opioid crisis*. I can just imagine *the boys* having conversations about the *opioid crisis*. These conversations would likely have been rife with rumours and misinformation. I can only speak for myself, but I never felt at risk of an overdose when I consumed powder cocaine. I felt impervious to the potential serious and long-term consequences associated with all the drugs that I consumed over the years. I always woke up the next morning and eventually returned to feeling like myself… even if it took several hours of sleep, a few cups of caffeine, and a hot shower.

A Deadly Cocktail

According to an extensive report that analysed adulterants, contaminants, and the co-occurring substances found in Canada's illegal drug supply, fentanyl and its analogues were commonly identified (Payer et al., 2020). For example, analysis from this report revealed that "…among cocaine-containing samples, one in 20 (5%) contained another psychoactive substance, which increased to almost a third (29%) when including cutting agents" (Payer et al., 2020, p. 1). Across Canada, up to 3% of stimulant-containing samples included fentanyl or its analogues (Payer et al., 2020). The presence of fentanyl or its analogues in non-opioid drugs such as cocaine is particularly concerning since accidental poisonings are more likely to occur when drug consumers are not anticipating the consumption of opioids, are *opioid-*

naïve (i.e., not already taking opioids), or have a low tolerance to opioids (Hatton, 2012; Payer et al., 2020).

According to Crabtree et al. (2020), between 2015 – 2017 most of the deaths from illegal drug use in British Columbia (BC) involved opioids. However, among the drug-related overdose deaths not involving opioids, cocaine (47.1%) was the most common drug identified, followed by methamphetamine (39.0%), amphetamines (34.0%), and alcohol (27.0%) (Crabtree et al., 2020). A report from The Ontario Drug Policy Research Network revealed that in 2015 nearly one-third (32%) of opioid-related deaths involved cocaine (Gomes et al., 2017). Furthermore, this report also found that 40% of cocaine-related deaths involved fentanyl. In the US, cocaine-related overdose deaths increased considerably between 2000 and 2006, but then declined between 2006 and 2010 (McCall Jones et al., 2017). However, after 2010 cocaine-related overdose deaths increased by 60% (McCall Jones et al., 2017). This increase in mortality occurred during a period of growth in the street supply of opioids such as heroin (McCall Jones et al., 2017).

Secondary Reflection

> A few years following my cessation of drug use (except for alcohol), an overdose death touched my personal life. A mixture of cocaine and opioids was rumoured to have contributed. Hearing about this death was regrettably unsurprising to me, but incredibly unfortunate, nonetheless. Less than two years later, another untimely death touched my personal life. There were also rumours of opioid consumption leading up to this death. Years later, a childhood peer notified me that his best friend had overdosed and passed away. In all my experiences consuming *hard* drugs such as cocaine, I never once had a conversation with *the boys* about overdose. There was no plan in place in the event of an overdose, and as mentioned I was never concerned that something like this would happen to me.

At that time, I felt that I was safe from a cocaine overdose because I figured that I would never have had the opportunity (and funds) to consume enough of the drug to trigger an overdose. However, on the night of the *Hollywoods,* we must have come close.

Cocaine Confidential

1, 2, 3, 4, 5, 6, 7, 8, 9…
It's the ten crack commandments, what?
Nigga can't tell me nothing about this coke
Can't tell me nothing about this crack, this weed, my hustlin' niggas
Niggas on the corner I ain't forget you niggas, my triple beam niggas…
- *The Notorious B.I.G. (1997)*

Between the fall of 2002 and the summer of 2003, I had only used powder cocaine on only a handful of occasions. I was beginning to distance myself from *the boys* and returned to spending most of my time with *the church boys*. Cocaine was not as present in my new (yet, old) social circle, so there were not many opportunities to consume this drug. However, I did not hesitate to snort *rails* if given the opportunity. Yet, using cocaine was highly stigmatized among our larger peer group and was also perceived as an undesirable behaviour among the females I was romantically interested in. Being labelled as a *coke head* (chronic cocaine user) was likely a one-way ticket to singlehood, unless you wanted to get romantically involved with the females who also consumed *hard* drugs; however, these females were not particularly desirable. As such, cocaine was always consumed in private (e.g., bathrooms). The legal consequences of getting *pinched* for the possession of cocaine carried a much greater punishment compared to the possession of cannabis, so this drug's consumption was typically confidential and swift.

An alternative route of consuming cocaine is to smoke it. At that time, I held the belief that smoking powder cocaine mixed with cannabis (we mistakenly called this mixture, *chronic* or *coco puffs*) was a more socially acceptable route of consuming cocaine among *the church boys.* In my mind, it was also a milder way of introducing *the church boys* to powder cocaine. I figured it was a clever, less invasive, and inoffensive route of administration, especially since I (we) could disguise smoking *chronic* at larger social gatherings, which included some peers who viewed snorting cocaine as an unacceptable behaviour. What I (we) did not know, was that powder cocaine cannot be smoked. For powder cocaine to be smoked

it needs to be converted to *freebase* or *crack* (Hart et al., 2019). Yet, smoking *crack* carried a much greater stigma compared to snorting powder cocaine. Moreover, being labelled a *crack head* (chronic crack user) was certainly a one-way ticket to being ostracized, even from peers who snorted powder cocaine. Possibly, the only label worse than a *crack head* was to be referred to as a *junkie* (chronic heroin user). On one occasion, I planned to purchase some powder cocaine, so me and some of *the church boys* could smoke *chronic*. I paid a visit to Gee and described my plan to smoke a mixture of powder cocaine and cannabis. To this plan, he replied, "you don't want this, you want that," and he pointed to the small bag of *crack* on the table. In that moment, I felt embarrassed and clueless, but I trusted Gee and made the purchase. Mind you, I never offered *chronic* to someone who was unaware of the *joint's* contents. Some of *the church boys* enjoyed smoking *chronic* and I believed that my efforts to access and demonstrate the consumption of this drug increased my status in this peer group. As mentioned, I felt that I still had something to prove to *the church boys*. Around that time, I also introduced powder cocaine to one of the younger *church boys.* I'll call him Craig (pseudonym). Craig seemed eager and curious to experiment with powder cocaine, and I was more than willing to demonstrate how to prepare and snort *rails*. After Craig snorted his first *rail*, I felt immediately responsible for his well-being and hoped that nothing bad would happen to him while he was under the influence of powder cocaine. During that interaction, I basically played the role of Chester mentioned earlier. I wonder if Craig ever played the role of Chester for someone else.

Primary Reflection

> Consuming *hard* drugs such as powder cocaine was always kept a secret from outsiders. *The boys* (and *the church boys)* spoke about powder cocaine and *crack* in a stealthy fashion and used creative slang to refer to these drugs. This way, we could evade judgment and disapproval from outsiders. We snorted powder cocaine in a

> variety of places: basements, bathrooms, inside parked cars, and several other spots that were out of plain sight. The confidentiality of consuming powder cocaine seemed to increase its appeal. Powder cocaine was seductive and prestigious, which is likely the result of its powerful stimulating effects and high price. *Crack* was gritty and repugnant. Despite its appeal to *the boys*, powder cocaine was not a drug to flaunt or advertise in a social setting with outsiders and attractive females; and *crack* was most certainly not something to even mention unless someone expressed interest in consuming it with you. The irony is that powder cocaine and *crack* are pharmacologically the same drug (Vagins, 2006).

Read Between the Lines: Cocaine's Stigma

Based on my review of the literature, it is clear to me that there are several historical and cultural factors that have contributed to the public's perspectives of cocaine and *crack*. Many of these factors have contributed to the stigma that is still associated with cocaine, and especially *crack*. The following sections offer some discussion concerning these historical and cultural factors.

Crack, Racism, and the War on Drugs

In 1986, President Ronald Reagan and the US Congress passed the Anti-Drug Abuse Act as a part of the War on Drugs campaign, which sanctioned mandatory minimum sentences for specific quantities of cocaine (Turner, n.d.; Vagins, 2006). As a result, Congress established much harsher sentences for the distribution of *crack* compared to the distribution of powder cocaine (Vagins, 2006). For example, the distribution of just 5 grams of *crack* carried a minimum sentence of five years in a federal prison (Vagins, 2006). Yet, those who were charged with the distribution of 500 grams of powder cocaine (100 times the amount of *crack*) received the same sentence (Vagins, 2006). In 2010, President Barack Obama's administration enacted The Fair Sentencing Act which "…reduced the drug

quantity ratio between powder and *crack* cocaine that triggers the mandatory minimums from 100-1 to 18-1" (Gotsch, 2018, para. 8).

The racial issue at hand is that there was a statistically relevant correlation between ethnicity and the preference for *crack* over powder cocaine (Lowney, 1994). However, the specifics of that *preference* have been debated in the literature. According to Lowney (1994), Black and Latinos were more likely to consume *crack* than whites, and as a result they were more likely to be subjected to the harsher penalties imposed by Congress. Yet, Dr. Carl Hart claims that "… more than 80% of the people who were arrested and prosecuted under these laws were black, even though we know that black people didn't use *crack* cocaine at higher rates than white people in this country" (Lyons 2017, para. 14). Tuner (n.d.) adds that "… the War on Drugs focused on small-time drug dealers, who were generally poor young black males from the inner city… One in every four African-American males aged 20-29 was either incarcerated or on probation or parole by 1989" (para. 10). According to Palamar et al. (2015), African Americans are more likely to be convicted for *crack* offences, while powder cocaine convictions are more common in wealthier white communities. Furthermore, "… in 2003, African-Americans accounted for over 80% of those sentenced for *crack* offences even though whites and Hispanics accounted for over 66% of *crack* users" (Palamar et al., 2015, p. 3). Back in 1993, Shein weighed in on the issue with the following: "… although there is no indication from case law and legislative history that Congress harboured a discriminatory intent when enacting the Anti-Drug Abuse Act, statistical evidence shows a discriminatory effect in its application (p. 61).

Perceptions and Meanings Associated with Cocaine Inside a Drug Culture

Fazio et al. (2011) conducted a study examining the perceptions and meanings associated with cocaine consumption in the dance scene of the San Francisco Bay area. Data was collected through in-depth, face-to-face interviews with gay and bisexual Asian

American men from the Bay area. The sample included 40 participants and had a median age of 26.5. This sample was identified as middle-class and well educated. As well, each of the participants had a history of using a variety of drugs such as alcohol, cannabis, ecstasy, cocaine, amyl nitrite (*poppers*), methamphetamines, and GHB.

The results of this study were presented thematically. The first theme uncovered two sets of vastly different attitudes and opinions towards cocaine. On one hand, cocaine was perceived as stigmatized and dangerous, whereas others believed that cocaine posed relatively few risks. The second theme revealed the perception that consuming cocaine enhanced sociability; as such, this was one of the most frequently cited motivating factors for consuming this drug. "The nonchalant attitude toward cocaine use and emphasis on social aspects of the drug were typical of many of our participants" (Fazio et al., 2011, p. 8). The third theme discovered various perceptions of cocaine. This drug was perceived as either popular or out-of-favour, glamorous or stigmatized, safe or dangerous and was shaped by the comparisons made between cocaine and other drugs such as alcohol, GHB, and methamphetamine. For example, one participant viewed cocaine as popular and dismissed GHB as unpopular. Other participants discussed cocaine's ubiquity within the dance scene and held the perception that everybody was using it. The fourth theme demonstrated discussion about the safety of cocaine. For example, cocaine was described as benign and acceptable, whereas methamphetamine was labelled as dangerous and its consumption as shameful. Here is one of the conclusions drawn by the authors of this study "…it is possible that social acceptance of drug use can only truly occur in this community when drug use is taking place in the absence of sexual practices, which carry with them the risk of HIV transmission" (Fazio et al., 2011, p. 15).

Language and Terminology Associated with Cocaine's Stigma

Not all drugs are equally stigmatized (Kulesza et al., 2013). Some preliminary research has revealed that *crack* and intravenous drug consumers are the most stigmatized by both the general public and drug consumers themselves (Kulesza et al., 2013). For example, according to Davis et al. (2004), ethnographic research found that powder cocaine consumers disparaged those who consumed *crack*, implying that consuming powder cocaine was more conventional and less associated with the code of the streets compared to the consumption of *crack* or heroin. According to Furst et al. (2010), the term *crack head* is an expression that was created in the mid-1980s to denigrate and typecast the people who consumed *crack* or who were believed to be *crack* users. As such, the widespread use of the term took on a social control function by the 1990s (Furst et al., 2010). "One outcome of this is that some adolescents have taken pride in not using *crack*. Being acutely aware of the stigma attached to crack and the potential for being labelled a *crack head* by their peers and significant others has acted as a symbolic constraint against using *crack*" (Furst et al., 2010, p. 154). The Global Commission on Drug Policy (2017) add that the language used when speaking about people who consume drugs has a tremendous impact on how they view themselves and how drug consumers are viewed by others. As a result, stigma has a double effect: the more society stigmatizes and rejects people who consume drugs, the fewer opportunities there are for treatment; at the same time, stigma drives individuals who need help away from the services that are available (Global Commission on Drug Policy, 2017). Disapproval of powder cocaine and *crack* remains prevalent today and their consumption continues to be stigmatized (Palamar & Ompad, 2014), especially among the Black community, it seems.

Secondary Reflection

On occasion, I'm asked to share some of my lived experiences of drug use. I've shared these experiences at conferences, informal gatherings, recovery events, and with my closest friends and family. Whenever I discuss my use of powder cocaine, it

seems to spark interest. But whenever I mention my consumption of *crack*, it's typically met with shock and disappointment. Even as a child in the late 1980s and early 1990s, I can remember drug prevention and education campaigns being saturated with messages that *crack* was an awful drug that should be avoided at all costs. "Just say no!" These types of messages appeared in cartoons, comic books, and television commercials where they were often endorsed by professional athletes and celebrities. Remember that ominous Pee-wee Herman PSA about *crack* from the 1980s? Ironically, Paul Reubens, the actor who played Pee-wee Herman, also played the role of a cocaine kingpin named Derek Foreal (aka Richard Barile) in the movie *Blow*, which was a popular film among *the boys* in the early 2000s. I think a lot of people of my generation reflect on those PSAs from the 1980s and early 1990s whenever there are discussions about cocaine, and especially *crack*. At the time I consumed cocaine and *crack,* I was an adolescent. I wasn't homeless, overdosing, *tweaking* (compulsive, disorganized behaviour), committing violent crimes or performing sexual favours for the next *hit*. Yet, these are the stereotypes that some people seem to have when they think about those who consume *hard* drugs such as cocaine and *crack*.

The End of The Line

This is the end
Beautiful friend
This is the end
My only friend, the end
- *The Doors (1967)*

The end of my high school career concluded with a massive outdoor party (referred to as *prom party*). In those days, it was common for these types of gatherings to take place following high school graduation or prom. Someone discovered a campground and effectively promoted that year's *prom party* because there were hundreds of adolescents and young adults in attendance. Tobacco, alcohol, and cannabis consumption were prominent the entire weekend. People began consuming these substances as soon as they arrived at the campground. There was plenty of excitement in the air and absolutely no adult supervision to be found. Some people appeared to be enjoying their camping experience responsibly by having campfires, playing music, and consuming alcohol moderately. Others were visibly intoxicated and displayed out of control behaviours, such as drinking and driving and setting picnic tables on fire. There was also a handful of people that would disappear into a tent or parked car to snort cocaine. I was certainly among this group.

I was well prepared for *prom party*. I brought cannabis, cocaine, alcohol, and a couple droplets of GHB (Gee gave me a sample of this drug to try, but I had no idea what it was at that time). I shared my small *coke stash* with some of my peers on the first night and was hoping they would return the favour. The favour was indeed returned the following night. But one thing that I remember most about that weekend is the romantic opportunity that I may have missed out on. That school year, I had a crush on one of my schoolmates. She was physically attractive, intelligent, and friendly. However, I had only spoken to her briefly a couple of times throughout the school year. That weekend, I formally introduced myself and made it clear that I was romantically interested in her. She appeared to be receptive to my

advance and I was feeling good about our potential in that moment. We held hands, stood by a campfire, and chatted for a few moments. However, soon after, one of my peers reminded me that it was time for him to return the favour. I hesitated for a few seconds as I contemplated my dilemma, but I eventually decided to snort cocaine. When I returned to the campfire, she appeared to be no longer interested in me. "You went to do *coke*," she said disappointingly. "Nope. I just went to use the washroom." I replied quickly. She knew I was lying and walked away. I was disappointed that I had sabotaged myself, as I was interested in more than just an immediate future with this girl. Damn…

Not long after *prom party,* I decided that I would never consume cocaine or any other *hard* drugs again. A month or so later, I confessed my experiences with *hard* drugs to my mother. She seemed equal parts understanding, compassionate, concerned, and relieved that I was deciding to discontinue my use of *hard* drugs. I was comforted by her support and felt as if I had gotten the *monkey off my back.* I was ready to change my life. However, this did not mean that I was going to abstain from consuming all drugs. No way! After weighing the pros and cons of the drugs that I had consumed over the years, it was clear to me at that time that cannabis was the safest and best option. Afterall, cannabis was always my *drug of choice,* but at that point I decided to double down on my consumption of this drug and became incredibly preoccupied with finding and smoking cannabis. There is no doubt in my mind that at that point I became psychologically dependent on cannabis. However, despite my dependence on cannabis, I remained proud that I was able to abstain from consuming *hard* drugs, especially cocaine and *crack.* In hindsight, my abstinence from using *hard* drugs was a significant step in my recovery process.

Primary Reflection

During my adolescence, I had a variety of romantic relationships. I savoured female presence and enjoyed courting them. However, my compulsion to get *high* interfered

with my romantic pursuits on many occasions. Moreover, my drug use likely negatively impacted my mate value since the females I was romantically interested in did not consume drugs on a regular basis. If they did consume drugs, it was likely alcohol at weekend parties or the occasional cigarette or hit from a *joint* containing cannabis. These types of females had good grades, part-time jobs, healthy relationships, seemed to come from good families, and appeared to be from a higher SES. They were everything that I wasn't, and I wanted someone like that in my life. I'm now married to an intelligent, beautiful, kind, and loving woman. She's also a wonderful mother to our charming and loveable children. I eventfully found what I was longing for all those years ago: a healthy romantic relationship and a secure family. The absence of these two aspects in my life caused me so much emotional pain over the years and now that I have them both, I can clearly understand why I felt so empty without it. I've been abstinent from consuming drugs other than alcohol since December 17th, 2005 and have been abstinent from consuming alcohol since October 1st, 2014. Some people likely perceive my abstinence from drugs and alcohol as a success and consider these markers as evidence of my success in *recovery*. But what I value more than anything in my life and recovery is my family and friends. The love, support, and positive experiences that I've had over the years has given me more than the many pleasures that I experienced with drugs (including alcohol) as an adolescent and young adult. I can't emphasize how very fortunate and grateful I am to have had such wonderful family and friends who have loved and supported me over the years. I'm also very fortunate and grateful to have had the care and support of such wonderful health care providers and mental health professionals over the years. Without all these individuals, I would not be enjoying

the quality of life that I do now. Thank you from the bottom of my heart. However, the road of recovery will continue for the rest of my life.

Harm Reduction

According to CMHA (n.d.), "Harm reduction is an evidence-based, client-centred approach that seeks to reduce the health and social harms associated with addiction and substance use, without necessarily requiring people who use substances from abstaining or stopping" (para. 1). In contrast, an abstinence-based approach is characterized by the complete cessation of drug and alcohol consumption (Behavioural Health of the Palm Beaches, n.d.). "Historically, the treatment of patients suffering from addiction has been completely dominated by an abstinence goal" (Musalek, 2013, p. 636). However, demanding abstinence too soon may drive away patients who are at the brink of dealing with their addiction more directly (Publishing, 2009). Yet, some people contend that harm reduction and abstinence are not incompatible. For example, "… while harm reduction emphasizes a change to safer practices and patterns of drug use, it does not rule out the longer-term goal of abstinence. In this way, harm reduction is complementary to the abstinence model of addiction treatment" (British Columbia Ministry of Health, n.d., p. 5). However, Jenkins et al. (2017) argue that abstinence-based programming and educational strategies developed for the youth, often do not resonate with their target audience. For example, these types of abstinence-based programs and strategies lack an acknowledgement of young people's social context and how this population perceives the positive effects of drug use (Jenkins et al., 2017). According to Leslie (2008), the target population and the context in which harm reduction strategies are delivered have an influence on the specific interventions applied. "Health care practitioners who provide care to adolescents should be aware of and familiar with the types of harm reduction strategies aimed at reducing the potential risks associated with normative adolescent health behaviours" (Leslie, 2008, para. 1).

Jenkins et al. (2017) presented findings from the Research Adolescent Distress and Resilience (RADAR) study, which was a qualitative study involving youth across three communities in BC, Canada. The findings presented in this study highlight the youths' reflections on their social and community context for their experiences of drug consumption, as well as their own harm reduction strategies. The RADAR study recruited youth participants from multiple sites in BC, which were labelled as The City, The Valley, and The North. The City sample included 29 participants, The Valley sample included 27, and The North sample included 27. The results of this study were presented thematically.

The first theme presented was labelled as the *context and experiences of consumption*. Of all the drugs discussed by the participants from The City, *hard* drugs such as cocaine and methamphetamine were consumed the least in their high school and peer group. Several interviews from The City revealed that *hard* drug use was outside of shared social expectations in their youth community. Take the following quote for example:

> There's always a rumour that someone snorted a line of cocaine or something… you're just like 'someone did that?' Like, 'sorry this isn't the Bronx or something.' We usually don't do that here. That kind of stuff, that's really a shock…" (Jenkins et al., 2017, p. 4).

The participants from The Valley described their social context as stratified based on drug consumption. The interactions between those who consumed drugs and those that did not was limited. Take the following quote for example, "… most of us just kinda wanna get through high school and never see some of these kids again… 'cause we're going to be going on to university while they're still here doing drugs" (Jenkins et al., 2017, p. 6). The participants from The North described drug use as commonplace among their peers. In fact, most of the participants from The North consumed alcohol or other drugs.

The second theme presented was labelled as *substance use management*. As for the participants from The City, they predominantly managed their drug consumption by strategically avoiding contexts in which their management of drug consumption may be compromised by their peers who are present in those contexts. Take the following quote for example:

> I personally smoke *weed* sometimes on the weekends, I'm not going to lie, I've never done other drugs… Then there's also like the kids doing *coke* and all this stuff but I'm not into that, my friends are not really into that. I know some people do this stuff but it's not my thing, it's not my life, I don't really care (Jenkins et al., 2017, p. 6).

For the participants in The Valley, they made efforts to reduce the potential harms associated with drug consumption by avoiding individuals and social groups who consumed drugs. Several of the participants from The Valley described evading friendships with people who used drugs. As for the participants from The North, harm reduction strategies arose from witnessing or experiencing the negative effects of drug consumption. "I went on a complete binge, never going to do that again. I can see why a lot of people are messed up from drinking so hard core, really harsh on your body" (Jenkins et al., 2017, p. 8).

The findings from this study demonstrate that youth experiences, perspectives, and strategies related to drug use are firmly grounded within geographical, social, and cultural contexts. The authors of this study recommend that the development and implementation of drug use programming must be informed by evidence from harm reduction approaches so that these programs resonate with the youth. Furthermore, the authors posit that effective harm reduction programming must also be honest and informed by youth experiences.

Lau et al. (2015) conducted a qualitative study aimed at gaining a deeper understanding of older adult cannabis consumers' beliefs and substitution practices as part of

a harm reduction framework. This study included a sample of 97 participants from the San Francisco Bay area. This sample included 62 men and 35 women with a median age of 58. Among the sample, 73% identified as white and all the participants were long-term cannabis users with a median of 42 years of consumption. The results of this study found that the participants consumed cannabis as a safer alternative for alcohol, illicit drugs (including cocaine), and pharmaceutical drugs. The participants viewed cannabis as having less adverse side effects, lower risk for addiction, and a greater efficacy for pain relief (e.g., chronic pain). Take Kristina for example, "… the reason I didn't like [cocaine] is because I felt like with it, I didn't really have control, I felt like when I smoked *weed*, I had a little bit more control and if I did get a little high, I could eat a little something and like, come back down" (Lau et al., 2015, p. 656). Then there is Karl, "… usually *crack* was just my drug of choice… [A]nd so in the transition, smoked *weed*… As long as I'm not messing with *crack*, I'm cool… Cause it was like 'Hey, that's a victory for me'" (Lau et al., 2015, p. 656).

Aharonovich et al. (2006) conducted a quantitative study investigating the effects of cannabis consumption on treatment retention and abstinence from cocaine among cocaine dependent patients with attention deficit hyperactive disorder (ADHD). This study sample included 92 participants, of which, 84% were male, 60% identified as white, and overall had a median age of 37. At baseline, this sample reported consuming cocaine an average of three days per week and spent $42 on cocaine daily. The results of this study found that among the three categories measuring cannabis consumption (abstinent, intermittent/moderate, and heavy/consistent), the participants who fit into the abstinent and heavy/consistent categories had worst treatment retention compared to the participants from the intermittent/moderate category. Regarding the effect of cannabis on the outcomes of cocaine consumption, 32% of the participants achieved two or more weeks of abstinence from cocaine. Further data analysis revealed that among the aforementioned categories, there were no significant

differences for the rates of cocaine abstinence of two weeks or more. Among the abstinent category, 26% achieved abstinence from cocaine. Among the intermittent/moderate category, 39% achieved abstinence from cocaine. Among the heavy/consistent category, 31% achieved abstinence from cocaine. As such, this study found that cannabis consumption during treatment was not associated with the worsening of cocaine consumption outcomes among the sample. Although few patients achieved abstinence from cocaine, there was significantly better treatment retention among those who consumed cannabis intermittently/moderately, which is consistent with previous study findings on cannabis consumption for patients who were opioid dependent.

Secondary Reflection

I identify as someone who is in an abstinence-based recovery, which means I do not consume any drugs except for caffeine and the anti-depressants prescribed by my doctor. However, I've never received any formal addiction treatment. I was never admitted to residential addiction treatment, nor was I ever an inpatient at a mental health facility. Both these institutions typically require their patients to remain abstinent during their treatment. In theory, I understand why these institutions would want their patients to remain abstinent from drugs. It is very difficult to address the various issues associated with SUDs and addictive behaviours while the patient is continuing these behaviours and not entirely committed or focused on the treatment process. However, in my opinion, abstinence from the drugs and other addictive behaviours that have caused the patient problems in their life should be the long-term goal. Requiring a patient to abstain from all drugs and addictive behaviours during treatment is a lot to ask of the patient and places a heavy burden on that individual. Moreover, if that patient does not adhere to the rules of abstinence, their rights and privileges to receiving treatment are revoked. As such, the patient will

likely feel as if they have failed, are incapable, guilty, ashamed, and not worthy of treatment. I have always felt compassion for people who struggle with abstinence because I know how difficult it can be to achieve this outcome and how horrible it feels to be unsuccessful. My recovery began after *prom party* in the spring of 2003 when I decided that I was no longer going to use *hard* drugs. My recovery continued in the fall of 2005 when I decided that I was no longer going to consume cannabis. I took another step in my recovery in the fall of 2014 when I decided that I was no longer going to consume alcohol. As such, I have been abstinent from all drugs (except caffeine and anti-depressants) for less than six years. Therefore, I would argue that I demonstrated a harm reduction approach over the period of 11 years to reach abstinence.

Ghosting The Boys

I'm diggin' my way
I'm diggin' my way to somethin'
I'm diggin' my way to somethin' better
I'm pushin' to stay
I'm pushin' to stay with somethin'
I'm pushin' to stay with somethin' better
- *Metallica (1996)*

In addition to abstaining from *hard* drugs, I decided that I would no longer associate with any individuals who used *hard* drugs on a regular basis. This meant that I was going to *ghost the boys*. *Ghosting* is distinct from other forms of relationship dissolution because it occurs in the absence of the *ghosted* partner's awareness that it has happened (Freedman et al., 2019). "Although the idea of ending a relationship by cutting off contact has likely been around for a very long time, current forms of technology are making *ghosting* a more prominent relationship dissolution strategy" (Freedman et al., 2019, p. 908).

Ghosting the boys was an uncomfortable and unnerving experience that caused me a significant amount of anxiety at that time in my life. *The boys* still knew where I lived and had my home phone number, so I decided that I would no longer answer phone calls or knocks on the front door of my home. I always kept the blinds closed and locked the windows and doors because I was worried that some of *the boys* would break into my home, which they had done once before while I was at school. I also avoided visiting places around the city (e.g., parks, basketball courts, restaurants) that *the boys* would frequent. As such, I began to feel like a prisoner in my own city, and even in my own home. This was a dark time in my life. I just wanted to avoid interacting with *the boys* altogether. Social media was not prominent yet, so I did not have to worry about *unfriending, blocking,* or *unfollowing* any of my peers or hiding my *digital footprint.* However, some of *the boys* took exception to my *ghosting*, which I expected because I was fully aware that excluding *the boys* and avoiding social interactions with *the boys* without a valid excuse were violations of the unwritten rules.

Not only was I blatantly violating the unwritten rules, but I was also trying to evade the repercussions associated.

Primary Reflection

Ghosting the boys was a strategic move on my part. I felt that it was something I had to do to improve the quality of my life. It was clear that I was spiralling out of control and my future was in jeopardy. After careful consideration, I determined that my association with *the boys* had to end. However, John was unwilling to accept my decision to discontinue our association (perceived friendship). He continued to call my house every day for several weeks. He'd show up to my family home uninvited over the next several months and I'd occasionally spot his vehicle driving through my neighbourhood. I was literally hiding from *the boys*. I just wanted to be left alone. It was like a bad breakup with an abusive partner. I wanted nothing to do with *the boys* and wanted to erase them from my past. After several weeks of *ghosting*, John and Charles showed up to my family home, "why the fuck don't you answer my calls, man!?" John exclaimed. "Maybe because I don't wanna fucking hang out with you!" I fired back. Charles looked surprised, but I also wanted nothing to do with him either. They both understood that I was serious and that something about me had changed. John sneered and then walked off the porch defiantly. Charles followed. In that moment, I felt closure, but I continued to *ghost the boys*. I never saw Charles again, but he did send me a friend request on Facebook several years later, which I did not accept. I didn't see John for about five years until a mutual peer of ours invited him out to a bar that we were at. We were both cordial and got along fine. We remained *friends* on Facebook for several years until I *unfriended* him eventually. All *the boys* had challenges and struggles during their adolescence, as do most (if not all) adolescents. I don't blame them for the decisions that I made, even my decisions to

use cocaine. But as much fun as I had associating with *the boys*, the toll that lifestyle took on my biopsychosocial development was evident. Biologically, I was becoming very lean and lost some of my athletic abilities. I was malnourished and not getting enough exercise. Furthermore, it is possible that my drug consumption (including cocaine) caused irreversible changes to my brain, as the disease model of addiction would suggest. Psychologically, I was struggling. My moods were becoming unstable, and I was experiencing paranoia and psychological distress from *ghosting the boys.* Sociologically, I was askew. Up to that point, I had spent a large part of my adolescence developing relationships with *the wrong crowd*. Yet, in the years following my escape from *the boys*, I continued to spend time with peers who consumed drugs. However, these peers did not consume cocaine on a regular basis (if at all). Looking back, I had great difficulty finding peers to spend time with that were not using drugs. Drug use was ubiquitous. Furthermore, I had to repair my relationships with my family. I grew distant from my family during my heaviest periods of cocaine (and other drug) use. My relationship with each family member was already hanging on by a thread, especially my relationship with my father. We went lengthy periods without speaking or seeing each other. I really missed my father and enjoyed spending time with him, but I declined many invitations to family gatherings with him over the years. I was just more interested in hanging out with *the boys* and getting *high*.

Change of Social Environment and the Cessation of Drug Use

Social factors play an important role in the development and resolution of drug-related problems, and in relapse to SUDs (Kelly et al., 2014). Successful recovery from SUDs often involves shifting from social environments that support drug use to social environments that support abstinence and recovery (Kelly et al., 2014). This sort of change can reduce

exposure to drug-related cues and facilitate the procurement of coping skills for recovery which may mitigate the risks associated with stress-related relapse (Kelly et al., 2014).

Pettersen et al. (2019) examined the role of social relationships in achieving and maintaining stable recovery after many years of SUD. The study sample included 10 men and 8 women that had a mean age of 54. Each of the participants reported an active period of problematic drug use from 13 to 36 years, which was followed by periods of abstinence ranging from 5 to 18 years. The participants used drugs such as heroin, alcohol, and a mix of other drugs. The participants were interviewed face-to-face for approximately one hour. The results of this study revealed that to reach or maintain abstinence from drug use, it was crucial for the participants to maintain positive relationships and to engage in self-agency to protect oneself from being influenced by negative relationships. Although, all the participants in this study received some form of treatment for their problematic drug consumption, they reported that social relationships outside of treatment were just as helpful in their successful recovery from their SUDs. Moreover, the results of this study found that having a caring relationship with siblings influenced the participants' decisions to remain abstinent from using drugs. The authors of this study concluded that "… a change of scenery is important for both initiating and maintaining abstinence" (Pettersen et al., 2019, p. 7). Moreover, the authors recommend that SUD treatment providers involve significant others, family, and friends in the treatment programs, as their involvement can facilitate promoting and prolonging positive relationships relevant to establishing recovery.

Secondary Reflection

> Changing my social environment was probably the most important step in my early recovery. I had to make a change. I had to cut people out of my life, even some individuals who I considered to be my closest peers. I just knew that there was more to life than using drugs, especially cocaine. Life was passing me by, and I was

falling behind in terms of meeting society's expected milestones as an adolescent. The most challenging part of my recovery was finding people to spend time with that did not consume drugs. Even at the age of 36, there are still people in my life that consume drugs, but we're able to find common ground, enjoy our time together, and I'm not pressured into using drugs with them. However, I do have several people in my life that do not consume drugs (e.g., my wife) and our interactions are still enjoyable and meaningful. I just wish that I could have had these people in my life when I was an adolescent. Drugs were everywhere. It seemed as if I could not escape them. Drugs weren't just a feature of my adolescence; they were the fabric of my existence.

Discussion

This autoethnography aims to add my story to the body of scholarly literature on adolescent drug use. To unpack my story, I developed the following research questions: Why did I consume cocaine as an adolescent? What were my experiences with cocaine during this developmental period? How did my consumption of cocaine impact my development? The data collected from this study is paired with relevant findings from the literature to help answer my research questions. The key findings from this study offer an informative, intimate, and provocative perspective of the psychosocial, cultural, environmental, and historical factors that permeate the subculture of adolescent drug use. In this chapter, I provide direct answers to my research questions, highlight my key findings, discuss the possible implications of these findings, and then address the limitations of this study.

I would like to preface the remainder of this chapter with the following quote from Fast et al. (2010): "While it is acknowledged that individual agency is intimately associated with drug-related risk taking, a growing body of research emphasizes the intersection of social, structural, and physical environmental factors in powerfully shaping drug use practices among youth" (p. 1).

Why Did I Consume Cocaine as an Adolescent?

To answer this question, I considered many possible contributing factors. However, without access to neuroimaging, genetic testing, and family health records, I can only speculate about the biological factors (e.g., genetic predisposition) that may have contributed to my use of cocaine (and other drugs) as an adolescent. Therefore, I chose to focus my attention on the psychosocial factors that I believe contributed to this behaviour. As such, I used a psychosocial perspective to help me find the answer to my first research question. A psychosocial perspective focuses on the combination of psychological and social factors that influence human behaviour (Upton, 2013). Social factors consist of a broad spectrum of

elements at the level of a society concerned with social processes and social structures that affect an individual (Upton, 2013). Psychological factors consist of features at the individual level concerned with individual processes and meanings that influence mental states (Upton, 2013). Psychosocial factors include social support, loneliness, marriage status, social disruption, bereavement, work environment, social status, and social integration (Upton, 2013). Based on the autoethnographic data collected in this study, it is evident that several psychosocial factors contributed to my decision to initiate and maintain my consumption of cocaine (and other drugs) as an adolescent. I explore each psychosocial factor in the sections below.

Curiosity

One of the psychosocial factors contributing to my decision to begin using cocaine as an adolescent was my curiosity about the drug. I had very little knowledge about cocaine before my first experience, so I was curious about several things. For example, I was curious about cocaine's appearance and texture, as this drug had never been in my presence before. I also wanted to know how to prepare cocaine for consumption. At that point, I had only ever seen *rails* or *bumps* of cocaine in movies like *Scarface*, *Goodfellas*, and *Blow*, so I was curious to know if the preparation methods were like what I saw in these Hollywood blockbusters. However, I was most curious about how the consumption of cocaine would affect me. Again, I had only ever seen cocaine in the movies, so I expected to react to this drug like Tony Montana did in *Scarface*, Henry Hill in *Goodfellas*, and George Jung in *Blow*. In my review of relevant scholarly literature, curiosity was also identified as a factor for initiating and consuming *hard* drugs such as cocaine and heroin.

Witteveen et al. (2007) conducted a qualitative study to identify the self-reported factors that facilitated the initiation of cocaine and heroin consumption among older adolescents and young adults from Amsterdam, Netherlands. This study sample included a

total of 50 participants who were explicitly identified as *problem drug users*. The participants were between the ages of 18-30, of whom 72% were male, 64% were poly-drug users, and 36% were homeless. The researchers collected data via in-depth interviews to obtain the participants' retrospective histories of drug use. The findings from the interviews revealed that curiosity was among the seven most common self-reported factors facilitating the initiation of cocaine and heroin use.

Baluku and Wamala (2019) examined the critical gaps in the knowledge surrounding the initiation of injecting drugs. This study was conducted in Uganda, East Africa and included a sample of 102 males and 23 females who identified as *people who inject drugs*. The researchers collected data via semi-structured interviews, where the participants were asked about their experiences of transitioning to injecting drugs. This study found that the participants transitioned to injecting drugs because a close friend was already injecting (47.2%), the desire to achieve a greater *high* (26.4%), and out of curiosity (12%). Among the participants who reported curiosity as a motivating factor, they specified curiosity to feel the injection.

Draus and Carlson (2006) investigated the contextual factors associated with the initiation of heroin injection among a sample of 13 men and 12 women from rural Ohio, U.S. The participants were identified as *people who recently injected heroin*. Data was collected via semi-structured interviews and through focus groups between June 2002 and February 2004. The results of this study uncovered several factors that contributed to the initiation of heroin injection. These factors included the growing pressures of drug dependence and economic need, the influence of intimate and group relations, and curiosity about heroin's effects.

Fast et al. (2010) completed a qualitative study investigating young people's perspectives regarding the evolution of their drug use in the context of a local drug scene in

Vancouver, Canada. This study included 18 men, 18 women, and two transgender participants between 18 and 26. This sample was recruited from a cohort of young drug consumers known as the At-Risk Youth Study. Data was collected via semi-structured interviews and ongoing ethnographic fieldwork. Among other results from this study, the thematic analysis of the data demonstrated that most youths characterized their past drug consumption transitions as non-exceptional, mainly 'spur-of-the-moment' decisions motivated by evolving feelings of curiosity.

My lived experiences and the findings from the studies mentioned above indicate that curiosity may be a risk factor for some adolescents to initiate the consumption of *hard* drugs such as cocaine and heroin. So, how do drug education programs adequately address the issue of curiosity? Unfortunately, I do not have a definitive answer, but I can confidently offer some recommendations based on my lived experiences and the findings from the literature. I believe it is essential to be genuine and honest about drugs in any drug education program. Not only should these programs provide accurate information about drugs, but they should also incorporate guest speakers to discuss their lived experiences with drugs. These guest speakers should reflect the local community and include more than just law enforcement or people recovering from a SUD.

Furthermore, young people should be able to correctly identify drugs if they encounter them in their natural environments. Therefore, I think it is crucial to provide at least some exposure to drugs in these education programs. Given the ongoing trends and changes in drug culture (e.g., *opioid crisis*) and drug policy (e.g., cannabis legalization), I believe it is critical to update drug education programs annually to reflect the current social climate surrounding drugs. Moreover, considering that some youth begin misusing drugs by age 12 or 13 (Robertson et al., 2003), it is vital to provide this type of drug education before

this stage of life. Lastly, drug education programs should attempt to identify those curious about drugs and connect them with additional educational resources and social supports.

Distress and Emotional Pain

Another psychosocial factor contributing to my decision to initiate and maintain the consumption of cocaine (and other drugs) as an adolescent was the desire to find quick relief from the distress that I was experiencing at that time. During my adolescence, I experienced some significant developmental challenges, which negatively impacted my self-esteem, self-worth, self-confidence, and self-efficacy. For example, I struggled academically during high school. I failed many courses and was forced to attend summer school or enrol in classes with the younger age groups the following year. Both scenarios were embarrassing for me, but I hated attending summer school, so I typically chose the latter. I was eventually expelled for truancy in what should have been the twelfth grade. Being removed from high school was a significant source of distress for my family and another point of contention with my mother. As a result of my expulsion, I could not achieve some important developmental milestones: graduate high school with my peers, obtain my first part-time job, and begin post-secondary education. My future was uncertain. I was going nowhere fast, and I began to experience early symptoms of anxiety and depression. Yet, I could always find some relief from my distress and feelings of embarrassment by consuming drugs, especially cocaine.

I also experienced considerable emotional pain during my adolescence. At that time, I had not yet developed effective coping skills to address these issues healthily. Furthermore, I lacked adequate social support, which could have buffered me from my emotional pain. My primary source of emotional pain was the separation of my parents and the subsequent dissolution of my family. At that time, my relationships with each of my family members deteriorated quickly. My family life was something that I occasionally reflected on while I was *high*, despite my efforts to forget about it when I was with my peers. Another significant

source of emotional pain was my failed romantic pursuits. I had fallen in love during high school. She broke my young heart twice, and both times I felt betrayed and used. I was emotionally overwhelmed by these rejections and sought comfort in drugs. Ultimately, consuming drugs helped me cope with the emotional pain that I was experiencing at that time. Cocaine was a particularly effective short-term solution because it produced powerful euphoria, boosted my self-esteem, and inflated my sense of self-worth. More importantly, I felt these effects immediately after consuming the drug.

Self-Medication Hypothesis. The self-medication hypothesis (SMH) is an evidence-based psychological theory from the 1970s (Khantzian & Albanese, 2008). The SMH posits that pain and suffering are at the heart of addiction and that vulnerable individuals resort to addictive behaviours because they discover that their addictive behaviours provide them with short-term and otherwise unobtainable comfort, relief, or change to their distress (Khantzian & Albanese, 2008). In particular, the short-term effects of addictive drugs relieve, change, or make more tolerable the distress associated with problems of dysregulated emotions, relationships, and self-worth (Khantzian & Albanese, 2008). Furthermore, people who have experienced trauma (e.g., physical, or sexual abuse) have long-term difficulties containing or regulating their emotions and, as a result, are more likely to develop addictive disorders (Khantzian & Albanese, 2008). The SMH includes two key components: first, addictive drugs become addicting because they have the power to alleviate, remove, or change psychological suffering (Khantzian & Albanese, 2008). Secondly, there is a significant degree of specificity in a person's choice of drugs or addictive behaviours (Khantzian & Albanese, 2008). In other words, a person deliberately chooses a specific type of drug or addictive behaviour because that drug or behaviour has a specific action or quality that relieves distinct feeling states that tend to have the most significant impact on the individual (Khantzian & Albanese, 2008).

Garland et al. (2013) conducted a quantitative study to examine self-medication among youth in residential treatment for antisocial behaviour. This study sample included adolescent residents of the Missouri division of youth services in the U.S. The sample consisted of 723 adolescents between the ages of 13-17. The participants were involved in interviews for over three months. The results of this study found that a relatively large sample of at-risk adolescents had exposure to traumatic experiences (e.g., been badly hurt or been in danger of being badly hurt or killed). These traumatic experiences were significantly associated with drug use and psychiatric symptoms, indicative of psychological distress. Statistically, the researchers found that drug consumption mediated the effect of trauma and psychological distress. Furthermore, a history of trauma was significantly associated with a feedback loop between psychological distress and drug use.

Umberson et al. (2016) carried out a qualitative study to strengthen their understanding of the major behavioural and psychosocial processes through which childhood adversity may contribute to relationship strain among men later in life. This study sample included 15 Black men and 15 white men from a large metropolitan area in the Southwestern U.S. Data was collected via in-depth interviews between 2008 and 2009. The study results showed that the most common themes of childhood adversity were poverty, violence and abuse, alcohol or drugs in the household, neglect, and relationship loss/disruption (e.g., separation from a parent and death of family members). Black participants experienced more childhood adversity than white participants. Among other results from this study, self-medication during adolescence emerged as a theme. For example, in response to the chronic stress associated with childhood adversity, many participants described how they began to smoke, drink, and use drugs during adolescence. The authors of this study offer the following regarding self-medication:

> These behaviours may provide some relief in the short run (and, in this sense, are effective coping responses), but they typically take a toll on relationships in the long run. Short-term relief comes in the form of pleasure seeking, social connection, and escape from stress (Umberson et al., 2016, p. 907).

The SMH certainly provides some explanation for my decision to initiate and maintain the consumption of drugs, especially cocaine. When I felt bad, I took something that offered instant relief. It is a simplistic but effective short-term coping strategy. This strategy is similar to having an alcoholic beverage after a rough day at work or taking Tylenol for a headache. It is not surprising that after I stopped consuming illegal drugs in my early twenties, I was diagnosed with a mood disorder and treated with prescription medication. I never properly addressed the distress and emotional pain that I experienced at the time. Essentially, I have been medicated for my mental health since I began consuming illegal drugs as an early adolescent. My self-medication started around the time my parents separated, and my relationships with my family began to suffer.

I wish I would have had the opportunity to speak with a psychologist or social worker to get to the root of my distress and emotional pain. I wish I were taught healthy coping strategies to help me regulate my emotions. I truly believe that psychotherapy would have at least minimized my consumption of drugs at that time or perhaps prevented my maladaptive coping strategies from developing. I did not get this opportunity until I was in my late twenties, and those sessions have been the most impactful part of my recovery. I strongly recommend that anyone who suspects their child or adolescent is struggling with their mental health seek professional treatment. Otherwise, the child or adolescent may engage in maladaptive coping strategies such as consuming drugs to find relief.

Desire to Experience Euphoria

Another psychosocial factor in my decision to initiate and maintain the use of cocaine (and other drugs) as an adolescent was the desire to experience euphoria. As mentioned, cocaine had a remarkable ability to enhance my mood. As an adolescent, no other activity brought me euphoria like cocaine did. I still enjoyed some of the same activities (e.g., playing hockey and video games) that I engaged in before I began using drugs. However, the pleasure I experienced from these activities was far less intense or rewarding than the euphoria I experienced from using drugs, especially cocaine. Metaphorically, playing hockey and video games as an adolescent was like riding a bicycle, whereas consuming cocaine (at least at first) was like riding a roller coaster with corkscrews and loops. Riding a bicycle is fun but nowhere near as stimulating as the g-force and excitement provided by a roller coaster.

There are various explanations for drug use; among them is that people consume drugs to feel good (NIDA, n.d.a). Most psychoactive drugs produce strong feelings of pleasure (NIDA, n.d.a). For example, the *high* from cocaine produces feelings of power, self-confidence, and increased energy (NIDA, n.d.a.). Consuming drugs such as cocaine through inhalation or injection creates a powerful rush of pleasure as the drugs enter the brain within seconds (NIDA, n.d.a.). One area of the brain affected by psychoactive drugs is the limbic system, which contains the brain's reward circuit (NIDA, n.d.a). The limbic system connects several brain structures that regulate and control our ability to feel pleasure (NIDA, n.d.a.). Drugs such as cocaine over-activate the limbic system, which produces feelings of euphoria; however, with repeated exposure to the drug, the reward circuit adapts to the presence of the drug (NIDA, n.d.b.). As such, the reward circuit diminishes its sensitivity, making it difficult to feel pleasure from anything other than the drug (NIDA, n.d.b.). Experiencing pleasure is how a healthy brain identifies and reinforces beneficial behaviours, such as eating, listening

to music, socializing, and having sex (NIDA, n.d.b.). Our brains are designed to increase the odds that we will repeat pleasurable activities (NIDA, n.d.b,).

Kennett et al. (2013) conducted a qualitative study to examine the role and value of pleasure in addiction. Kennett et al. (2013) interviewed people with SUDs to provide insight into their inquiry. The interviews revealed a genuinely ambivalent and complex relationship between addiction, value, and pleasure. The participants were candid with their discussion about pleasure and its role in their consumption of drugs. Although the participants usually valued the pleasurable properties of drugs, it did not mean that they valued a life of addiction. Take one participant's quote as an example, "… well don't get me wrong, I love using, mate. If I could use successfully I would. I'd still be using. I love using; I just don't like all the shit that comes with it" (Kennett et al., 2013, p. 6). "Pleasure seems to play a significant role in addiction though this diminishes across time and users become increasingly resentful of, or despairing of, the effects of their substance use on their capacity to realize other values" (Kennett et al., 2013, p. 10).

Whenever I share personal experiences about drug use, I usually tell stories that highlight the good times. I typically felt euphoric and had fun when I consumed drugs as an adolescent. The only exception was if I had a bad trip after ingesting psilocybin (aka magic mushrooms) or mixed cannabis with alcohol and vomited. Consuming cocaine was almost a guarantee to experience euphoria unless the *coke* was heavily *cut* (aka adulterated) and weakened through its production. There is no way that I could have experienced the degree of euphoria that I did with cocaine by engaging in any other activity during my adolescence. However, I believe that having access to fun and healthy social activities could have reduced my dependence on drugs for enjoyment. I think the same could be said for *the boys*. For example, one of *the boys* rented the gymnasium at the local Boys and Girls Club on one occasion. We all gathered there for an afternoon and played floor hockey, basketball and had

a great time together. I wish we had more opportunities like that back then. It was a safe place for all of us to hang out and be physically active. Granted, most of us likely smoked cannabis before we played, but nobody got drunk because you would not be able to participate if you were uncoordinated from the effects of alcohol. For most of *the boys*, alcohol was often paired with cocaine, and those were usually drugs that were reserved for the evenings (typically weekends). I do not believe that these types of activities (e.g., floor hockey) would have completely replaced our weekend cocaine binges. However, I do believe that if we had some other enjoyable options available at a low cost or free of charge (especially on Friday and Saturday evenings), we would not have consumed as much cocaine as we did or depended on drugs as much as we did to have a good time.

Socialization and Peer Status

Another psychosocial factor in my decision to initiate and maintain the use of cocaine (and other drugs) as an adolescent was because it was a social activity that was common and encouraged by my peers and was a behaviour that gained and maintained my peer status. *The boys* and *the church boys* both consumed drugs regularly and bonded over this pastime. Consuming drugs together was like a rite of passage and encompassed many rituals that outsiders would likely not appreciate or understand. To be welcomed and accepted by my peers, I needed to participate in each group's social activities. Consuming drugs was always the common denominator among my peers, and cocaine was essentially the next level or stage of drug use that all *the boys* quickly embraced. Keep in mind; we did socialize in other ways, such as playing pickup basketball, street hockey, video games, or going to the driving range and batting cages in the summer. However, none of these activities were valued as much as consuming drugs, especially cocaine, on Friday and Saturday evenings.

As mentioned, I still think we would have consumed drugs (cannabis at the very least) even if we had other enjoyable social activities available at that time. For example, on

one long weekend, several of *the boys* were invited up to a beautiful cottage. There were plenty of opportunities to go swimming, hiking, and fishing, but instead, we spent most of our time inside the cabin consuming drugs. This lifestyle was so deeply engrained and regularly practised that it is difficult to imagine us doing anything different at that time. If one of *the boys* decided or announced that they were going to reduce their drug use or discontinue altogether, they would have been ridiculed and ostracized by the group. At that time, I was unwilling to sacrifice my status among my peers because I was no longer no gaining acceptance or praise in any other areas of my life (e.g., competitive hockey). There was nowhere else to turn for respect and camaraderie. I was unemployed, expelled from high school, and unqualified to attend post-secondary education. As mentioned, I no longer played competitive sports, so my options were limited. Yet, as one of *the boys*, I was respected and maintained my peer status by engaging in the group's social activities. The following section highlights research findings that reflect my experience.

Killeya-Jones et al. (2007) examined peer status and drug use in early adolescent grade-level networks. The sample included an ethnically diverse group of 156 male and female adolescents at two times in the seventh grade. The researchers tested two competing hypotheses: the *behaviour hypothesis* and the *person hypothesis*. The former posits that regular consumption of alcohol and cigarettes during early adolescence results in an elevated peer status. The latter argues that the popular and more highly visible youth are more likely to engage in regular drug consumption. The findings of this study provided stronger support for the *person hypothesis*. The researchers found that the adolescents who reported current drug (e.g., alcohol and cigarettes) consumption enjoyed higher social status among their peers in the fall semester. However, these adolescents did not lose their high social standing if they discontinued consuming drugs by the spring. As such, the researchers suggest that "… there's

something about the timing of regular use that's quite important in this particular age group" (Killeya-Jones et al., 2017, p. 9).

Socialization models (also known as social learning models) argue that the attitudes and behaviours held by a social group are actively passed on and spread among its members (Strickland & Smith, 2013). In particular, the group's members model group-accepted behaviours, leading other group members to imitate those behaviours (Strickland & Smith, 2013). Furthermore, behaviours that follow group norms are reinforced, and those that deviate from these standards are punished (Strickland & Smith, 2013). In other words, drug use is established through the imitation of peer-modelling and then maintained by social reinforcement from peers, whereas abstinence-related behaviours are punished (Strickland & Smith, 2013). The socialization model is reflected in my lived experiences and provides further explanation for why I initiated and maintained my use of cocaine (and other drugs).

Substance Use Disorder

Perhaps the most obvious explanation (not exclusively psychosocial) for why I initiated and maintained the use of cocaine (and other drugs) as an adolescent was because I developed a SUD. Yet, I was never officially diagnosed with a SUD, nor were any of my peers at that time (as far as I know). However, I believe that most of them would likely have met the necessary criteria to be diagnosed with this condition. Most of us demonstrated the symptoms of a SUD: impaired control, social impairment, risky use, and pharmacological criteria (e.g., tolerance and withdrawal) (NIDA, n.d.a.). How could such a large group of adolescents evade clinical interventions, diagnoses or treatments? Answering this question is beyond the scope of this paper. But in short, most of us knew how to disguise our drug use from our families (if necessary). Even if our parents did have some suspicion of our drug use, they likely either ignored it, tolerated it, did not understand the severity, or outright accepted it.

Some of *the boys'* parents also consumed drugs, and, in some cases, these parents supplied their sons with drugs (usually tobacco, alcohol, and cannabis). As a father, I cannot imagine ever providing my teenage children with drugs so they can have a good time with their friends. For some of us, our parents were complicit in our drug use and unhealthy lifestyles. Again, I do not have a definite answer, but I can confidently make some suggestions on how parents can approach the topic of drugs with their kids. If you suspect that your child is consuming drugs, talk to them about it. Engage in open and honest conversations. Share some of your lived experiences with drugs if you consumed them. Lecturing or shaming your child is an ineffective approach and will likely create more division in your relationship. Try to understand why your child has chosen to engage in this lifestyle and attempt to address the underlying issues. However, your child may require professional help if their drug use is severe (i.e., meets the criteria for a SUD). Also, learn about their peer group. Get to know your child's peers because they are likely engaging in the same behaviours.

What Were My Experiences with Cocaine During This Developmental Period?

I never used cocaine alone, so for this question, I focused on what it was like to consume this drug (and other drugs) within my peer group. I used a cultural perspective with a particular focus on drug subcultures to address this question. The concept of culture refers to the commonly held beliefs, shared language, history, and systems of meanings that link large groups of people together (Parrillo, 2014). A subculture refers to a definable, recognizable group within the larger culture distinguished by its own beliefs, customs, and values (Parrillo, 2014).

> Drug use is often a social activity in which groups of users are known to one another but not publicly identified. At each stage of the process, from finding dealers, to purchasing drugs and equipment, to finding a safe space to use, to the consumption

> itself, drug use is characterized by elaborate and mostly secret symbols and slang (Parrillo, 2014, para. 2).

In some ways, using cocaine was the apex of our drug-using careers. It was the *hardest* drug that most of us had consumed at that point. There was distinguishable excitement and enthusiasm about cocaine among *the boys*. Before cocaine exploded onto the scene, our usual Friday and Saturday night menu consisted of alcohol and cannabis. On special occasions, we ingested psilocybin (*magic mushrooms*) if we had access. The excitement that once existed for alcohol and cannabis had subsided, so the introduction of a newer and much more powerful drug was welcomed with enthusiasm. In some ways, cocaine helped us mature as drug users (I guess).

There was an element of seriousness and tension that accompanied cocaine. After all, this was an expensive substance that we went to great lengths to access. We never wasted the drug and always treated it with care. We created unique slang terms (e.g., *Tonys*) for cocaine that only our peer group would recognize and understand. Although we were open about our consumption of cocaine amongst each other, we typically snorted *rails* in a basement or bathroom. If there were outsiders present, we consumed the drug out of plain sight. While under the influence of cocaine, we seemed sharper, wittier, and much more self-confident. However, some of *the boys* also became aggressive, paranoid, and desperate. These latter behaviours were only present near the end of our cocaine binges. In general, *the boys* would engage in lively conversations, fiery debates, hilarious freestyle raps, or exchange harsh insults over unsettled *beef* (disputes) while under the influence of cocaine (and other drugs). Ultimately, this drug created a subcultural shift within our peer group once it arrived on the scene. It became the centrepiece of our social gatherings and influenced our behaviours, unlike any other drug up until that point.

How Did My Consumption of Cocaine Impact my Adolescent Development?

To answer this question, I had to consider how my use of cocaine (and other drugs) as an adolescent affected my physical, psychological, and social development. As such, I used a developmental perspective to help provide an answer. At its core, the developmental perspective is concerned with the biological, psychological, and social changes that occur during childhood and adolescence (Holmbeck, 2002). As mentioned, adolescence is a transitional developmental period, which takes place between childhood and adulthood (Holmbeck, 2002). Except for infancy, this period of life is marked by more biological, psychological, and social role changes than any other stage of life (Holmbeck, 2002). Furthermore, adolescence is a critical period for developing lifelong positive health-related behaviours, but it is also a time when risk factors for drug use and other psychiatric disorders begin to develop (Castellanos-Ryan et al., 2013; Holmbeck, 2002). If left untreated, these psychiatric disorders can result in severe and long-term disability later in life (Castellanos-Ryan et al., 2013).

Through the lens of a developmental perspective, one could argue at least to some degree, that many of the problems associated with health behaviours and the management of illness during adolescence occur because of difficulties in managing the normative developmental changes and milestones that occur during this period (Holmbeck, 2002). Since adolescent health and illness occur within the development context, the quality of research on adolescents will likely advance if a developmental perspective is adopted by researchers who study the second decade of life (Holmbeck, 2002).

Physical Development

I am not exactly sure how my use of cocaine (and other drugs) impacted my physical development. I do not have access to my medical records or measurable clinical data points from back then to help me analyse the impact that drugs had on my body. However, I recall that I had much different eating habits back then and was particularly lean for my age. I have

always been smaller in stature, but at the height of my drug-using career, I skipped meals regularly, did not exercise consistently, and was likely underweight. I probably lost some muscle mass and healthy body fat. In fact, I recall having one of the lowest body fat percentages in my twelfth-grade gym class. I generally did not take care of myself physically outside of practising basic hygiene. I was still growing physically but was not living a healthy lifestyle to assist with this important developmental process. I can only speculate, but it is likely that my use of drugs altered my nervous system permanently. I believe that my use of drugs changed my dopaminergic system (i.e., reward pathway) forever, which is one of the reasons why I am still susceptible to addictive behaviours. Again, this is just speculative, but I cannot help but wonder how my drug use affected my neurological development.

Psychological Development

I can confidently say that my psychological development was significantly impacted by my use of drugs, especially cocaine. As mentioned, I adopted maladaptive coping strategies and did not address my distress and emotional pain healthily. As I alluded to in the *cocaine confessions* chapter, I experienced bouts of sadness and despair following cocaine binges. At the age of 21, a few years after I had quit consuming *hard* drugs, I was clinically diagnosed with anxiety and depression. Under the guidance of my family physician, I still take a daily dose of a selective serotonin reuptake inhibitor (SSRI), called paroxetine (Paxil) which is an antidepressant drug prescribed for the treatment of depression (NHS, n.d.). It is hypothesized that SSRIs work by increasing serotonin levels in the brain (NHS, n.d.). As discussed earlier, serotonin is a neurotransmitter partially responsible for regulating appetite, mood, and sleep, and cocaine is known to immediately increase serotonin levels in the brain (Morton, 1999). Again, this is one reason why I believe that my consumption of drugs, particularly cocaine, had a significant influence in the development of my mental illness.

Social Development

In my experience, consuming drugs during my developmental years was predominantly a social activity. Whether it was smoking cigarettes with the older girls at lunch hour while in elementary school, smoking *weed* with the *church boys* during my time in high school, or snorting *rails* with *the boys* on those cold winter evenings, my consumption of drugs typically occurred in the presence of my peers. During my adolescence, I met, interacted, and developed relationships with many individuals who enjoyed using drugs. We all had a mutual interest in consuming drugs and getting *high*. As such, we bonded through these behaviours. I developed the necessary social skills to thrive within a drug subculture. However, I did not develop the required social skills to become a respectable, productive, and law-abiding citizen as an adult.

As referenced throughout my autoethnography, I spent a significant portion of my adolescence with *the boys*. Looking back, I would formally describe *the boys* as a collection of vibrant adolescent males who were entertaining but ultimately misguided and unhealthy. *The boys* exemplified the stereotypical *wrong crowd* that our parents and teachers warned us about as children. We swore and spat often, disregarded rules, bylaws, and laws frequently, consumed drugs regularly, and in general, lived our lives on the edge. Despite the many warning signs, I was committed to this disreputable peer group. *The boys* were fierce, funny, loyal, trendy, and unruly. At first, I was eager to gain acceptance and elevate my status among *the boys.* Once I accomplished these goals, I settled into my role comfortably and was no longer the *new guy*. However, the presence of cocaine seemed to shift the group's dynamic and exacerbated the existing intragroup conflicts. It also shook up the hierarchy within our group.

With the presence of cocaine, drug deals were more expensive and riskier, and drug-related debts increased. Our moods and behaviours became sometimes erratic while under the influence of cocaine (and other drugs). As mentioned, peer status shifted within the group,

but this seemed to depend on income, the possession of cocaine, and a willingness to share this drug. Moreover, there appeared to be less interest and effort in pursuing or maintaining romantic relationships. *The boys* eventually divided, and outsiders were occasionally welcomed into the group (e.g., other *hard* drug consumers). As mentioned, several of *the boys* (including myself) began showing signs of a SUD (e.g., craving, consuming ever-larger amounts, tolerance, etc.) (NIDA, n.d.a.). By these measures, the presence of cocaine had an overall negative effect on our social development.

Conclusion

Before embarking on this autoethnographic journey, I spent many hours reflecting on my experiences of drug use as an adolescent. I have reflected on the good times and the bad, but invariably, my reflections focused on my collection of interpersonal relationships during that time. Until I engaged in the reflexive process required for autoethnography, I could not justify my association with *the boys*. Despite the fun times together, I typically reflect on my time with *the boys* with regret. Although I have a deeper understanding of my relationships with *the boys,* I cannot help but wonder how my development would have evolved if I had (and made myself available to) consistent healthy and supportive relationships during that time. I imagine these relationships would have included harmonious friendships, enlightening mentorships, enjoyable romantic relationships, and strong kinship. As a father of two young children, I hope they both have these types of consistent healthy and supportive relationships throughout their lives, especially during adolescence. I hope that they are compassionate, non-judgmental, and understanding towards those who find themselves in the *wrong crowd*. I also hope that my children are wise enough to select a peer group that will positively impact their social development. My children may consume drugs during their adolescence. However, I just hope they make healthier decisions than I did and reach out to their mother and me whenever they need us. I will also do my best to lead by

example and show my children that it is possible to have a fulfilling life without consuming drugs regularly or at all.

Study Implications

This study's findings have the potential to help young people, parents, educators, policymakers, health care providers, those in recovery, and others understand the intricacies and more contextual factors that influence and are involved in adolescent drug use. Many proximal factors contribute to drug use, which means that there are opportunities to intervene at the individual level. Social change takes time, and drug policies are finally starting to shift in the direction of science (e.g., harm reduction). However, ignorance, morality, and stigma will likely never disappear from conversations about drugs, addictions, and SUDs. As such, this paper offers an olive branch to those willing to see things from a different perspective and possibly change their existing beliefs about adolescent drug use.

Study Limitations

This study has some limitations. The most glaring limitation is that the data collected from this study was taken from one participant. As such, the findings from this study cannot be generalized. Someone may have had a much different experience consuming cocaine as an adolescent, so readers must not perceive my experience as universal. Another limitation is that the data collected is based on my memories from nearly two decades ago. Therefore, I may have forgotten some important details. Although I pride myself on my ability to recall events from my childhood and adolescence, my timeline of events may not be entirely accurate.

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Eric Collins

Curriculum Vitae

Education

Doctor of Philosophy, PhD
Health & Rehabilitation Sciences: Western University, London, ON
Completed: Fall 2021

Master of Science, MSc
Health & Rehabilitation Sciences: Western University, London, ON
Completed: December 2014

Bachelor of Health Science, BHSc (honours)
Faculty of Health Sciences: Ontario Tech University, Oshawa, ON
Completed: April 2011

Teaching Experience

Lecturer: The Psychology of Physical Health and Illness (PSYCHOL2036A/B)

- Duties: I am currently instructing an online, second year undergraduate course (approx. 300 students), using a combination of PowerPoint, YouTube, and personal audio recordings via Adobe Audition CC to deliver the course material. Students are introduced to the role of psychological factors in the prevention of illness and maintenance of good health, as well as the treatment of already-existing illness. Course topics include the stress/illness relationship, psychological influences on physical symptom perception and reporting, personality and health, behavioural factors in disease, etc.
- Faculty of Social Sciences, Department of Psychology: Western University, London, ON
- May 2018 – Present

Lecturer: Social Media & Health (HS4120A/B)

- Duties: Instructed a fourth-year undergraduate course (approx. 60 students). I delivered weekly lectures in-person, as well as online. I used a combination of PowerPoint, YouTube, and personal audio recordings via Adobe Audition CC to deliver the course material. Students were introduced to a range of topics associated with social media and health including mental health, sexual health, public health, and health promotion. Students were also introduced to a variety of theoretical perspectives, as well as real-world examples to help them achieve a better understanding of the topics covered. Students were encouraged to participate, think critically, and work together throughout their learning experience in this course.
- Faculty of Health Sciences, School of Health Studies: Western University, London, ON
- January 2020 – Present

Lecturer: Understanding Stress (HS4208)

- Duties: Instructed this fourth-year undergraduate course using a combination of in-class and online lectures. I introduced students to some of the most important concepts, theories, scientific investigations, and treatments associated with stress and trauma from a bio-psycho-social-spiritual (BPSS) perspective. Topics including adverse childhood experiences (ACEs), post-traumatic stress disorder (PTSD), affect dysregulation, the intergenerational transmission of stress and trauma etc.
- School of Health Studies: Western University, London, ON
- January 2018 – April 2018

Guest Lecturer: Disability Studies (DS1010)

- Duties: Guest lectured on the topic of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactive Disorder (ADHD). The discussion focused on the impact of ADD/ADHD within an academic environment, as well as the stigmas and misunderstandings associated.
- Disability Studies: King's University College, London, ON
- June 1, 2017

Guest Lecturer: Personal Determinants of Health (HS1001)

- Duties: Guest lectured to approximately 300 undergraduate students on the use and abuse of psychoactive drugs
- School of Health Studies: Western University, London, ON
- March 21, 2017

Graduate Student Teaching Assistant: Introduction to Ethics and Health (HS2610)

- Duties: Facilitated multiple weekly tutorials (approx. 30 undergraduate students in each section), mentored undergraduate students during office hours, lead a writer's circle, proctored exams, and wrote letters of reference
- School of Health Studies: Western University, London, ON
- Winter 2016, Winter 2017

Graduate Student Teaching Assistant: Health issues in childhood and adolescence (HS2700)

- Duties: Facilitated multiple weekly tutorials (approximately 30 undergraduate students in each section), mentored students during office hours, assisted with instructor duties on OWL, proctored exams, and wrote several letters of reference
- School of Health Studies: Western University, London, ON
- Fall 2011, 2012, 2017

Publications

- Collins, E. (2020). Understanding the risk factors and lived experiences of prescription drug abuse among Canadian children and adolescents: A retrospective phenomenological study. *Journal of Child & Adolescent Substance Abuse,* https://doi.org/10.1080/1067828X.2020.1736223

- McPherson, C., Collins, E., Boyne, H., Kirklady, E., & Waseem, R. (2017). Self-reported chronic pain as a predictor of relapse post residential addiction treatment: A

six month follow up pilot study. *International Journal of Mental Health and Addictions, 15,* 1069-1079. https://doi.org/10.1007/s11469-017-9751-1

- McPherson, C., Collins, E., Boyne, H., Strom, J., & Waseem, R. (2017). Expanding cultural competency policy for addiction service delivery in Canada: A case for consideration. *Journal of the Ontario Occupational Health Nurses Association*

- Collins, E. (2015). A Phenomenological study of prescription drug abuse among children and youth. *Western Graduate & Postdoctoral Studies: Electronic Thesis Repository*

Research Experience

Research Assistant

- Project Title: It takes a village, social inclusion, support, and purpose as a means of supporting individuals with substance use disorders in a rural First Nation in Ontario, Canada
- Duties: Grant application, data collection (in progress)
- Funding: $35,000 (one year), Canadian Research Initiative in Substance Misuse (CRISM)
- Western University, London, ON, and Whitefish River, ON
- September 2019 – Present

Project Leader

- Project Title: Evaluating success in residential treatment
- Duties: Interview transcription, data analysis using NVivo 12 software (in progress)
- Western University, London, ON
- September 2019 – Present

Research Assistant

- Project Title: Assessing graduate student mental health
- Duties: Research design, ethics application, data collection (in progress)
- Western University, London, ON
- November 2019 – Present

Research Assistant

- Duties: Involved in the research program at Cedars studying outcome data of the patient population. I also helped analyze evidence-based practices in the scientific literature. We published two original studies during my time at Cedars.
- Cedars at Cobble Hill: Cobble Hill, BC
- September 2016 – November 2017

Graduate Student Researcher

- Master's Thesis: A phenomenological study of prescription drug abuse among children and youth (Collins, 2015).
- Duties: Conducted extensive literature review, designed study, obtained ethical approval, conducted multiple interviews, conducted data analysis, completed a traditional monograph thesis, gave a public lecture, defended and published thesis

- Health & Rehabilitation Sciences: Western University, London, ON.
- September 2011 – December 2014

Research Assistant

- Project Title: Readiness of transition to the community: validating the effectiveness of inter-professional discharge information package for cardiac patients (mixed methods).
- Duties: Extensive literature review, assisted with study design, obtained ethical approval, recruited participants via telephone, and completed a poster presentation.
- Faculty of Health Sciences: University of Ontario Institute of Technology, Oshawa, ON.
- September 2010 – April 2011

Presentations & Guest Speaking Appearances

Poster Presentation

- A phenomenological study of the early-life experiences and interpersonal relationships among individuals with childhood trauma and opioid-use disorders (Collins, E, 2018)
- 2018 International Conference on Opioids, Harvard University, Boston, MA
- June 10-12, 2018

Poster Presentation

- Self-reported chronic pain as a predictor of relapse post residential addiction treatment: A 6-month follow-up pilot study (McPherson, C., Collins, E., Boyne, H., Kirklady, E., & Waseem, R., 2017)
- Enviros: Shifting Perspectives Conference, Mount Royal University, Calgary, AB
- April 25, 2017

Poster Presentation

- Expanding Aboriginal cultural competency for addiction service delivery in Canada (McPherson, C., Collins, E., Boyne, H., & Strom, J., 2017).
- Think Indigenous Conference, University of Saskatchewan, Saskatoon, SK
- March 21, 2017

Panelist

- Joined a panel of experts to speak about our lived experiences of addiction and recovery
- Healthy Minds Canada: Bright future mental health and addictions recovery conference, Toronto, ON
- August 19, 2016

Oral Presentation

- A phenomenological study of prescription drug abuse among children and youth.
- HRS Graduate Research Conference 2016: Western University, London, ON.
- February 3, 2016

Honours & Awards

- Graduate Student Teaching Assistant Award – 2018 (Recipient $500)
- Graduate Student Teaching Assistant Award – 2013 (Recipient $500)
- Graduate Student Teaching Assistant Nominee – 2012 (Nominee)

Volunteerism

Radio Western, 94.9FM

- Radio talk-show host
- Producer
- Duties: I am the host and producer of Health, Illness, & Recovery. Join me and my special guests, as we discuss a variety of health issues, and explore the many pathways of illness and recovery

PSAC Mental Health Committee

- PSAC Local 610
- Duties: As a co-chair of the committee, my role was to organize and lead meetings, as well as to help draft a literature review for the $50,000/year allotment for graduate student mental health
- June 2017 – October 2018

Ontario Team Leader

- Canadian Mental Health Association (CMHA): Ride Don't Hide
- Duties: My role was to help strategize logistics and promote the event, as well as to increase sponsorship and ridership.
- London, ON
- Winter 2017 – Summer 2018

Ontario Team Leader

- Healthy Minds Canada: Bell Let's Talk Campaign
- Duties: Recruited participants across Canada via social media, raised awareness about mental health, mental illness and addictions via social media, contributed campaign ideas to the executive director and national campaign manager via teleconference, and in 2016 helped raise a record breaking $6,295,764.75 for Canadian mental health initiatives
- London, ON
- Winter 2016, Winter 2017