A critical analysis of discursive practices in personal accounts of “drug” use: Implications for health professional education

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Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy

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A CRITICAL ANALYSIS OF DISCURSIVE PRACTICES IN PERSONAL ACCOUNTS OF “DRUG” USE: IMPLICATIONS FOR HEALTH PROFESSIONAL EDUCATION

(Spine title: Discursive Practice and “Drug” Use)

(Thesis format: Monograph)

by

Niki Kiepek

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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The thesis by

Niki Catherine Kiepek

entitled:

A critical analysis of discursive practices in personal accounts of “drug” use: Implications for health professional education

is accepted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

Date _____________________________

Chair of the Thesis Examination Board

Dr. Sandra DeLuca

Dr. Lilian Magalhães

Dr. Sandra Galheigo

Dr. Rick Csiernik

Dr. Allan Pitman

Dr. Louis Charland
Abstract

The purpose of this research project is to explore discourses of drug use outside therapeutic and self-help settings, acknowledging that social conceptualisations of drugs and drug use impact how health professionals understand the experiences and perspectives of clients. A discursive narrative methodology is implemented to reveal multiple discourses of drugs embedded in individual accounts. A critical analysis of discursive practices investigates how the concept of drugs is put into discourse and to consider the influence of discursive practices on how people act and how they are acted upon.

Six people volunteered to share their stories through the narrative interview process. The analysis is presented in three sections. In Section 1, the term “hiding” is interpreted to convey either “concealment” or “non-disclosure” of drug use. The research participants express that being able to talk openly about drug use is desirable and has the potential to be beneficial. Section 2 focuses on the need to negotiate how drugs are talked about within particular contexts because disclosing personal drug use can be associated with particular undesired consequences. The education of children is a distinct negotiated space where contradictions are evident between what people do and what people say. In Section 3, non-disclosure of drug use is presented as a social achievement that acts to avoid negative consequences. The analysis reveals the enactment of discursive practices that attempt to construct drug use as socially acceptable. Personal accounts are positioned as a response to the diagnostic criteria of substance dependence and substance abuse. Finally, flipping the script on drugs and pushing is demonstrated to provide a strategy to problematise distinctions between illicit and pharmaceutical drugs.

The research participants portray drug use as individual choice and convey a perspective that drugs and drug use are social constructs. In addition, the “effects” of doing drugs reach far beyond any possible physiological response of the body. The major contribution of this research is that it applies novel perspectives and approaches to an otherwise extensively researched and extensively theorised subject in health professional education, and describes potential implications for health practices.

Keywords: Drug use, discursive narrative methodology, recontextualisation, interdiscursivity, critical analysis, discursive practice
Epigraph

*Metamorphoses*

by Ovid (1955)

Full sail, I voyage
Over the boundless ocean, and I tell you
Nothing is permanent in all the world.
All things are fluent; every image forms,
Wandering through change. Time is itself a river
In constant movement, and the hours flow by
Like water, wave on wave, pursued and pursuing,
Forever fugitive, forever new.
That which has been, is not; that which was not,
Begins to be; motion and moment always
In process of renewal.
Dedication

I would like to dedicate this thesis to “Sharon,” “Paul,” “Sean,” “Joshua,” “Haylei,” and “Jenna” who were gracious to “help me” with my doctoral thesis and to share their stories with me.

I also dedicate this work to the clients with whom I have worked with as an occupational therapist and addictions counsellor, who have subsequently influenced my beliefs and practice. In particular, it is dedicated to the person who told me that he didn’t want to attend a medical appointment because “[they] only ever see that I do drugs, and they don’t see that I need help.” This is dedicated to every person who has ever felt as though they were seen as their drug use first and a person second.
Acknowledgements

First and foremost I want to acknowledge how fortunate I was to have the guidance of my thesis advisors, Dr. Lilian Magalhães and Dr. Sandra DeLuca. Sandy taught me to unlearn everything I’d ever known, to find strength in kindred spirits and to trust my voice in its many forms. Lilian taught me to speak from the heart with a conscientious awareness to the political and social nature of words and to embrace scholarly approaches that offer strength to convictions.

I extend my gratitude to Tania Granadillo, whose enthusiasm was unwavering and who always provided great advice and suggestions. Thank you to Treena Orchid for her insight and recommendations as a committee member for my comprehensive examinations. I would also like to acknowledge the members of the examination committee, Dr. Sandra Galheigo, Dr. Rick Csiernik, Dr. Allan Pitman, and Dr. Louis Charland.

I also want to thank Debbie Toppozini for graciously going out of her way to accommodate my busy university and conference schedules and Doug Moynihan for championing me along the way. Thanks to Mary Rykov for her “eagle eye,” patience and encouragement.

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### List of Abbreviations

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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AA</td>
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</tr>
<tr>
<td>CSAM</td>
<td>Canadian Society of Addiction Medicine</td>
</tr>
<tr>
<td>D.A.R.E.</td>
<td>Drug Abuse Resistance Education</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>DSM-IV-TR</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision</td>
</tr>
<tr>
<td>ICD-10</td>
<td>International Classification of Diseases, 10th Revision</td>
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<tr>
<td>NA</td>
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<td>NIAAA</td>
<td>National Institute on Alcohol Abuse and Alcoholism</td>
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<td>NIDA</td>
<td>National Institute on Drug Abuse</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Chapter 1

1 The Metamorphosis of Drugs and Addiction

*When we ‘do’ the human sciences...we have to relate ourselves somehow to a social world that is polluted by something invisible and odourless, overhung by a sort of motionless cloud. It is the cloud of givenness, of what is considered ‘natural’ by those caught in the taken-for-granted, in the everydayness of things.* (Greene, 1995, p. 47)

Maxine Greene (1995) calls for a self-reflective and thoughtful approach to knowing that allows people to name and transform their intersubjective worlds. This involves a willingness to suspend static and absolute views of reality that influence one’s way of knowing, being, and acting. It is with attention to the “cloud of givenness,” and an attempt to suspend taken-for-granted truths that I approached this project.

The purpose of this research project was to afford an opportunity to explore discourses of drug use outside therapeutic and self-help settings, acknowledging that social conceptualisation of drugs, drug use, and addiction impact how health professionals attempt to listen to and understand the experiences and perspectives of clients. This in turn influences what constitutes effective and ethical care. The research was conducted in Canada and drew on English-language literature in the Western social context. The goals of this project were to advance a rationale for a critical review of the discourses of drugs and drug use that inform health professional education, and to consider the importance of incorporating an understanding of drugs and drug from people who may meet the criteria of addiction and do not access treatment.

In this thesis, the term “drug” refers to any psychoactive substance and is defined broadly to include chemical substances that can cross the blood-brain barrier to alter brain function, including perception, mood, consciousness, cognition, and action. Historically, psychoactive substances have been conceptualised and categorised in different ways. Current distinctions include illicit and licit drugs, hard and soft drugs, designer drugs, club drugs, pharmaceutical and psychotropic medication, sacred plants, traditional medicine, and psychedelic plants. Other products that include psychoactive properties are categorised according to non-drug classifications, with the psychoactive property not
always being thought of as the primary feature of this substance; examples include coffee, tea, and energy drinks as *beverages*; nutmeg as a *spice*; chocolate as a *food*; and Lysol as an *aerosol spray*. Alcohol and tobacco are two classifications of psychoactive substances that are subject to government regulation.

In Canada, particularly in health care settings, the concept of non-prescribed drug use is often treated as synonymous to addiction. North American addiction policy construes drug use as deviating from the norm by drawing on and shaping two “official discourses” (Stevens, 2007), namely, addiction as a criminal act and addiction as a health concern. In this thesis, I attend primarily to the medical aspect of discourse, which is not intended to privilege the medical construct or to that medical discourses weigh more heavily in the individual accounts of drug use. Rather, the research project is situated in the field of health professional education and addresses a health professional audience.

Social conceptualisations of drugs, drug use, and addiction have important implications for health services, legal decisions, and policy development. However, a majority of research about the experience of drug use includes participants identified through their involvement in addiction services or legal systems. Individuals who may meet the diagnostic criteria for substance abuse or substance dependence according to the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, text revision* (DSM-IV-TR) but who do not access addiction services have been largely absent from research pertaining to the experience of drug use. Yet, according to research estimates, only 6–18% of Canadians who meet the diagnostic criteria for substance abuse or substance dependence access addiction-related services (Sobell, Sobell, Toneatto, & Leo, 1993; Stinson, Grant, Dawson, Ruan, Huang, & Saha, 2005). Finding about the experiences and consequences of drug use that are provided by people who have attended addiction counselling or self-help groups are extrapolated to the larger population. However, research shows that individuals who access addictions services are more likely to have a concurrent mental illness (Centre for Addiction and Mental Health, 2001), developmental delay (Didden, Embregts, van der Toorn, & Laarhoven, 2009), and inadequate social supports (Granfield & Cloud, 2001), which may contribute to the presence of more severe negative consequences from drug use.
One of implications of drawing on personal accounts of drug use subsequent to involvement in structured organisations is that clients learn and adopt language that is used by health care providers, corrections staff, and other people who identify the client as an addict (Reinarman, 2005). The person learns to “retrospectively reinterpret their lives and behaviors in terms of addiction-as-disease” (p. 315). As a result, individuals who identify themselves as having an addiction “tell and retell their newly reconstituted life stories according to the grammatical and syntactical rules of disease and discourse that they have come to learn” (Reinarman, 2005, p. 315).

In Canada, health professional practice and education are guided by “evidence-based practice” or “evidence-informed practice” which involves integrating research findings into clinical decision-making. Application of research is expected to contribute to the development and design of more effective programs, to improve health professional practices, and to improved health outcomes (Jack, et al., 2011). Yet, there is a paucity of research and theory that explores drug use from the perspectives of individuals who engage in drug use in a way that may satisfy the criteria of substance abuse or substance dependence, but who do not access health services. Accordingly, the available research regarding drug use may not represent the wide range of experiences that people have, focussing instead on a segment of the population who meet certain criteria of problematic drug use.

At the same time, research shows that health professionals receive insufficient education about addiction (Bina, et al., 2008; Campbell-Heider, et al., 2009; Graves, Csiernik, Foy & Cesar, 2009; Vastag, 2003). In the United States, less than 1% of the medical curriculum addresses addiction (Vastag, 2003) and nurses receive an average of 1.67 hours of education about addiction (Campbell-Heider et al., 2009). These findings may be similar to the provision of health professional education about drugs in Canada. A lack of education about drug use and addiction is reported to be associated with a negative attitude of health professionals toward working with clients who are identified as having an addiction (Bina, et al., 2008). Given the paucity of education about drug use and addiction in formal education settings, it can be inferred that health professionals’ conceptualisations of drug use and addiction may be largely influenced by discourses
positioned outside formal health education settings. Some of the ways in which discourses of addictions are shaped and propagated are through family, public policy, news stories, sermons, movies, songs, works of art, television programs, literature, advertisements, and self-help groups.

By analysing drugs, drug use, and addiction as discursive social practices that are embedded in cultural and institutional contexts, discourses can be regarded as functioning to shape how activities are constituted and how they are deemed acceptable and normal or abnormal and deviant (Foucault, 1972). Drug use is often associated with stigma and may have societal repercussions, which can prevent individuals from disclosing personal experiences or voicing contradictory perspectives. Silence should not be assumed to indicate an absence of an alternative discourse, but an absence of the opportunity for expression of the alternative discourse (Severns, 2004). Mariana Valverde’s (1998) Canadian research further suggests that there is an “absence of a democratic public sphere” to consider alternative understandings regarding consumption, desire, freedom and the experience of problems (p. 204). Simultaneously, research about drugs and drug use frequently involves research participants drawn exclusively from legal and addictions services settings where there may be informal constraints regarding the public discussions about drugs.

Certain types of knowledge are subjugated in relation to the discourses of drug use (Moore, 2011). The concept of drug use is interpreted from many disciplines, yet the legal and medical discourses are often the most influential. Moore (2011) states that:

As a ‘social field’, the production of knowledge about drugs is constituted through a network of positions occupied by individuals (e.g. researchers, policy-makers, practitioners, community members) and institutions (e.g. research centres; federal, state and local government; drug services). These positions are related through relations of domination, subordination or equivalence, and through struggles over a distribution of power that enables and reproduces access to scarce resources (e.g. research funding, ‘impact’ on policy and practice). Subjugated knowledges, such as qualitative accounts of drug use, struggle for legitimacy with the dominant discourses of biomedicine and epidemiology. The need to produce knowledge that is ‘policy relevant’ and ‘accessible’ also tends to stifle innovation and critical research. (p. 75)
This research project, to further inform health professional education, was designed to draw on a segment of the Canadian population who choose to use psychoactive substances on a daily basis and have never identified a reason or need to attend addiction counselling. This research is based on the assumption that stories have political consequence (Threadgold, 2005). “What matters is who has the power to name, to represent common sense, to create ‘official versions’, and to represent legitimate social worlds, while excluding other stories which might construct these things very differently” (Barker & Galsiński, 2001, p. 54). By and large, the stories of people who do drugs on a daily basis yet who have not identified a reason or need for therapeutic intervention have largely been absent from theories and models about drug use and addiction.

1.1 Normalisation of Drug Use

The term “normalisation,” closely associated with the work of Howard Parker, entered the addiction lexicon in the 1990s to reflect increased positive attitudes toward drugs and drug use and a corresponding increased rate of accessibility and availability of drugs in the United Kingdom (Wilson, Bryant, Holt, & Treloar, 2010). Presented more thoroughly in the first edition of Illegal Leisure: The Normalisation of Adolescent Drug Use (Parker, Williams, & Aldridge, 1998), the theory of normalisation has since been explored by researchers in other countries as well (e.g. Duff, 2003).

Normalisation has been used to reflect the general increased social acceptability of drug use, including by people who do not use drugs themselves. One of the important shifts in the conceptualisation of drug use has been to question the idea that people who use drugs, and young people in particular, are acting irrationally and are not aware of the risks associated with drug use. For example, it had previously been thought that it was troubled youth who used drugs as a result of psychological and social factors. However, there is evidence that drug use may actually be approached rationally and that the person using drugs is typically well-informed (Järvinen & Demant, 2011). People may chose to do drugs not because they are ill-informed or uninformed about the potential risks, but because the perceived pleasure and excitement afforded by the drug outweighs the potential dangers (Järvinen & Demant, 2011; Järvinen & Østergaard, 2011).
The beneficial use of illicit and non-medically prescribed drugs is rarely addressed in the research literature. Two notable exceptions are the work by Hende, Leonard, Sterk, C., & Elifson (2007) and Pearson (2001). In a study of “functional” drug use, interviews were conducted with 40 individuals who had used methamphetamines at least 10 times in the past 30 days (Hende, et al., 2007). Through these interviews, the three themes the researchers identified to indicate the functional nature of methamphetamine use for this group are 1) enhanced functioning in the performance of life skills and work skills, 2) increased professional and recreational productivity, and 3) the ability to function normally. One respondent contrasts the use of methamphetamines with alcohol, stating:

Drinking completely messes with your whole lifestyle, you know, I mean. Drugs, you go out with your friends to a party and you do speed all night and then you know, it’s like you go home and go to bed. (p. 472)

Pearson (2001) conducted an ethnographic study over a period of seven years that involved visiting two public houses in London, UK, becoming acquainted with the men and women who frequented these pubs, and establishing a network of core contacts. Having identified his role as a researcher, he engaged in informal, non-intrusive observations by participating in conversations with these men and women. He maintained records of these interactions about drug use. Pearson noted that although some individuals discussed using substances on a daily basis (primarily cannabis), they did not identify themselves as “drug users.” Rather, it was a peripheral, normal, aspect of their lives, often in the areas of work and leisure. Substance use was reported as an “unexceptional and unremarkable aspect of everyday life and conversation” (p. 174). Pearson concluded that the normal recreational use of a myriad of regulated, illegal substances has been overlooked in British public policy.

It may be understandable that research regarding drug use has focussed on the problematic aspects of use, since medical and criminal disciplines have guided the impetus for research. Yet, there are a large number of people who use drugs regularly who do not access addictions services and are not identified by the criminal system. Ironically, it may be argued that the predominant perception of drug use as problematic overshadows what may be the more prevalent experience of drug use as normal, functional, and recreational, and subsequently under-represents non-problematic
experiences in policy and education. In a position statement about alcohol use, Dwight Heath (2010) cautions against focusing “attention on the less-than-10% of alcohol use that is bad news and deliberately ignores the overwhelming majority of the human experience with alcohol which is — and always has been — healthful and enjoyable for most of those who choose to drink” (p. 203).

Growing criticism amongst some researchers exists regarding the relative neglect of the experience of drug use as pleasurable while placing emphasis on potential risks. A longitudinal cohort study undertaken in Britain to investigate the “normalisation” of drug use found that individuals who use drugs undertake informal cost-benefit analyses of their drug use, and modify their use accordingly (Aldridge, Measham, & Williams, 2011). When the actual or perceived risks to one’s health or well-being begin to outweigh the pleasurable effects of the drugs, the person reduces or stops drug use. However, the evaluation of what constitutes acceptable risk was determined to be subjective and to change over a lifetime. Toward adulthood, what was considered an acceptable aspect of drug use, such as “coming down,” became an imposition, particularly as the person took on different responsibilities and roles. This analysis drew on rational-actor theories to present “the ‘sensible’ adolescent recreational drug use of the majority” (Aldridge, et al., 2011, p. 217).

In Cocaine Changes, Waldorf, Reinarman, and Murphy (1991) describe the findings from interviews with 228 people who used cocaine daily for at least six months. They separated the types of drug use into five categories. The “coke hog” described people who use large amounts of cocaine and disengage from daily activities and people and even neglect to eat and drink for extended periods of time. The “nipper” is the person who uses cocaine everyday and drug use is integrated into daily activities but does not take precedence over other activities. The “binger” is the person who temporally separates drug use from daily activities, for example by working during the week and using large amounts of cocaine on the weekend. “Ceremonial” cocaine use involved using cocaine only at specific moments or events, such as when going out to a party or to enhance the experience of sex. The “experimenter” is the person who only tries cocaine once or twice in his or her lifetime. It was reported that the people classified as “bingers”
or “coke hogs” were more likely to experience problems associated with their drug use. The authors argued, “what keeps many heavy users from falling into the abyss of abuse, and what helps pull back those who do fall, is precisely this stake in conventional life. Jobs, family, friends – the ingredients of a normal identity” (p. 10). The researchers found that use of cocaine did not necessarily escalate and many people quit over time.

Drug-related research has significant implications for the development of policy and educational curricula. Decisions about research questions and methodology have the potential to shape knowledge and practices. Research about drug use has disproportionately focussed on the perceived negative effects and problems associated with drugs and informed theoretical models. Yet, there is a sound body of critical theory and research addressing the complex and dynamic nature of drug use. It was observed:

\[\text{However powerful a drug may be, its effects are always mediated by the norms, practices, and circumstances of its users.}\]

Such a finding does not lend itself to simplistic slogans about the dangers of drugs. Nor will it lead to simple solutions to our drug problems. But if it forces us to think in more complicated ways about drug use and its cultural context, then we will be in a better position to develop rational public policies towards drug problems. (Waldorf, Reinarman, and Murphy, 1991 p. 10)

Building on this, thinking more complexly about drug use can inform health professional education in relation to drug use.

Continuum models can function to imply that a person who uses drugs will progress in a direction toward increased use and increased experience of problems. The DSM-IV-TR distinguishes between alcohol and substances, though both are psychoactive substances. In the DSM-IV-TR, alcohol “problems” are depicted to fall on a continuum from no/low risk, at risk, mild, moderate to severe (American Psychiatric Association, 2000). The suggestion is that even someone who is not drinking alcohol is potentially at risk for problems. The definitions of no/low risk included “Is not already experiencing consequences due to drinking behavior” (American Psychiatric Association, 2000) and implies that the person is “at risk” of experiencing problems. The use of the word “already” indicates that the problems are expected, but they haven’t happened yet. This type of continuum has been used to inform alcohol and drug intervention strategies, such as prevention, for people who do not have problems and are therefore constantly at risk.
Rowe, 2010) that acknowledged the possibility of experimentation and integrated use. “Integrated use” is defined as “the casual and/or occasional drink, smoke or toke. Drug use remains at a controlled level” (Csiernik & Rowe, 2010, p. 7). According to the process, drug use falls into the categories of experimental, integrated, excessive, and addiction. Drug use may change over time and may return to an integrated style of use.

These two models of drug use that represent beneficial, non-problematic, and integrated use are not prominent. Yet, this may not be surprising given the focus of research about drug use. I conducted a cursory review of the literature by searching the separate terms “substance-related disorders,” “drug use,” and “normalisation” combined with “drug.” I searched Medline, CINAHL, PsycINFO and SocINDEX. Medline is a database designed for medicine, CINAHL for health professionals including nurses and social workers, PsycINFO for psychology, and psychiatry and SocIndex for the social sciences. The articles for each database are listed in Table 1.

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</tbody>
</table>

The term “substance-related disorders” was recognised as a keyword in each of the databases, and so I did not review the articles further. “Normalisation” and “normalization” were not recognised keywords so I scanned the titles and selected abstracts to estimate the number of articles that pertained to normalisation of recreational drug use. In Medline, I searched the terms “normalisation” and “normalization” separately. I combined “normalization” with “substance-related disorders” after several trials with other words (e.g. recreational, illicit) to limit the number of unrelated articles and maximise the number of related articles. “Drug use” was recognised as a keyword in SocINDEX and PsycINFO, but not in CINAHL and Medline. It can be noted that
research databases that inform health professional education and practice (Medline and CINAHL) publish many more articles about substance use disorders than about normalisation. The social sciences (SocINDEX) and psychology (PsycINFO) databases included a greater number of articles about normalisation and tended to investigate drug use more frequently than substance-related disorders.

While conducting the research project I drew on academic literature across several fields, including medicine, sociology, anthropology, linguistics, and philosophy. I also consulted popular culture sources, including movies, television series, music lyrics, autobiographies, and news reports. These sources informed my perspectives and contributed to the critical approaches that I developed throughout the research process. The remainder of this chapter will provide a review of the social construction of concepts related to drugs, drug use, and addiction.

1.2 Historical Considerations of Psychoactive Substances

The classification of drugs is fluid and unfixed, with far-reaching historical roots. It has been theorised that the shift to cultivation and agriculture was for the purpose of cultivating intoxicating substances (McGovern, 2010). Over time, historical and cultural shifts in ideology resulted in inconsistent conceptualisations of drugs as a benign substance, a medication, a source of pleasure or altered state, and a spiritual guide. In fact, a single substance could be viewed as all of these things at any given time. There is evidence that the opium poppy was cultivated as early as 3400 BC along the Tigris-Euphrates by the Sumerians (Singer, 2006). In 711 AD, the Moors brought opium into Spain as a medicine. When Columbus set sail in 1492 he was instructed to bring back opium, but when he arrived in the New World he found tobacco instead. Tobacco was described as a drug to “comfort the limbs, enhance wakefulness, and lessen weariness” (Singer, 2006). Tobacco was initially used as a medicine, but as a result of its mood-altering properties its use became common practice of the working class. Under King James of England, moral arguments were mounted against smoking, and policies were instituted to restrict the use of tobacco. However, the economic benefits of tobacco sales became apparent, making it an important taxable commodity; alternate means of consumption were designed — the cigarette — to increase the perception of
sophistication associated with tobacco and to increase its appeal to a larger segment of society (Singer, 2006).

During the colonial period in North America, cocaine, marijuana, opiates, and alcohol were legal and commonly consumed (Singer, 2006). Marijuana was used as a pain medication until 1901 when it was replaced by aspirin. Opiates were used as a medication to treat a myriad of health concerns, including “body pain, cough, nervousness, TB, diarrhea, dysentery, cholera, athlete’s foot, baldness, and cancer” (Singer, 2006, p. 43). Throughout the 1800s the typical opiate user seemed to be middle-aged, female, rural, middle-class, and white (Conrad & Schneider, 1980, as cited by Singer, 2006, p. 48). Near the end of the 1800s, coca leaves were imported from Peru and incorporated into a beverage with wine. In 1886, Coca-Cola was produced as a soft drink, which was later followed by more than 40 soft drinks that contained coca leaves (Singer, 2006). These beverages were considered to be a cure for nearly every ailment.

The active ingredient of cocaine, coca, was isolated in the 1860s. Over time, cocaine, opiates, and marijuana became associated with societal fears relating to minority and racial tensions (Singer, 2008). In the early 1900s, the combination of racial prejudices and international economic issues led to a federal law in the United States restricting the use of psychoactive substances (Singer, 2006). It was noted that the bill did not emphasise health impacts or addiction (Singer, 2006). Merrill Singer (2006) said that “[a]s a result of newly forged social labels, use of some psychoactive drugs (but not others) came to be synonymous with deviance, lack of control, violence, and moral decay” (p. 58). Yet, the widespread use of medically prescribed substances meant that an estimated 200,000–500,000 Americans had developed an addiction (Singer, 2006). This created a market demand for illicit substances and an underground network of suppliers was established. Since psychoactive substances were no longer provided by physicians but by drug dealers, the population of users shifted from middle-class women to young men, who often were immigrants. Furthermore, groups of drug users became concentrated in poorer sections of town, and violence emerged as a way to vie for control over distribution (Singer, 2006).
Categorisations of psychoactive substances shift over time and across contexts. The term “drug” initially referred to the medicinal use of psychoactive substances, and pharmacists were known as “druggists” (Singer, 2006). Druggists lobbied for the term “drug” to be restricted to the medicinal use of substances. However, newspapers continued to use the term to apply to non-prescription use of substances. Accordingly, druggists changed their title to pharmacist to maintain a distinction between the forms of substance use.

The consumption and supply of psychoactive substances are continually in flux and distinctions between legal and illegal drugs are influenced by national laws and historical contexts. Attempts to regulate and identify the medicinal use of psychoactive substances as distinct from how they may contribute to individual or social problems also changed over time. In the next section, I present critical perspectives about responses to drug conceptualisations.

1.3 Blurring the Lines: Drugs, Pharmaceuticals, Spiritual Guides

Helen Keane (2011) describes the complex contemporary views regarding the nature of psychoactive drugs. She points out that on one hand “[i]llicit drugs are believed to possess a unique ability to disable the user’s self-control and thereby destroy physical, psychological and social well-being. On the other hand the development, marketing and supply of a growing array of commodified psychoactive pharmaceuticals is a central activity of biomedicine and one of the most profitable sectors of global capitalism” (p. 106). Singer (2008) likewise questions the categorical distinction between drug cartels and pharmaceutical corporations, arguing that both cartels and corporations are engaged in global commerce of psychoactive substances. He reports that illicit drug sales are estimated to be between US$300–$500 billion annually, while the revenue of the pharmaceutical industry is approximately US$300 billion (Singer, 2008, p. 168). Graham (1972) highlights the overproduction of amphetamines by pharmaceutical companies, stating that:

The American pharmaceutical industry annually manufactures enough amphetamines to provide a month’s supply to every man, woman and child in the country. Eight, perhaps ten, billion pills are lawfully produced, packaged, retailed, and consumed each year…. [The] industry has skilfully managed to convert a
chemical, with meagre medical justification and considerable potential harm, into multi-hundred-million-dollar profits in less than 40 years. (as cited in Singer, 2008, p. 162)

The marketing of pharmaceuticals to physicians and consumers has been proposed to contribute to over-prescription of psychotropic medications and consumer demand for the product (Singer, 2008). While use of amphetamines has subsequently declined, parallel argument for over-availability may be made with methamphetamine and anabolic steroids.

Biomedicine has increasingly become a source for street drugs. While researchers and pharmaceutical companies develop medications to “improve health” and “treat disease,” the drugs may be found to have other desirable effects that result in them being diverted for non-medical illicit marketing. In some cases active substances are isolated in plants, such as heroin from the opium poppy. In other cases psychoactive substances are synthetic derivative, such as Ecstasy (3,4-methylenedioxymethamphetamine) and experimental trials are conducted to determine its effectiveness as a medication.

Furthermore, pharmaceutical companies endeavour to develop profitable new cures for new illness (Conrad, 2007). Singer (2006) reinforced the socially constructed nature of disease, indicating that many of the newer psychoactive substances were developed to treat illnesses that are in vogue at historical moments. Prominent examples include hysteria which was defined as a madness experienced by women due to a “wandering uterus,” multiple personality disorder, and, it is argued by some, contemporary attention deficit hyperactivity disorder (ADHD) (Singer, 2006). Classifications of disease and mental illness, with a corresponding proliferation of pharmaceutical intervention and marketing of both the disease and medicinal cures, have increasingly been a subject of debate (see Conrad, 2007; Greenberg, 2010; Horwitz, 2002; Szasz, 2007; Watters, 2010; Whitaker, 2002).

When the categories of illicit drug/pharmaceutical medication and drug cartel/pharmaceutical company become blurred, so do the divisions between user and abuser, junkie and patient. As an occupational therapist, I worked with a young man who had been prescribed barbiturates as medical management of chronic back pain. He
reported having attempted to quit using the medication several times, but without lasting success. Together we reviewed the list of therapeutic effects of the medication, the side effects, and the withdrawal effects. Interestingly, one of the withdrawal effects was back pain. After reviewing the properties of the medication, the young man exclaimed, “I’m a junkie!” indicating a realisation that the difficulties he was experiencing were directly linked to the effects of the drug itself. In his mind, a beneficial medication had been transformed to a powerful drug that he was physically and psychologically “hooked” on.

In Canada, the potential harms associated with prescription medication entered the spotlight in late 2011 and early 2012. In 2009, an Ontario First Nations Chiefs meeting was held in Thunder Bay to discuss the social problems associated with the abuse of prescription medication, as well as potential strategies for reducing the occurrence of substance abuse. For example, in 2006 the M’Chigeeng First Nations Community in Ontario established the M’Chigeeng Drug Strategy. One of their initiatives was to reduce the abuse of prescription medication, with a focus on OxyContin™. Changes that were introduced included the signing of a physician-patient contract regarding the use of the medication, and the implementation of an ethical review board of three doctors to oversee all prescriptions, and particularly OxyContin™ (Sioux Lookout First Nations Health Authority, 2009). In 2007, Perdue, the manufacturer of OxyContin™ admitted to “misbranding” the product, thereby misleading regulators, doctors, and patients about dependence liability and potential for abuse (Meier, 2007).

Alternatively, specific psychoactive substances may be used in sacred rituals as a form of traditional practices and for healing rituals. For example, in Peru, ayahuasca is an infusion of various psychoactive plants and is consumed as part of a religious or spiritual ceremony under the guidance of a shaman. Some cacti, such as peyote and San Pedro, contain mescaline, which has psychoactive properties and is used by indigenous Americans for medicinal and spiritual practices. These practices add to the complexity of understanding the categorisation and legal aspects of psychoactive substances. For many people these substances are considered to be an important aspect of traditional, cultural and spiritual practices. This was recognised by the Department of Justice Canada when designating controlled acts. While mescaline is classified as a schedule III drug, peyote is
exempt (Department of Justice Canada, 2006). As a comparison, the classification system includes eight categories, with schedule I including opium, coca, and methamphetamines; schedule II includes cannabis; schedule III includes amphetamines and psilocybin (magic mushrooms); and schedule IV includes barbiturates, benzodiazepines, and anabolic steroids; schedule V includes propylhexedrine; schedule VI includes ephedrine; and schedules VII and VIII include small amounts of cannabis resin and marijuana (Department of Justice Canada, 2006).

Psychoactive substances that are used in sacred rituals, traditional practices, and healing rituals are increasing being used by non-indigenous people. Concerns have been raised that there is a potential for certain healing aspects to be overlooked, including the interpersonal dynamics, spatio-temporal organisation, singing and chanting that are important features of the experience (Tupper, 2009). Tupper frames this as an issue of “cultural appropriation of traditional knowledge and spirituality” (p. 123).

Furthermore, much of the traditional knowledge regarding the medicinal properties of plants has been usurped in order to conduct research to isolate the active molecular, chemical derivatives that are then developed in laboratories, packaged, and marketed. It was estimated that two-thirds of Western medications are derived from plants or are synthetically derived from lead compounds found in plants (Monks, et al., 2011).

Psychoactive substances have been conceptualised in pharmacology according to the categorisation of effects. The effects may be described as therapeutic effects, desired effects, intoxicating effects, side effects, adverse effects, undesired effects, and withdrawal effects. Furthermore, psychoactive substances are represented in health practice as having negative and positive consequences. Because psychoactive substances have effects that can be both desirable and undesirable and can have both positive and negative consequences, emphasising certain properties over others and the intended purpose for consumption can shape perceptions about a substance.
1.4 Drug Use and Addiction as Discursive Facts

During my education to become an occupational therapist, I came to understand the term “occupation” to apply to any activity that is considered to have purpose or meaning for the person who engages in it. A few years later, I completed a diploma in addiction counselling and it seemed natural to conceptualise addictions as occupations which contribute a sense of purpose and meaning to an individual, albeit, with the potential for the experience of negative consequences. Many activities that we engage in during the day pose the potential for risk, whether it is carpal tunnel syndrome from repetitive typing, a fractured wrist from slipping on ice, an acquired head injury from a motor-vehicle accident, or liver damage from long-term alcohol consumption.

I found immense gratification in my work as an addiction counsellor that surpassed my experience in more traditional mental health or physical health roles. Accordingly, it never ceases to amaze me when people comment on how they could never work with “addicts,” and assume that being an addiction counsellor is fraught with frustration and dissatisfaction. I wondered to myself, how is it that addicts become addicts and not “a person who engages in an activity that may be associated with negative consequences”? Are there not people who are considered “respectable,” “successful,” and “honourable” who may meet the “criteria” of addiction, but are able to conceal the drug use and minimise the risk for negative consequences? Furthermore, as a health care professional I wondered how our conceptualisation of drug use affects how we come to understand the experience and perspectives of our clients and our ability to provide effective, ethical, and compassionate care?

In undertaking this research project, it was not my intention to uncover or reveal the truth about drugs or drug use, but to question the assumptions underlying conceptualisations of drugs and drug use that inform health professional education. In this thesis, I propose that the concept of “addiction” is not a unified, known phenomenon and does not convey a single, universal truth. Rather, it can be understood as a discursive construct that is comprised of multiple, often competing, discourses.
Discourse is a relational process through which the “truth” of a concept is constituted; this process simultaneously establishes and maintains social hierarchies, locates sources of authority, and produces forms of individual and population regulation (Foucault, 1978/1990). Discourse is a form of communicative interaction that includes speaking and writing, as well as body movements and aesthetic practices. In this sense, discourse is the way in which concepts are talked about and truths constituted as a process that ascribes appropriate ways of being and acting (Miller, 2008). In other words, “A discourse thus asserts a preferred version of the world, one that disqualifies competing versions” (Miller, 2008, p. 252). The complexity of the conceptualisation of drugs and addiction was portrayed by Jacques Derrida (1993):

As with addiction, the concept of drugs supposes an instituted and institutional definition: a history is required, and a culture, conventions, evaluations, norms, and entire network of intertwined discourses, a rhetoric…. the concept of drugs is not a scientific concept, but is rather instituted on the basis of moral or political evaluations: it carries in itself both norm and prohibition, allowing no possibility of description or certification – it is a decree, a buzzword (mot d’ordre). (p. 1).

In this way, drug use can be viewed as a discursive fact.

Michel Foucault (1978/1990) used the term “discursive fact,” to describe the ways in which a concept is “put into discourse” (p. 11). Foucault (1967/1972) described discursive practice as not only “manifested in a discipline possessing a scientific status and scientific pretentions; it is also found in the operation of legal texts, in literature, in philosophy, in political decisions, and in the statements made and the opinions expressed in daily life” (as cited in Scheurich & McKenzie, 2005, p. 846). According to Foucault, a critical analysis of discourse(s) that inform our knowledge about a concept involves exploration of what is being spoken about, acknowledgment of the sources of the discourse, recognising the positions and viewpoints from which the discourse is presented, and identifying institutions that are involved in the shaping, analysis and dissemination of knowledge.

It is further recognised that not all discourses are attributed equal status or authority. Hook (2001) notes that what are considered “the strongest discourses are those that have attempted to ground themselves in the natural, the sincere, the scientific—in short, on the level of the various correlates of the ‘true’ and reasonable” (p. 524).
Accordingly, discourses that demonstrate “calculated, analytical rationality” are considered valid, whereas properties of “context, judgment, practice, trial and error, experience, common sense, intuition, and bodily sensations” are insufficient to inform ways of knowing (Flyvbjerg, 2001). Foucault elaborates that knowledges of bodily experience “have been disqualified as inadequate to their task, or sufficiently elaborated naïve knowledges, located low down in the hierarchy beneath the required level of cognition or scientificity” (as cited in Sawicki, 1986, p. 30). This is not to suggest that knowledge is only produced through authoritative discourses. Rather, it reinforces the need to develop an awareness of how authority is ascribed and to recognise who is allowed to speak and who is not. Questions that arise are who is a part of the development of the concepts, who and what are excluded (and who is doing the excluding), and are the concepts definitive, unfinished, tentative, or absolute.

Discourse is a relational process through which social hierarchies are constituted and certain forms of knowledge are attributed authority, which subsequently influences how individuals act in society (Foucault, 1978/1990). Discourses establish the way that concepts are known, and effect what are considered appropriate ways to be and act (Miller, 2008). Foucault (1978/1990) noted that “we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play at various strategies” (p. 100). We need to develop an awareness of what is said and what is concealed, what discourses are permitted and which are prohibited.

1.5 The Production of Truth in Discourses of Addiction

One conundrum of conceptualising addictions is that the concept of addiction encompasses increasingly more behaviours or activities over time (Reinarman, 2005). Gambling is defined as an impulse-control disorder in the DSM-IV-TR, yet is often colloquially referred to as an addiction. In anticipation of the publication of the DSM-V in 2012, there is a debate in the practice and research communities regarding the classification of “disordered” patterns of activity engagement. Terms to categorise the other activities include “addiction,” “addictive behaviours,” “process addictions,”
“behavioural disorder,” “behavioural addiction,” “problematic behaviour,” “compulsive behaviour,” and “impulse-control disorder.” Activities that have been proposed as problematic include sex (Allen & Hollander, 2006; Bancroft & Vukadinovic, 2004), Internet use (Block, 2008; Shapira, et al., 2003; Shaw & Black, 2008), work (Piotrowski & Vodanovich, 2008), exercise (Allegre, Souville, Therme, & Griffiths, 2006; Hausenblas & Downs, 2002), shopping (Black, 2006), and eating (McElroy & Kotwal, 2006). The concept of addiction increasingly encapsulates a broader range of everyday activities, while at the same time developing scientific and valid measures to distinguish normal from pathological engagement in those activities. On one hand, there is an attempt to develop systematic measures of addiction, while on the other hand the term is used to describe any activity that a person has a strong desire, or “compulsion,” to engage in.

The concepts of drug use and addiction become unavoidably entangled in the discussion of drug use and health professional education. One reason can be reflective of the fact that the health professional role generally begins once addiction or problems associated with drug use are identified. At the same time, in day-to-day settings these concepts and terms may unintentionally be used interchangeably. For example, I recently attended a meeting in a health institution where a case scenario was presented, and small groups collaborated with one person reporting back to the larger group. Two points that I raised were “Why do we hold clients who do drugs to a higher standard than we hold our friends, family, or selves?” and “Why do you assume that people who do drugs are more violent than those who don’t?” When reporting back to the larger group, the spokesperson casually and naturally replaced the term “clients/people who do drugs” with “addicts.”

Reference to addiction has become highly prevalent in colloquial, everyday situations and in research literature, clinical and therapeutic discourses, and popular culture discourses. In peer-reviewed journals one may find references aligning addiction with chocolate consumption (Benford & Gough, 2006), reading Harry Potter books (Rudski, Segal, & Kallen, 2009), and citing Foucault in critical work (Schaff, 2002). There is also a plethora of self-help groups that are based on the framework of Alcoholics Anonymous, such as Overeater Anonymous, Debtors Anonymous, and Online Gamers Anonymous.
By analysing addiction as a discursive social practice that is embedded in cultural and institutional contexts, discourses can be regarded as functioning to shape how activities are constituted and how they are deemed acceptable and normal or abnormal and deviant (Foucault, 1972). Foucault (1978/1990) identified several techniques through which the concept of sexuality is shaped through discourse. These, applied to explore the concept of addiction, include codification, causation, clandestine nature, method of interpretation, and distinguishing normal from pathological. Investigation of these techniques can reveal how certain discourses have become more prevalent and prominent, as well as dominant and normalised.

**Codification.** A system of codification involves the identification of signs and symptoms through interrogation and assessment. Historically, the confession is performed as a ritual in the production of truth:

It plays a part in justice, medicine, education, family relationships, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites; one confesses one’s crimes, one’s sins, one’s thoughts and desires, one’s illnesses and troubles; one goes about telling, with the greatest precision, whatever is most difficult to tell. (Foucault, 1978/1990, p. 59)

Confession takes place in the presence of another person who is expected to judge, forgive, console, punish and determine restitution (Foucault, 1978/1990). The confession, then, acts to produce the truths of addiction through a discursive practice. The categorisation of disordered behaviour and definition of diagnostic criteria are forms of codification.

The two most influential classification systems of addiction in North America are the DSM-IV-TR, published by the American Psychiatric Association, and the International Classification of Diseases, 10th Revision (ICD-10), developed by the World Health Organisation (WHO). In the DSM-IV-TR, alcohol or drug use may be diagnosed as “abuse” or “dependence.” The diagnostic criteria for these “disorders” according to the DSM-IV-TR (American Psychiatric Association, 2000) and the proposed adaptations for the DSM-V (American Psychiatric Association, 2012) are summarised in Table 1.
### Table 2: Diagnostic and Statistical Manual of Mental Disorders Criteria

<table>
<thead>
<tr>
<th>Substance Dependency (DSM-IV-TR)</th>
<th>Substance Abuse (DSM-IV-TR)</th>
<th>Substance-related disorders (Proposed for DSM-V)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Three or more of the following, within a 12-month period:</strong></td>
<td><strong>One or more of the following, occurring within a 12-month period:</strong></td>
<td><strong>To merge categories of abuse and dependency.</strong></td>
</tr>
<tr>
<td>Tolerance. Increased amounts of substance to achieve desired effect or diminished effect of substance.</td>
<td>Failure to fulfil major role obligations at work, school, or home.</td>
<td>To present a dimensional approach to measuring severity via symptom count (mild, moderate, severe)</td>
</tr>
<tr>
<td>Withdrawal syndrome or use of another substance to relieve/avoid symptoms.</td>
<td>Use in situations in which it is physically hazardous.</td>
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<tr>
<td>Substance is used more than intended.</td>
<td>Recurrent substance-related legal problems.</td>
<td></td>
</tr>
<tr>
<td>Efforts to control substance use are unsuccessful.</td>
<td>Continued use despite having persistent or recurrent social or interpersonal problems.</td>
<td></td>
</tr>
<tr>
<td>Much time is spent in activities to obtain the substance, use the substance or recover the effects.</td>
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<td></td>
</tr>
<tr>
<td>Decreased time is spent doing important social, occupational, or recreational activities.</td>
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<tr>
<td>Substance use continues despite personal knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance.</td>
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*Note.* Adapted from the DSM-V-TR (American Psychological Association, 2000)
The publication of the DSM-V revised definition for substance-related disorders is expected in 2013. The categories of “abuse” and “dependence” are expected to be reformed into one category and the severity of the disorders will be measured using a dimensional approach. It is reasonable to expect that the criteria will remain similar.

A summary of the diagnostic criteria for the ICD-10 definitions of harmful use and dependence syndrome is outlined in Table 2.

<table>
<thead>
<tr>
<th>Table 3: International Classification of Disorders Criteria</th>
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<tbody>
<tr>
<td>Harmful use (Psychoactive substance abuse)</td>
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<tr>
<td>Dependence syndrome (Chronic alcoholism, Dipsomania, Drug addiction)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Harmful use</th>
<th>Dependence syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>A pattern of psychoactive substance use that is causing damage to health. The damage may be:</td>
<td></td>
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<tr>
<td>- Physical (e.g. hepatitis)</td>
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<tr>
<td>- Mental (e.g. depressive disorder attributed to alcohol consumption).</td>
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<tr>
<td>A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use. Typically includes:</td>
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<td>- A strong desire to take the drug</td>
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<td>- Difficulties in controlling its use</td>
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<tr>
<td>- Persisting in its use despite harmful consequences</td>
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<tr>
<td>- A higher priority given to drug use than to other activities and obligations</td>
<td></td>
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<tr>
<td>- Increased tolerance</td>
<td></td>
</tr>
<tr>
<td>- Physical withdrawal</td>
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*Note: Adapted from the (World Health Organization, 2012)*

**Causation.** The concept of addiction is also shaped through the process of identifying engagement in drug use or particular activities as the causal factor for the potential experience of a vast array of negative consequences. In the early 19th century, alcohol was transformed to be considered “the direct cause of crime, violence, poverty, divorce, and virtually all other problems in America” (Reinarman, 2005, p. 311).

This type of discursive practice was portrayed in Canada by Project CREATE (Curriculum Renewal and Evaluation of Addictions Training and Education), which was developed (in approximately 2002) as a web-based initiative to provide education about addictions to students in medical schools across Ontario. In overview program overview,
it is explained that alcohol, tobacco, and other drug use constitute significant public health issues that affect children, families and society.

The devastation experienced by families because of injury and death caused by drunk drivers, the pain and suffering experienced by women and children because of domestic violence, the costs of absenteeism and workplace injuries because of alcohol and drug use, and the fear and vulnerability experienced by the whole population because of drug-related crimes are compelling reasons why physicians must begin to diagnose and treat individuals with [alcohol, tobacco, and other drug] problems more vigorously. (Create Canada, 2004, para. 1)

In this quote, alcohol, tobacco, and drugs are represented as primary factors in contemporary Canadian social problems. This subsequently provides a rationale for urgent identification by health professionals of individuals who use drugs and the implementation of corrective measures.

**Clandestine nature.** A prominent factor in constructing the concept of addiction corresponds with the notion that the truth is hidden from oneself, be it the individual who is doing drugs, friends, or family members. The confession extends beyond the revelation of secrets to the need to uncover the truth that is not in conscious awareness. In addiction discourse, for example, the proposition that a person is in denial acts as a rhetorical device that positions personal accounts and judgements as unreliable and open to accurate analysis and interpretation by an expert. Denial will be discussed in more depth in a subsequent chapter.

**Method of interpretation.** The establishment of a scientifically valid method to detect and identify dysfunction or disorder results in a discourse of truth that is constituted through a hermeneutical process in which authority is attributed to a specific person (Foucault, 1978/1990); when described in relation to therapeutic interactions, the client is positioned as knowable, malleable and deferring (Guilfoyle, 2006). This assumes that a health professional can “know” the client, and can understand the experiences and behaviours of that client. The client is malleable, in that they are assumed to be able to change their ways of thinking, talking, or doing. Finally, the client is expected to defer the interpretation of the meaning of their experiences to the health care professional. This demonstrates that the true meaning of client utterances is considered “yet-to-be-decided” by an authoritative figure (Guilfoyle, 2006).
Since its inception, Alcoholics Anonymous has become central to interpretations of drug use. Alcoholics Anonymous (AA) forms a context in which members learn the propositions of the program, learn to appropriate forms of interpretation of events, and learn to tell personal narratives using the AA propositions (Cain, 1991). These cultural propositions include:

Alcoholism is a progressive disease; the alcoholic is powerless over alcohol; the alcoholic drinker is out of control (or is insane); AA is for those who want it, not for those who need it; and AA is a program for living, not just for not drinking. These propositions enter into stories as guidelines for describing the progression of drinking, the desire and inability to stop, the necessity of "hitting bottom" before the program can work, and the changes that take place in one's life after joining AA. (Cain, 1991, p. 228)

**Distinguishing normal from pathological.** Establishing a “norm” creates the potential for corrective measures to be implemented for those who transgress or deviate from what is considered normal or acceptable in society (Foucault, 1978/1990). Through medicalisation, what was once viewed as error or sin and excess or transgression, is evaluated in relation to “normal” or “pathological” (Foucault, 1978/1990, p. 67). The result in this shift in conceptualising addiction means that in contemporary time, “addiction and the ‘addict’ are therefore a problem both of and for medicine” (May, 2001).

### 1.6 Historical Shift to the Disease Model

In Canada, the disease model of addiction predominantly informs health professional education, research, policy, and treatment about drug use. The Canadian Society of Addiction Medicine (CSAM) (2008) defines addiction as a “primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour” (Canadian Society of Addiction Medicine, 2008). In the USA, the National Institute on Drug Abuse (NIDA) (2009) defines addiction as “a complex brain disease ... characterized by drug craving, seeking … [that] may become compulsive in large part as a result of the effects of prolonged drug use on brain functioning and, thus, on behavior” (para. 5). Similarly, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (2007) defines alcoholism as “chronic, meaning that it lasts a person's lifetime; it usually
follows a predictable course; and it has symptoms.” Overall, the disease model attributes
the aetiology, development, and expression of addiction to biological factors (Whiteford
& Bennett, 2005).

There are many excellent historical analyses that provide a historical context to
the concept of addiction and the development of the disease model and therefore this
section will provide a very brief overview. The disease model of addiction emerged in the
late 18th and early 19th century in relation to a systematic reconceptualisation of the
consumption of alcohol that was later applied to other substances (Levine, 1978).

Historically, drinking alcohol was considered to be a common part of everyday life
(Reinarman, 2005). In the 17th century and throughout most of the 18th century, alcohol
consumption was viewed to be a choice. In North America and Europe rum, brandy and
gin were considered to be nutritious and used to treat certain maladies (Severns, 2004).

Beer and wine were often considered to be a necessity, given the inadequate supplies of
sanitary drinking water. The idea that one might be addicted to alcohol and experience an
“overwhelming and irresistible desire for liquor” gained prominence starting in the late

Discourses of addiction were first applied to the consumption of “spirits,” with
wine and beer being exempt (Valverde, 1998). A significant transformation occurred with
the advent of Protestantism and early capitalism, which contributed to the development of
a discourse that “demanded the renunciation of pleasure for the sake of piety in
productivity” (Reinarman, 2005, p. 310). Alcohol consumption was initially identified as
a problem of the labour class that threatened social stability, both politically and
economically (May, 1997). Alcohol use was viewed as a problem of appetite and self-
indulgence, and excessive drinking was regarded as a moral failure and lack of self-
governance (May, 2001).

Alcohol use became a key issue in religious debates in the 17th and 18th centuries
(Valverde, 1998) and was a central topic in relation to the perception that individuals
exert control over their selves and their destinies (Valverde, 1998). At this time, people
were considered to have a will and therefore alcohol consumption was considered to be a
choice. At the same time, the notion of abstinence (which applied to all forms of
indulgence, including tea, tobacco, meat, and in some cases chewing gum) owed its possibility to the doctrine of Christian perfectionism (Warner, 2009). The practice of abstinence was higher among denominations that believed in human agency and the possibility to sanctify one’s own body (Warner, 2009).

In the early 19th century, alcohol use was re-conceptualised to be a disease of the will, such that “drunks” were not able to enact volition (Reinarman, 2005). Two of the early and influential advocates of the concept of alcoholism were Benjamin Rush and Thomas Trotter. The temperance movement that marked the 19th century included claims that inebriety, or habitual drunkenness, was a disease and a consequence of moderate alcohol consumption (Levine, 1978). Accordingly, the only cure was abstinence, a belief that was later applied to other drugs, like opiates. Harry Levine (1978) argues that during Prohibition the disease model viewed alcohol as inherently problematic and the causal factor resulting in a loss of control. Accordingly, abstinence was the ultimate solution. Post-Prohibition, loss of control associated with alcohol was thought to result from factors that reside within individual bodies. This perspective provided reasoning for the belief that alcohol affects different people in different ways.

Discourse of addiction as a disease of the will continues to form one of the major tenants of AA, in which members admit to being powerless over alcohol, more consistent with the Prohibition concept of disease. The notion of disease of the will took some of the blame from the individual with an addiction, while creating a dilemma for agency and responsibility (Valverde, 1998). Elvin Jellenick’s work on the symptomology of alcoholism was influential at this time. In 1950, the World Health Organisation (WHO) defined alcoholism as a disease and in 1954 it was described as, “A chronic behavioural disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social needs of the community and to an extent that interferes with the drinker’s health or his social or economic functions (Severns, 2004, p. 162). In the early 20th century, the potential for physiological dependence on opiates was proposed and the term “drug addiction” was defined by WHO in 1950 (Reinarman, 2005). “The addict emerged with the development … of a medico-legal discourse capable of reconceiving human identity in the language of pathology” (Redfield & Brodie, 2002, p. 2).
There are several ways that addiction is conceptualised from a medical perspective (Csiernik, 2011; May 2001). A person may be considered to have a genetic predisposition, in which case the tendency to use particular drugs in a particular way is considered to be a product of inherited traits. Addiction is also viewed as an organic disease where addiction is an effect of a disease of the endocrine system or central nervous system. Theories of brain dysfunction assume that substance use may damage brain cells responsible for willpower and judgment and postulate neurological differences between people who are dependent on a substance and those who are not. Biochemical theories described chemical imbalances associated with drug use, either as a pre-existing phenomenon or as a result of drug exposure and withdrawal.

Drug use is also defined through psychological models that presuppose an interaction between individual and degenerative influences. Psychological models include learning, psychodynamic, personality, humanistic and rational theories (Csiernik, 2011). During the time of Prohibition in North America, the disease model of alcoholism essentially disappeared in response to political pressure and dominance of the moral model of addiction at that time (Warhol, 2002). Accordingly, the influence medical discourses subsided and psychoanalytical discourses took root (Warhol, 2002). Drug use is not simply an activity in which someone engages, nor is it purely a disease; in fact, the use of drugs may form part of the individual’s identity. Parallel to how Foucault (1975/1995) describes the penal system to focus “not only on what they do but also what they are, will be, may be” (p. 18), concepts of drugs use do not only work to delineate what activities are appropriate and acceptable, but also what ways of being are proper. This can be seen in the literature evaluating drug use in relation to identity theories (Bailey, 2005; Cherrier & Murray, 2002; Gibson, Acquah, & Robinson, 2004; Hughes, 2007; Koski-Jännes, 2002; May, 2001; McIntosh & McKeganey, 2001; Reith, 2004; Rødner, 2005; Shinebourne & Smith, 2009). Even if the individual rectifies their problematic engagement in drug use, they are viewed to be perpetually “in recovery.” The activity, or disease, becomes an inescapable part of who the person is. Instead of being able to reduce their vigilant monitoring of their engagement in the activity, they must become even more vigilant.
Craig Reinarman (2005) suggests at least two ways that a person could be incorporated into the frame of addiction-as-disease. The first he calls a “pedagogical process,” whereby individuals learn and adopt language that is used by health care providers, corrections staff, and other people who identify themselves to be addicts. The second he calls a “performative process,” whereby the individuals who consider themselves to have an addiction tell reconstituted life stories. Ian Hacking (1995) further proposes, “people classified in a certain way tend to conform to or grow into the ways that they are described; but they also evolve in their own ways, so that the classifications and descriptions have to be constantly revised” (as cited in Dryden & Still, 2007).

The concepts of drugs, drug use, and addiction convey what is considered appropriate and acceptable in society by defining how drugs can interfere with other aspects of a person’s life. The DSM-IV-TR (American Psychiatric Association, 2000) defines pathology attributed to substance or alcohol use as the neglect to fulfil expectations at work, school, or home. Similarly, arguments with one’s spouse and withdrawal from family activities may provide evidence of a problem. Engagement in illegal activities is often attributed to drug use, despite the fact that drug use itself frequently constitutes the criminal offense. Concepts of drug use and addiction, therefore, serve to provide ways to identify when engagement in an activity interferes with participation in other roles and activities that are valued in society. The importance of moderating or abstaining from drugs requires ongoing personal assessment and reflection. The consequences of drug use activity are considered from the perspective of others, including family members, employers, and even strangers who may be indirectly affected by his or her choices.

1.7 Critical Perspectives on Drug Use

Increasingly, theoretical epistemologies of health professional practices, diagnosis, and interventions have come under scrutiny. Ontologically, research that informs health professional education is typically framed as objective, rational, and factual. However, relativist ontological positions point to the subjective and constructionist projects embedded in science to question beliefs that research can truly be objective, or that there is a singular truth (see Feyerabend, 2010; Kuhn, 1971; Latour, 2005). Annemarie Mol
(2002) exemplifies this proposition when she says that “no object, no body, no disease is singular. If it is not removed from the practices that sustain it, reality is a multiple” (p. 6).

This ontological shift in interpreting health professional research, education, and practices has contributed to the development of theories that address the medicalisation of contemporary society (see Conrad, 2007; Szasz, 2007) and, often intertwined, the creation or “manufacturing” of mental illness (see Greenberg, 2010; Horwitz, 2002; Watters, 2010; Whitaker, 2002). Peter Conrad (2007) notes that in the last thirty years there has been a marked increase in the number of “life problems that are defined as medical” (p. 3). Have medical problems increased? Have medicinal practices improved the identification of problems? Or “does it mean that a whole range of life’s problems have now received medical diagnoses and are subject to medical treatment, despite dubious evidence of their medical nature?” (Conrad, 2007, p. 3). The term medicalisation began to take hold in the 1970s and is defined as a societal process in which “nonmedical problems become defined and treated as medical problems, mostly in terms of illness and disorders” (Conrad, 2007, p. 4). Conrad notes that one of the primary occurrences of medicalisation pertains to phenomena that are considered to be deviant, such as alcoholism and opiate addictions. One of the criticisms of medicalisation Conrad identifies is that it “transforms aspects of everyday life into pathologies, narrowing the range of what is considered acceptable” (p. 7). It also constitutes the source of the problem to reside in the individual, which narrows interventions toward treating the person rather than looking toward collective or social solutions.

Medicalisation has more recently been criticised for its high reliance on pharmaceutical intervention. Lucrative pharmaceutical and biotechnology industries are significant actors in the construction of what is perceived to be a problem and the ideal means of treatment. Conrad (2007) states, “pharmaceutical companies ... [are] now marketing diseases, not just drugs” (p. 19). Advertisements develop public awareness in consumers about diseases and disorders that can be amenable to medical intervention and pharmaceutical treatment. “Selling a treatment by selling a disease” is a public relations strategy that started in the 1950s and became prominent in the 1990s (Elliott, 2010).
To sell Prilosec, you have to sell acid reflux; to sell Lotronex, you have to sell irritable bowel syndrome; to sell Viagra, you have to sell erectile dysfunction; to sell Adderall, you have to sell ADHD. You market a treatment by convincing doctors and patients to diagnose the illness that your drug or procedure treats. (Elliott, 2010, p. 96)

The notion of medicalisation has implications for this research project from several points of view. For one, it provides insight to the medical discourses of addiction. At the same time, there is awareness that the social construction of disease and pathology is part of a larger social process because “as conditions are medicalized, there is an ever-growing expansion of the jurisdiction of medicine over arenas of social life and experience” (Singer & Baer, 1995). Furthermore, medicalisation delineates which drugs are acceptable and under what circumstances. It must be noted that while there are certainly pharmacological interventions to reduce, alter, or mitigate alcohol and drug consumption, this aspect of medicalisation is not a focus of this research project.

Health and risk are two other concepts that can be discussed in relation to medicalisation. Medicalisation projects gain credence contingent with the assumption that health is a goal toward which we aspire; and one of the ways that we can achieve health is to avoid anything that could pose risk to health. In the book, Against health: How health became the new morality, the authors commented that while health is a valued good, the social construction of what constitutes health and the inequalities in access to and control over health-related resources and services are of concern (Metzl, 2010). Health in critical sociological and anthropological fields has been conceptualised as an “elastic condition” influenced by a sociological context (Singer & Baer, 1995). The term “health,” noted Jonathan Metzl (2010), is “replete with value judgments, hierarchies, and blind assumptions that speak as much to power and privilege as they do about well-being” (pp. 1-2) that is furthermore constructed “as a moral obligation, a commodity, and a mark of status and self-worth” (p. 6). At the same time that addiction is considered a disease, there are remnants of the moral model, but moral responsibility now shifts to an individual responsibility to engage in recovery (May, 2001).

In North America, the contemporary concept of health acts discursively as a powerful rhetorical device given its position as a meta-value on which other values are
predicated (Betts, 2007). However, drawing on the work of Nietzsche, Christopher Betts (2007) questions whether the focus on health as an indication of successful living might overshadow living with passion and enjoyment. “[I]f the preeminent impetus of living is: (a) the evisceration of suffering; (b) the amelioration of disease; and/or (c) the extensive prolongation of life, then one becomes in effect more concerned with suffering, dying, or getting sick than living” (Illich in Betts, 2007, p. 43).

In contemporary Western society, it is assumed and expected that rational individuals will strive toward health and longevity.

It seems, then, that behavioural choices that do not prioritize health and safety constitute a challenge to psychologists, and one way of meeting this challenge has been to re-conceptualize such choices as the product of psychopathology or false beliefs, and thus not really choices at all. As a result, instead of looking at the meanings of these behaviours within the lifeworld of the individual, psychologists look for the pathology or cognitive bias that generates them. (Willig, 2008, p. 691)

In other words, actions that may have a negative impact on health are assumed to be irrational and a sign of pathology. The body became something that is meant to be “cared for, protected, cultivated, and preserved” (Foucault, 1978/1990, p. 123). Moral individuals are expected to strive toward health, and to achieve optimal health they are expected to avoid risk and risky situations. According to modern societal values and definitions of moral character, “to be healthy is to be a good person” (Benford & Gough, 2006, p. 428).

People who chose to engage in risky activities frequently need to do so in secret, which can instil feelings of guilt, fear, and shame (O’Bryne & Holmes, 2007). Essentially, in order to be considered a “good citizen,” one must take actions that support health, minimize risk, and reinforce healthy choices by others (O’Bryne & Holmes, 2007).

Accordingly, the diagnostic criteria for substance abuse and substance dependence include consequences of impaired health and increased risk of physical harm, such as operating machinery when intoxicated (American Psychiatric Association, 2000).

Scientist and feminist scholar, Karen Barad rejects the idea that objects possess independent attributes that interact in predictable ways with other objects (Fraser & Moore, 2011). By adopting this position she problematises biomedical perspectives that
predict material effects of a drug on a particular body. More broadly speaking, “The materiality of drugs matter, but so too do ideas, discourses, practices, histories and politics. All these produce each other and produce drugs, their effects and their circumstances” (Fraser & Moore, 2011, p. 6). In this way, the biomedical model is not viewed as irrelevant, but perhaps as insufficient to explain and understand drugs and drugs use. Similarly,

[T]he phenomenon of addiction – that is, the idea of addiction as well as the activities and objects associated with addiction, and the state of addiction itself – are produced through social and cultural practices, such as medical procedures, policing practices, media texts and the ways we talk about addiction in everyday life. (Fraser & Moore, 2011, p. 7)

When working as the director of the National Institute of Drug Abuse (NIDA), Alan Leshner (1997) defined drug addiction as “a chronic, relapsing disease that results from the prolonged effects of drugs on the brain” (Leshner, 1997, p. 45), arguing that addiction can be classified as a “brain disease” because it is associated with “changes in brain structure and function” (Leshner, 1997, p. 46). Bennett Foddy (2010) identifies some of the empirical and philosophical limitations of the biomedical and neurological theories of addiction acknowledging that neuroscientists increasingly recognise that the human brain is characterised by neuroplasticity; accordingly, the brain changes structurally and functionally, making new neural connections, throughout a person’s life. Essentially, all experiences, including physical, cognitive, emotional, and sensory impact the brain. Similarly, intake of nutritional sustenance, water, toxins, hormones and chemicals will have effects on the brain. Nevertheless, the neurological basis of drug addiction as a disease has been widely adopted.

Foddy (2010) problematises the disease model of addiction:

The disease label transforms drug-taking from an autonomous, responsible choice into an external phenomenon, something which happens to the addict against his or her will. Using this rationale, we can justify preventing drug users from taking drugs and even forcing them to undergo treatment without worrying about infringing on their autonomy. (p. 26)

He further notes that the concept of addiction as a disease has yet to be proven from either an empirical, medical standpoint or a philosophical understanding of human behaviour, including free will, agency, self-control, desire and responsibility.
Framing addiction as a “disease of the brain” and “emphasizing biological influences on substance use may lead to a vision of addiction as a phenomenon isolated within our bodies and neurochemistry, not lived daily within a complex social web of relationships and a particular political economy” (Dingel, Karkazis, & Koenig, 2011, p. 1363). There is the potential that if the biomedical discourse takes priority, other social, political, and economic interventions may not be allocated sufficient resources, and social responsibility may be compromised.

Exploring the delineation between basic human activity and disease, Timothy Melley (2002), observes that the belief that “any habit, drive or compulsion indicates a lack of self-control so dangerous it merits medical attention” (p. 38-39) proliferated after the publication of Love and Addiction (Peele & Brodsky, 1975). In fact, in 1991, Peele & Brodsky voice concern with how the notion of addiction is taken up, calling it a perversion:

For us, the main purpose of opening up the realm of addiction to nonchemical involvements was to free people's minds from commonly accepted (but incorrect) beliefs that some substances are universally addicting (like narcotics or, more recently, crack) or that some individuals are born to be addicted (for example, alcoholics).

Instead, we reasoned, if people can be addicted to any consuming experience, then addiction is not what we are accustomed to thinking it is. If what people get addicted to is an experience (whether precipitated by a psychoactive drug or by the feelings associated with an intimate relationship), if another person can be as predictable and comforting an object as a drink or a "fix," then we need a new understanding of the addictive process. An addiction is an experience that takes on meaning and power in the light of a person's needs, desires, beliefs, expectations, and fears. (Peele, 1975/1991)

Peele explains that their intention was to present a liberating “commonsense vision of addiction” which emphasises the capacity for choice and change in the face of “seemingly overpowering sensations.” Therefore, he said, “it is a sad irony for us that our work contributed inadvertently to the labelling of yet more ‘diseases’ over which people are ‘powerless.’”

Arthur Kleinman (1995) emphasises that biomedicine is more than a bureaucracy or a profession:
It is a leading institution of industrialized society’s management of social reality....No other therapeutic system can exercise this degree of power, because no other has become so powerful a part of the state’s mechanism of control. Indeed, in industrialized societies, biomedicine along with the mental health, disability, and welfare systems that closely relate to it arguably have become the major form of social control (p. 38).

As a result, Kleinman suggests that biomedical definitions of pathological and problematic human experiences are afforded legitimacy in public discourse and legal practices.

There are several reasons that the process of medicalisation has had such success. One of the reasons is that there is a general perspective that it is not entirely the “fault” of an individual for acquiring a disease, reducing blame and stigma (Payton & Tuhoits, 2009). While this is somewhat contradictory to the assumption that people will strive toward good health, avoid risk, and undergo therapeutic intervention, there is a perception that a disease is not a moral failure. Secondly, the disease model affords people with benefits, services, and advantages that they might not otherwise have access to (Gallagher & Ferrante, 1987). The addiction as a disease model brings alcohol and drug problems into the umbrella of health benefits and gives the individual increased rights in the workplace. There is also negotiation between the justice system and medical system regarding which services would better benefit the person and society. In this way, health intervention is often viewed as the more likely to prevent recidivism and at the same time is often preferable for the person who is facing possible imprisonment.

1.8 Denial, Justification, Rationalisation, Intellectualisation, Neutralisation

Psychoanalytical theories have become intertwined with the disease model of addiction. There are several aspects of analysis that contribute to interpretations of personal accounts of drug use as unreliable. Some of the more common theories that have been applied to individual accounts and interpretations of personal drug use are denial, justification, rationalisation, intellectualisation, and neutralisation. I endeavour to discuss these theories individually. However, in the literature they are frequently used interchangeably, so the overlap in concepts will be presented.
Denial. E. Summerson Carr (2011) states that addiction has been conceived of as “a disease of insight” (p. 123). In therapy settings, Carr observed therapists explaining the notion of “denial” to clients using an acronym of “D-E-N-I-A-L = Don’t Even Know I Am Lying” (p. 14). Denial is a term that was derived from the German word Verleugnung that has also been translated as “disavowal.” Sigmund Freud defined Verleugnung in 1924 as one of several ego defense mechanisms. The theory of denial was expanded on by his daughter Anna Freud who defined “denial in word and act” as a pathological phenomenon of adults (as cited in Carr, 2011, p. 87). When a person is in denial, the ego “must sacrifice both its synthesizing function and its capacity to recognize and critically test reality” (Carr, 2011, p. 87).

By structuring therapeutic discourse in a particular way, one that pre-establishes what talk is considered “insight” and what talk is considered “denial”; any critiques and challenges pertaining to the concepts of drugs and drug use are more easily disregarded and afforded little or no authority (Carr, 2011). The concept of denial, then, does not act simply as a therapeutic interpretation of an individual’s ability to accurately evaluation their own experience and the consequences of their choice to do drugs. Rather, it acts to discount the person’s individual account and interpretation of their drug use. Furthermore, the concept of denial perpetuates contemporary dominant discourses of drug use and addiction by acting to shield against alternative interpretations. Discourse that does not conform to dominant discourses are discredited as being the wrong interpretation.

It has been observed that the multitude of meanings attributed to the concept of “denial” in the field of substance “abuse” well exceed those intended in the originating field of psychoanalysis

One note of caution needs to be sounded about the use of “denial” as a label. Denial has become so widely acknowledged as a hallmark of alcoholism or drug abuse that to deny substance abuse is frequently considered diagnostic of the disease. Obviously, however, some individuals who deny that they are alcoholics or drug addicts do so only because they have been wrongly accused, not because they are SAs [Substance Abusers]. Caution would also be utilized in not overlabelling a multitude of substance abuse behaviors as “denials.” (Kaufmann cited in Carr, 2011, p. 89)
Neutralisation and justification. The theory of neutralisation has been attributed to Gresham Sykes and David Matza (1957). It is argued that Sykes and Matza originally developed this theory in response to dominant perspectives at that time, which proposed that criminal offenders adhered to oppositional subcultural values of law breaking, violence and rebelliousness (Topalli, 2005). Sykes and Matza found, instead, that juvenile delinquents frequently demonstrated guilt, which was seen as evidence that the person was aware of and subscribed to societal norms and values. They argued that deviant behaviour was based on the development of justifications, or rationalisations, that protected the individual from taking responsibility for the outcome or from “self-blame” and from blame imposed by others.

Sykes and Matza’s analysis of neutralisation can be useful to explore the discursive practices of individuals. However, the theory has been erroneously applied with the assumption that the presence of statements of neutralisation is evidence that the person, in fact, views their actions as wrong. For example, Patrick Peretti-Watel (2003) describes a quantitative survey, ESCAPAD, regarding drug use among adolescents. He reports that there was an optional section for additional comments at the end of the survey and approximately three hundred respondents spoke up in favour of cannabis use. He describes the responses to fall into one of three categories. First, many respondents compared cannabis to heroin, asserting that cannabis was not addictive, not a gateway drug, and had not impacted their interpersonal relationships or performance at school. Secondly, the respondent asserted that they had control over their cannabis smoking. Thirdly, the respondents commented that alcohol and tobacco are legal, yet more harmful than cannabis. Given the fact that these statements can be interpreted as “risk denial” and consistent with neutralisation theory, Peretti-Watel (2003) presented these comments as evidence that “in general, people neither seek risk purposely not endanger themselves unconsciously. They just find good ‘reasons’ to deny it” (p. 39). However, what is important to note here is that Peretti-Watel had never spoken to or met the respondents. The very fact that the respondents spoke up in favour of marijuana was interpreted as sufficient evidence of neutralisation and, accordingly, as evidence that the respondents were doing something wrong. However, perhaps if the researchers had an opportunity to talk to the research participants they might have interpreted the accounts to be credible. It
might be that research participants provided *explanations* their use of marijuana, rather than neutralisations.

Aldridge et al. (2011) similarly questioned the ways that theories of neutralisation have been applied to interpret personal accounts of drug use, recognising that although a statement *can* be interpreted as neutralisation this does not, unequivocally, mean the person implicitly believes that drug use is wrong. Rather, Aldridge, et al. (2011) argued that:

Neutralising statements can arise simply in *recognition* of existing social sanctions. Thus, rationalisations are made – healthily and appropriately – in order to provide a coherent and acceptable personal narrative to a possibly judgemental observer. These are what Maruna and Copes (2005) refer to as ‘good’ neutralisations, and what Scott and Lyman (1968) refer to as ‘justifications’ (accepting responsibility for behaviour but rejecting its pejorative sense), as opposed to ‘excuses’ (accepting the behaviour is wrong, but denying responsibility for it). (p. 220)

Margaretha Järvinen and Jakob Demant (2011) interpreted aspects of “normalisation” as a process of collective, social “neutralisations.” In their analysis, they did not think that neutralisations were designed to respond to an external discourse of “deviance.” Yet, it is interesting that the focus of the research was on the change toward accepting drug use, with *not approving* of drug use as the implied norm. For example, they categorised the following group discussion (6 males, aged 18–19) as exemplifying neutralisation by “the process of redefining cannabis as being part of a well-known and safe setting” (p. 174).

| Noah:     | Cannabis.       |
| Markus:  | That’s a good one. |
| Vincent: | Nice drug.      |
| Noah:    | It’s definitely not the kind of thing you would take if you were going out [to discos], because it’s a bit more relaxing and calming. |
| Sune:    | It’s more for parties at home, I would say. |
| Moderator: | But not for going to town? |
| Participants speaking all at once: | No. (pp. 174-175) |

The interpretations of normalisation were made in comparison to group discussions younger children, such as this group of 14- and 15-year-old males.
Moderator: What about cannabis?
All participants: No!
Simon: No, I would say we’re not that kind of persons.
Joakim: We are not abusers (…)
Simon: After all, we prefer to drink a little extra. Drinking doesn’t cause permanent damage. Some people say that cannabis isn’t life threatening but I don’t fancy it (…)
Felix: I can’t see why you should use it.
Joakim: When you see people who have smoked it, they just sit there hanging, staring into space. (p. 172)

It can also be noted that these boys spoke in the interview about having experiences of drinking to excess, including throwing up, passing out, and losing control over one’s alcohol consumption (Järvinen & Demant, 2011). One of the questions that we might ask is: how does one discriminate between the developments of the discursive strategy of neutralisation versus experiential learning that comes with age? After four years of drinking to excess, these boys may have come to realise that alcohol is not without its own harms and cannabis might in fact be a desirable alternative and may not, in fact, have as high a dependence liability as they may have thought when they were 14-years-old.

Shadd Maruna and Heith Copes (2004) present a review of the theory of neutralisation included a section entitled, “Neutralising negative behaviors, in itself, is not pathological.” Based on an extensive review of five decades’ worth of research regarding neutralisation theory, Maruna and Copes felt the need to explicitly reiterate that voicing justifications and excuses is a normal human behaviour. It is “as normal as breathing” (p. 65).

Furthermore, it is important to keep in mind that the evaluation of an activity as wrong is socially constructed. The theory of neutralisation was developed in the field of criminology to explain deviant, illegal activity. Applying the theory of neutralisation to personal accounts of drug use inherently applies a framework that is based on the assumption that the drug use is a deviant form of behaviour. Personal accounts of drug use may just as well be constructed to refute the position of drug use as deviant, which will thereby increase the likelihood that justifications, rationalisations and neutralisations will be presented.
From this point of view, neutralisations and justifications are less a response to an underlying belief that a person’s own use of drugs is wrong, but they occur in the context of a discursive interaction where it can reasonably be assumed that the audience (perceived or actual) will hold an oppositional viewpoint. When a person engages in any activity that they perceive to be contrary to the dominant discourse of what is normal, good, and acceptable, it is more likely that they will construct their narrative accounts in order to counter the preconceived notions that they expect the audience to hold. Finally, Aldridge, et al. (2011) posit that it is possible for individuals to conform to societal values in general, but to reject certain aspects of what is considered socially acceptable.

**Rationalisation.** The notion of rationalisation introduced by Ernest Jones (1908) states:

There exist elaborate psychological mechanisms, the effect of which is to conceal from the individual certain feeling processes which are often of the highest significance to his whole mind. The complexity and subtlety of these mechanisms vary with what may be called the extent of the necessity for concealment, so that the greater the resistance the individual shews to the acceptance of the given feeling the more elaborate is the mechanism whereby it is concealed from consciousness. (p. 162)

Jones went on to argue that when a person is asked to provide a reason for an action, his or her response falls into one of two categories, depending on whether or not that person provides a response. If the person believed that the act, such as which direction to go on a stroll, was self-explanatory or irrelevant it was intuited that the true, underlying motive must be “concealed” from consciousness. On the other hand, if the person were to provide a rationale or explanation, it is “a false one” (p. 165). Indeed, it would appear that there is an assumption that the person undertaking a particular act would always be expected to provide an inaccurate account for the underlying rationale.

Rationalisation has been defined as a process “whereby we make our own apparently irrational behaviour, thoughts and feelings appear plausible” (as cited in Zepf, 2011, p. 149). Similarly, Bibring, Dwyer, Huntington, and Valenstein (1961) described it as the ways in which “attitudes, beliefs, or behavior which otherwise might be unacceptable may be justified by the incorrect application of a truth, or the invention of a convincing fallacy” (as cited in Zepf, 2011, p. 149). Both these definitions are grounded
in the assumption that a phenomenon is irrational or unacceptable, whether to the individual performing the act, or to an outside observer. The truth of a person’s account is therefore always suspect and unreliable, since the person is expected to hide the truth even from his or herself. An example of rationalisation would include a person’s statement that smoking marijuana is preferable to drinking alcohol since alcohol is more likely related to injury and violence.

**Intellectualisation.** Intellectualisation was recently defined as “intellectual activity that is used as a means of controlling affects and impulses that involve generalisations and abstractions” (Zepf, 2011, p. 149). Accordingly, Zepf (2011) conceptualises intellectualisation as an unconscious process that protects the person from the emotional aspect of a particular phenomenon, or the “unpleasurable affects.” For instance, a person who uses a drug might investigate statistics of potential harms and risks associated with the drug. The term intellectualisation conveys that the person distances themselves emotionally from the drug use by focussing on empirical information.

Intellectualisation and rationalisation could also be considered as a response to the evidenced-based nature of medical discourse. Empirical research is afforded legitimacy and authority in regard to determining what actions will contribute to and negatively impact a person’s and a society’s health and well-being. It can reasonably be assumed that, within this context, individuals who use drugs will draw on research, documentaries, and personal experiences to provide evidence contrary to the dominant discourses of drug use and addiction.

The concepts of denial, justification, rationalisation, intellectualisation, and neutralisation are not without their merits and can be employed under certain circumstances to explore human behaviour. At the same time, I wonder if there is not the potential for these concepts to limit our understanding of a phenomenon. Each of these concepts assumes that the individual who is giving an account of his or her own actions, thoughts, and beliefs is not a reliable source. As a result, the outside interpreter has the impression that he or she can provide a more accurate interpretation. “Experience makes one’s voice suspect, and only those furthest removed from any experience with either drugs or drug users are entitled to legitimacy” (Warhol, 2002, p. 150). The more
legitimate interpretation is not necessarily offered only by the psychoanalyst, psychologist, or physician, but by the layperson as well.

Another assumption is that denial, justification, rationalisation, intellectualisation, and neutralisation are natural responses that a person experiences when involved in something that they believe to be wrong. Therefore, applying these concepts to accounts of drug use grounds the interpretations and attempts to understand the person from a point of view that not only are the accounts inherently flawed, but the act itself is wrong, bad, undesirable and unacceptable. Accordingly, these concepts may act to reinforce and perpetuate dominant discourses and may act to silence voices of resistance.

1.9 Drug Use as “Deviant”

Howard S. Becker (1963) advocated for the study of human engagement in deviant activities for the sake of attempting to understand the nature of the phenomenon. Forming the foundation for labelling theory in social deviance studies, he proposed that in order to more fully understand an issue it is important to study the perspectives and situations from multiple vantage points for the purpose of developing understanding rather than the intention of determining the value or truth underlying the situation.

Becker seemed to hold some contradictory positions. For example, he suggested that the “central fact” about deviance is that it is created by society:

[S]ocial groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an “offender.” The deviant is one to whom that label has successfully been applied; deviant behavior is behavior that people so label. (p. 9)

Accordingly, he advocated that the approach to research of a particular behaviour should be neutral in regard to value judgments. Nevertheless, he presented apparently concrete examples of deviant behaviours in order to exemplify particular points. More specifically, he frequently drew on “drug addicts” and “homosexuals” as prototypical examples of deviants. In contrast to positing that the phenomenon should be approached from a neutral standpoint in research, he referred to certain phenomenon as unquestionably “deviant.”
Overall, several aspects of Becker’s work provide an important foundation for the current research project. Keeping in mind that nearly half a century has passed since Becker’s book was published, it is intriguing to note that his analysis of marijuana use and its position in North American society has remained relatively unchanged. In fact, this observation becomes even more glaring when put in perspective in relation to the position and belief he presented in regard to homosexuality. Whereas in 1963 it may very well have been perceived as “common sense” that homosexuality and drug addiction would be prototypical examples of deviance, in 2012 the positioning of drug addiction in relation to homosexuality has, in general practice, shifted on the spectrum of normal and deviant. One of the questions to keep in mind, then, is why has drug addiction and drug use remained as a deviant, socially unacceptable behaviour, whereas there have been significant changes socially, legally, and politically in regard to homosexuality? What are some of the processes that continue to influence the social position of drugs and drug use in Canada?

In relation to this research project, Becker’s work has significant implications in regard to his interpretation of deviant behaviour as an interpersonal and discursive practice. Firstly, the underlying assumptions that influenced Becker’s work will be discussed, with the benefit of the passage of time to re-evaluate his position. Becker (1963) wrote about the tendency for people who engage in deviant behaviour to “justify,” “rationalise” and “neutralise” their actions. For example, Becker (1963) declared, “At the extreme, some deviants (homosexuals and drug addicts are good examples) develop full-blown ideologies explaining why they are right and why those who disapprove of and punish them are wrong” (p. 3). He elaborated:

First of all, deviant groups tend, more than deviant individuals, to be pushed into rationalizing their position. At an extreme, they develop a very complicated historical, legal, and psychological justification for their deviant activity. The homosexual community is a good case. Magazines and books by homosexuals include historical articles about famous homosexuals in history. They contain articles on the biology and physiology of sex, designed to show that homosexuality is a ‘normal’ sexual response. They contain legal articles, pleadings for civil liberties for homosexuals. Taken together, this material provides a working philosophy for the active homosexual, explaining to him why he is the way he is, that other people have also been that way, and why it is right for him to be that way.
Most deviant groups have a self-justifying rationale (or “ideology”), although seldom is it as well worked out as that of the homosexual. While such rationales do operate, as pointed out earlier, to neutralize the conventional attitudes that deviants may still find in themselves toward their own behavior, they also perform another function. They furnish the individual with reasons that appear sound for continuing the line of activity he has begun. (pp. 38-39)

As discussed earlier, the concepts of neutralisation, justification, and rationalisation are frequently applied to the interpretation of individual accounts of drug use. Becker does problematise aspects of these concepts, which will be discussed below. He also discusses aspects of “justification” that share common ground with the notion of “denial.” Referring to the preceding quotes, there are certain indications that Becker might question the validity of the justifications and rationale. For one, he used the term “self-justifying rationale” which seems to indicate that the rationale is directed to the person who identifies with being homosexual, rather than to an outside observer. Becker also, more tellingly, used the phrase “they furnish the individual with reasons that appear sound” [italics added] (p. 39), which insinuates that the reasons are not in fact sound. Rather they appear sound. On the other hand, Becker acknowledges that people whose behaviour is considered to be deviant are put into a position where they are “pushed” into defending their actions, as stated in the first sentence in the above quote.

What is important to note, and will be developed later, is that in this context the concepts of neutralisation, justification, and rationalisation were applied to the notion of homosexuality as a deviant behaviour. In 2012 Canada, this portrayal of homosexuality would likely be met with indignant outcry and viewed as an out-dated, socially taboo perspective. Yet, the concepts of neutralisation, justification, and rationalisation continue to be applied to the notion of drug use frequently and indiscriminately.

Despite the fact that Becker seemed to reproduce particular discourses in regard to the identification of certain activities as deviant, in the topic of research he advocated for a more neutral approach.

So it is with deviant behavior. We ought not to view it as something special, as depraved or in some magical way better than other kinds of behavior. We ought to see it simply as a kind of behavior some disapprove of and others value, studying the processes by which either or both perspectives are built up and maintained. (p. 176)
Becker’s selection of language in his analysis of marijuana use and the construction of deviance exposes certain biases and assumptions. Becker (1963) believes that all people who smoke marijuana have previously held conventional societal views with regard to drug use. However, he proposes that the person adapts a more “emancipated” view of moral standards to question the legitimacy of condemning certain activities in accordance to social convention. According to Becker (1963), neutralisation is the process whereby a person is less likely to accept the stereotype associated with an activity and adapts “an alternative view of the practice” (p. 73). Becker believes that neutralisation was necessary to the initiation, maintenance, and increase of marijuana use. He also posits that rationalisations and justifications are “acquired” according to “folklore of marihuana-using groups” (p. 74).

For the purpose of this research project, it is important to understand the findings of Becker’s work as well as to explore the tensions between his intention to be a neutral, unbiased observer and his use of language during interpretation that reveal underlying assumptions and biases. Researchers are inescapably located in particular historical and political contexts. Becker’s work continues to be influential in sociological studies of deviance. His theories have been influential in developing the labelling theory of deviance and afford a particular lens to analyse drug use as deviant. In undertaking this research project, I drew on Becker’s recommendations of attempting to understand drug use as a phenomenon that is socially situated. However, in my work I attempted to suspend an assumption that drug use is an inherently deviant activity.

1.10 Health Professional Education of Drug Use

[T]he starting point of their search to know more … is the debate of the concept. (Freire, 1970/2007, p. 123)

Kenneth Burke (1935) commented, “Every way of seeing is a way of not seeing” (as cited in Lingard, 2009, p. 625). In this way, a word is considered to reflect an aspect of a “reality,” or a concept, that simultaneously deflects other aspects of that reality (Lingard, 2009). In health professional education, drug use is often conceptualised in relation to disorders, as was depicted in Table 1. It is not the intention of this thesis to
dissuade from the place of addiction in health services, nor to question the efficacy of addiction services. It is, instead, proposed that addiction education for health professionals may be enhanced by inclusion of discourses of drug use that have been concealed, overlooked, or prohibited.

In this chapter, I presented a rationale for the need to reveal absent or hidden discourses of drug use. As Jen Severns (2004) states:

Silence is fostered by the assumption of dialogue when, in fact, the voice of the other has been appropriated into a monologue that reproduces itself and thereby maintains the version of truth by which it was created. Not only is the serviceable other silenced, but this silence itself becomes invisible. (p. 150)

In this way, silence is not assumed to indicate an absence of an alternative discourse, but an absence of the opportunity for expression of the alternative discourse.

Alternatively, when health professionals practice reflexivity and include silent voices, the potential for a transformation exists, as proposed by Paulo Freire (1970/2007):

People develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality but as a reality in process, in transformation. (p. 83)

This is a way to understand that our conceptualisations are not fixed realities, but processes; they affect our ways of being in the world. Reflexive practice is not limited to creating different ways of seeing, but as moving toward praxis, defined as action and reflection with the intention toward transformation (Freire, 2007). Indeed, reflexive work adapts “a social vision of a more humane, more fully pluralist, more just and more joyful community” (Greene, 1995, p. 61).

Addiction is constructed through discourse, and addiction is practised. The responsibility of health professionals to engage in reflective practice requires vigilant attention to the implications of conceptualisations to shape the subjective realities in which people understand and live their lives. It is important to explore how what is considered to be “normal engagement in an activity” is distinguished from the “abnormal” (Kiepek & Magalhães, 2011). Conceptually, it is possible to expand definitions of deviance to include any activity that poses potential risk, that is viewed as “excessive,” or that a person prioritises over other, more socially accepted activities.
Alternatively, it is possible to extend the view of normal to include excessive and seemingly irrational desires.

Conceptualisations of drug use that identify activities or patterns of participation as deviant have implications for how individuals are understood, how individuals are taught to act and to interpret their own experiences, and how individuals are expected to be and to continually act to improve themselves. Such conceptualisations do not assume that the experience of engaging in distinct activities is similar for each person, nor do they assume inherent commonalities between activities. The task is less about answering the question of what is addiction? Rather, the question becomes why is it that we perceive certain activities as addictions? and what or who informs this process? The intention of my research is to broaden the discourse and understanding of addiction by identifying hidden discourses embedded in individual accounts, thereby allowing us to question our assumptions. One of my intentions in writing this thesis is to reinforce the importance of creating spheres for alternative understandings about drug use specifically as it relates to health professional education.
2 Philosophical and Methodological Approaches

Sometimes I ain't so sho who's got ere a right to say when a man is crazy and when he ain't. Sometimes I think it ain't none of us pure crazy and ain't none of us pure sane until the balance of us talk him that-a-way. It's like it ain't so much what a fellow does, but it's the way the majority of folks is looking at him when he is doing it....And I reckon they ain't nothing else to do with him but what most folks say is right.

(Faulkner, 1930/1990)

In the quote above from William Faulkner’s novel, *As I Lay Dying*, a boy questions when a person “is crazy.” He concludes that everyone has the potential to be labelled as crazy, but it only occurs when “the balance of us talk him that-a-way,” which is largely related to “majority” opinion of what constitutes deviance. This perspective holds relevance to modern day medical and psychiatric diagnoses. In other words, pathology “is in the eye of the beholder” (Turner, 2008, p. 508), which is consistent with the philosophical positions of social constructionism.

2.1 Social Constructionism and Discursive Practices

In this chapter, drugs, drug use, and addiction are considered to be *social constructs*. From a social constructionist perspective, the terms “drugs” and “addiction” simultaneously *convey* and *construct* a shared understanding of a particular concept.

Social constructionism is considered to be an umbrella term (Sparkes & Smith, 2008), and I will therefore clarify how I envision social constructionism as it applies to the proposed methodology, which combines narrative and discursive methodology with discourse analysis from a critical orientation. A constructionist research of discourse requires attention to two simultaneously occurring forms of construction (Potter & Hepburn, 2008). Discourse is considered to be both *constructed* and *constructive*. These notions will be discussed in more depth in relation to addiction discourse research.

Briefly, the *constructionist* nature of discourse requires analysis of the social resources that contribute to expression, and includes words, categorisation, metaphor, and rhetoric (Potter & Hepburn, 2008). The *constructivist* aspect considers discourse to produce and “stabilize versions of the world, of actions and events, [and] of mental life” (Potter &
The concepts of drug use and addiction are intertwined and complex. Bryan Turner (2008) says, “in the everyday world, my consumption preferences may very well constitute someone else’s stigmatising addiction” (p. 508). As Turner points out, different people can evaluate a particular situation of drug use differently. Building on this idea, similar patterns of consumption can have different consequences for different people, and those consequences can also be interpreted differently. Furthermore, an individual’s perception of the potential judgements or evaluation by others will consequently impact the ways in which that person enacts and discursively practises drugs and drug use.

The six assumptions and characteristics that underlie the study of communication, including discourse, from a social constructionist perspective (Foster & Bochner, 2008) include:

1. Social relations are constituted through interaction and language;
2. There are multiple subjective realities;
3. Meaning is created and inscribed through communicative interaction;
4. Social, historical, and cultural contexts influence the production of meanings and actions;
5. Social inquiry is, itself, a form of interaction that requires reflexive awareness; and
6. “Social constructionist inquiry is necessarily moral, ethical, critical, and political inquiry” (p. 92).

These assumptions underlie the methodological design and analysis of this project.

Discourse is considered to be situated in discursive environments, or contexts, that are “characterized by distinctive ways of interpreting and representing everyday life, of speaking about who and what we are” (Gubrium & Holstein, 2003). Examples of context include educational facilities, health settings, judicial settings, and community centres. This corresponds with Foucault’s notion of governmentality, which supposes that within social contexts individuals acquire the skills and attitudes to effect “operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality”
The notion of discursive practice is fundamental to developing an understanding of how a concept — in this case drug use — is put into discourse in situated contexts with certain discourses attaining more authority or influence. The implications go beyond how a concept is thought about, to significantly affecting how people act and how they are acted upon.

Social constructionist projects describe the social construction of reality by social actors:

That is, to trace the process whereby some element of social life-meanings, institutions, identities, norms, problems, routines, and all other conceivable aspects of social reality-comes into being, emerges, take shape, becomes understandable, acquires visible and meaningful boundaries, and takes on constraining and/or facilitating characteristics. (Linders, 2008, p. 468)

A social constructionist project to address drugs and addiction encourages one to question perceived boundaries, characteristics, and the involvement of actors situated in particular contexts. In this case, the focus is on discourses that influence health professional education.

At the same time, some forms of discourse are attributed a higher degree of authority and legitimacy, while others may be concealed. For example, discourses that are located in scientific institutions are typically considered credible and often unquestioned. In a similar way, psychologists and counsellors are granted authority to (re)interpret client discourses to evaluate the proper meaning. Furthermore, the label of addiction is associated with stigma, which may deter individuals from voicing contradictory perspectives. Disclosure of engagement in drug use and personal experiences may have societal repercussions, as Foucault (1972) emphasised:

In every society the production of discourse is at once controlled, selected, organised and redistributed according to a certain number of procedures.…. In a society such as our own we all know the rules of exclusion. The most obvious and familiar of these concerns what is prohibited. We know perfectly well that we are not free to say just anything, that we cannot simply speak of anything, when we like or where we like; not just anyone, finally, may speak of just anything. (p. 216)

Two concepts presented by Mikhail Bakhtin (1981/2008) help to understand how some discourses are attributed higher status, privilege, and legitimacy. Authoritative
discourse tends to be bound by a historical development that creates a perception of legitimacy and status, including religious dogma, scientific findings, and distinguished texts (Bakhtin, 1981/2008). Bakhtin proposes that “The authoritative word demands that we acknowledge it, that we make it our own; it binds us…. It is therefore not a question of choosing it from among other possible discourses that are its equal. It is given…” (p. 342). He further suggests that a concept construed through authoritative discourse is inflexible, requiring one to either fully affirm it or fully refute it.

Internally persuasive discourse, on the other hand, is not just interpreted “as is,” but is freely and creatively applied to novel situations. Bakhtin believes that internally persuasive discourses are influenced by the discourses of others and “struggle” with one another, opening the opportunity for new ways of understanding. Internally persuasive discourse is considered to be “unfinished,” which allows it to be applied to new contexts, to develop new insights to the phenomenon, and generate new discourses. In this way, the discourses of others become embedded in our own voice, which continues to change as we continually engage in discourse.

In regard to the authoritative discourse of addictions, it has been demonstrated that addiction-as-disease is a predominant model that is supported by empirical and scientific research. However, as mentioned earlier, addictions research and theories have been informed largely in regard to individuals who were identified as having an addiction in therapeutic or criminal settings. This raises questions regarding posited truths asserted in the authoritative discourses of drug use.

This is not to suggest that the concepts of drugs and addiction are strategically manufactured within an elite structure and disseminated to the public. Rather, the discourse is produced through complex social interactions that are historically situated. The assumptions underlying the concept of addiction are contextual, fluid, and constructed through discourse. The Alcoholics Anonymous (AA) model, for example, blends multiple discourses, including scientific, spiritual, medical, and moral (Valverde, 1998). Through the AA definition of recovery, it becomes apparent that the meaning has shifted from a medical notion of cure to a chronic condition. “Recovery” means “learning to live with one’s dysfunction as peacefully as possible” (Valverde, 1998, p. 126).
As a practice of internally persuasive discourse, involvement in social organisations can influence personal accounts. Jaber Gubrium (2003) questions whose voice was heard during qualitative research interviews with pharmacists who had attended Narcotics Anonymous (NA). He asks whether the stories belonged to the individual or to the organisation that promulgated the discourse. At the same time, it was acknowledged that individuals who attend NA do not simply become “mouthpieces” for NA, but adapt it to their personal style of communication and life events (Gubrium & Holstein, 2003).

As a personal example, I once worked with a client who asked me several times if I thought she would be able meet her goal to reduce her alcohol consumption. I did not understand her reason for asking until she explained that she had attended AA for a period of time and was told the first step of AA is to admit that she is powerless over alcohol (Alcoholics Anonymous World Services Inc., 2012). She was uncomfortable with the label of “addiction,” and she wanted to believe that she was not powerless. She explained that she did not want to view “recovery” from alcohol consumption as a lifelong effort and central aspect of her life; she just wanted to stop drinking. In my opinion, these concerns demonstrate the struggles associated with the questioning of authoritative discourses that are conveyed through the rhetoric of AA philosophy. These examples demonstrate that narrative accounts about drug use provided by people who have attended addiction treatment might be influenced by institutional discourse.

Another way to understand how concepts are construed through discourse is offered using the notion of dialogism. Dialogism is used to convey that “truth is not born nor is it to be found inside the head of an individual person, it is born between people collectively searching for the truth, in the process of their dialogic interaction” (as cited in Shotter, 1995, p. 160). This means that knowledge is the result of how language is used to organise aspects of the material world (Vološinov, 1929/1973). It is further recognised that words are not isolated from other ways in which ideas are expressed, such as aesthetic practices or sacred rituals.

According to a dialogic perspective, knowledge is negotiated in dialogical interaction, rather than created within individual minds (Domenici, 2008). While dialogue
ongoingy maintains reality on one hand, it also functions to ongoingly modify it (Berger & Luckmann, 1966). Language is used to emphasise some aspects, drop others, convey “taken for granted” truths, provide legitimacy, and reinforce ideas:

What we call our thoughts are not first organised at the inner centre of our being…. Instead, they only become organised in a moment by moment, back and forth, formative or developmental process at the boundaries of our being, involving similar linguistically mediated negotiations as those we conduct in our everyday dialogues with others, where ‘the organising centre of any utterance, or any experience, is not within but outside’…. (Vološinov as cited in Shotter, 1995, p. 177)

It is important to explore what contexts and discourses influence health professional education. According to research findings, although health professionals receive little to no formal education about drug use or addiction, they are nevertheless pessimistic about treatment, not interested in working with “substance abuse” clients, and avoid working with clients who are identified to abuse substances (Bina, et al., 2008). This suggests that health professionals have formed concepts of drug use and addiction outside formal education contexts, which subsequently impact their work with clients. It is therefore essential to explore the informal discourses of drugs in relation to understanding the education and practice of health professionals. A discourse of drugs located in health professional education should not be isolated from the larger social discourses of drugs, drug use, and addiction.

In fact, Lilie Chouliaraki and Norman Fairclough (1999) emphasise that “what critical social science most needs is public spheres to both ground its critique and to put into place the open relationship between theory and social practice that it calls for” (p. 34). They acknowledge that knowledges, ways of being and ways of acting are influenced by magazines, books, and television programs. Accordingly, a brief discussion of the influence of media will be presented. Although an elaboration of this topic is out of the scope of this project, it is important to recognise that “we inhabit a secondhand world, one already mediated by cinema, television and other apparatuses” (Denzin, 2003, p. 141). In regard to the presentation of drugs and addiction, there are an increasing number of addiction-focused television series, such as “Intervention” and “Celebrity Rehab With Dr. Drew.” Addiction and rehabilitation have become a source of mass entertainment.
There can be pleasure in engaging in activities that are considered to be deviant and unacceptable; and while television programs about addiction and intervention provide a source of entertainment and pleasure, they also perform an informal educative role.

Robyn Warhol (2002) asserts that representations of drugs and drug use in English language cinema are largely unrealistic and potentially have more congruence with public policy than people’s experiences of using drugs. Cinematic representations of drugs and drug use lack realism and compassion, and tend to reinforce ideologies that perpetuate the War on Drugs. Robin Room (2004) emphasised the role of storying addiction to portray struggles and subsequent triumph. Cinematic and literature representations can have a direct impact on how individuals evaluate and understand their own and others’ experiences. It has been suggested that cinema has “offered to millions of spectators the flattering presumption of knowing more about addiction than addicts themselves”.

Media acts to reinforce the importance of closely examining a person’s actions to determine what is deviant, the identification of negative consequences that are socially unacceptable, the need for friends and family to be vigilant about requiring change, the need for self-admission about having a “problem,” and the expectation that rehabilitation requires professional, expert intervention. They also intertwine the concepts of drug use and addiction to the point that there is little distinction between the two. Using a Foucauldian analysis, it may be possible to interpret these television shows as inviting the audience through a promise of entertainment to provide instructions on how to avoid developing an addiction, how to identity people who have problems, and how to implement corrective measures.

In the following example, a man is standing outside the door of an AA meeting, attempting to interpret his own experience in relation to a movie he had watched:

How do I get into one of those A.A. meetings? What do I say? I seen them in the movies. That Michael Keaton in Clean and Sober. He went to one of them. He just stood up and said he was an alcoholic. Do I have to do that? I ain’t even sure I am one, but I drank a fifth of Black Jack last night an I started up agin this mornin’. I’m scared. (Denzin, 2003, p. 143)

When addiction is viewed as a discursive practice and it is understood that certain discourses are attributed more legitimacy while others are silenced, the “cloud of
givenness” that Maxine Greene (1995) describes becomes more visible. It is from here that reflexive practice and transformation becomes possible. It is important to note that while knowledge and action are considered to be a relational effect of institutional, social, and cultural factors, the potential for volition or change is not excluded. While no true discourse of drugs or addiction exists, these perspectives reinforce the notion that an understanding of concepts can be viewed as “unfinished” and “tentative.” The goal is to consider the ways our concepts are shaped, not to present a way of understanding that is irrefutable.

2.2 Language and Discursive Practice

The critical form of discourse analysis proposed in this research is distinct from what is known as critical discourse analysis (CDA), though it draws on many of its features and assumptions. CDA is “a type of discourse analysis that primarily studies the way social power abuse, dominance and inequality are enacted produced and resisted by text and talk in the social and political context” (Van Dijk, 2008b, p. 85). Accordingly, one focus of discourse analysis is “on the ways discourse structures enact, confirm, legitimate, reproduce, or challenge relations of power and dominance in society” (p. 86). In this thesis, the intention may be more accurately described as an analysis on the ways discourse structures enact, confirm, legitimate, reproduce, or challenge the very concept of addiction in society. Certainly, the analysis and findings may uncover issues of power, authority, legitimacy, dominance, or inequality; however, this is not the primary purpose of the research or analysis.

James Paul Gee (2011a) argues, “language-in-use is about saying, doing, and being” (p. 16). In this way, talk is a discursive practice that is located within context and associated with social groups, cultures, and institutions (Gee, 2011a). When people use language they simultaneously conform to conventions, such as grammar, and use languages in ways that are unique. Gee presents what he refers to as “building tasks” of spoken and written language. Building tasks are the ways in which “reality” is “constructed” and can, thereby, become the focus of a discourse analysis. The building tasks are used to construct significance, practices, identities, relationships, politics (the distribution of social goods), connections, sign systems, and knowledge. In this way, he
asserts, “language is always both old and new” (p. 16). Language is used not to portray meaning, but to create meaning. While each of these building tasks should be addressed in a discourse analysis, not all can feasibly be explored.

The notion of significance refers to how language is used to render certain things as more or less important. Language can also be used to construct an identity in the “here and now” and may be enacted in respect to others. Language can act to build social relationships or represent actual or desired relationships with others. In regard to politics, language can be used to attribute responsibility or blame and to create judgment of whether something is good or bad, acceptable or unacceptable. Language can be used to draw connections between various topics, or to present them as unrelated. Language is also used to give privilege or prestige to certain ways of knowing.

The decision to focus on discursive practices for this research project emerged in response to the analysis of the data. Gee (2011a) states “language has meaning only in and through social practice” (p. 12). By looking at the discursive practice, one can begin to understand the function of language as it is enacted discursively. For the purpose of this research project, a focus in discursive practices could provide an understanding of how new practices arise. While Gee says new practices are frequently variants of older practices, I would expand on this to suggest that it is not necessary that practices are “old” or “new” in regard to temporal measures of the existence of a practice. Instead, the focus may include shifts in the dominance of practices in societies or, at least, the power struggles within these practices, as Fairclough (2010) specifies:

Any instance of discursive practice can thus be interpreted in terms of its relationship to existing orders of discourse and discursive practices (is it broadly normative, reproducing them, or creative, contributing to their transformation?), as well as its relationship to existing social structures, ideologies and power relations. (p.130)

This is not to assume that the speaker is only performing a single practice within a particular interaction. In the context of the interviews, multiple practices will be explored in relation to the perceived and actual audience, as well as the particular context in which the narrative account is framed.
An integration of theoretical approaches in discourse analysis is necessary to address multidisciplinary issues of social context and linguistic aspects of text and talk (van Dijk, 2008b). Analysis of linguistic structures attends to how narratives are presented, not just what is conveyed. Analysis involves distinguishing how ideas or topics are introduced, how discourses are differentiated, sites of differentiated discourses, and the interaction between discourses. Certain linguistic features are considered to be indicative of voice, genre, register, and agency. Agency can be interpreted by attending to use of the active voice (e.g., *I drank a whole bottle of whiskey myself*) and passive voice (e.g., *I woke up to find an empty bottle*). Hedging is a technique that is understood to decrease emphasis and may indicate a source of interdiscursivity (e.g., *They say that more than three standard drinks per day is bad for you*).

Note in the previous example that choice of lexicon can inform analysis. Hypothetical use of the term “standard drink” is a formal term typically used in counselling settings in relation to the physiological effects of alcohol. Use of metaphor and rhetoric can also form components of analysis. Rhetoric is seen to enhance discourse meaning intentions, while de-emphasising interactional intentions (van Dijk, 2008a). An example of rhetoric may be seen in media reports regarding *the need to fight against addiction and crime in urban areas*. The term “fight” may be considered a metaphor for addressing social issues that are attributed to individual substance use. Awareness of prosody, particularly intonation, can also be used to indicate voice (Hill, 1995). Other non-linguistic cues include gesture, gaze, and body posture (van Dijk, 2008a).

To guide the analysis of discourse with a focus on discursive practices, the data was analysed attending primarily to the linguistic features of intertextuality and interdiscursivity, voice, speech genre and register, and decontextualisation and recontextualisation. Each of these linguistic features are described in more depth.

**Intertextuality and interdiscursivity.** Bakhtin (1981/2008) asserts:

We can go so far as to say that in real life people talk most of all about what others talk about—they transmit, recall, weigh and pass judgement on other people’s words, opinions, assertions, information; people are upset by others’ words, or agree with them, contest them, refer to them and so forth. (p. 338)
In fact, Bakhtin claims that at least half of the words in everyday conversation are the words of another. The polyphonic nature of discursive practice assumes that multiple discourses and voices are simultaneously present as personal narratives are produced (Tanggaard, 2009):

Language … lies on the borderline between oneself and the other. The word in language is half someone else’s. It becomes “one’s own” only when the speaker populates it with his own intention, his accent, when he appropriates the word, adapting it to his own semantic and expressive intention. Prior to this moment of appropriation, the word does not exist in a neutral and impersonal language … but rather it exists in other people’s mouths, in other people’s contexts, serving other people’s intentions: it is from there that one must take the word, and make it one’s own. (Bakhtin, 1981/2008, pp. 293-294)

Julia Kristiva (1998), influenced by Bakhtin’s work, coined the term “intertextuality” in regard to written text, suggesting that the “internal dimension of the text is connected to its external context” (p. 324). An author may explicitly refer to or quote another text, or may implicitly adapt ideas, forms of representation, or meaning. Western literature, for example, is thought to be largely influenced by Shakespearean and biblical texts (Gubrium & Holstein, 2009). Foucault (1972) acknowledges the influence of external texts, stating:

The frontiers of the book are never clear-cut: beyond the title, the first lines and the last full stop, beyond its internal configuration and its autonomous form, it is caught up in a system of references to other books, other texts, other sentences: it is a node within a network. (p. 23)

An example of intertextuality can be interpreted in the lyrics of It Will Rain performed by Bruno Mars (Mars, Lawrence, & Levine, 2011):

If you ever leave me, baby, Leave some morphine at my door 'Cause it would take a whole lot of medication To realize what we used to have, We don't have it anymore.

There's no religion that could save me No matter how long my knees are on the floor So keep in mind all the sacrifices I'm makin' Will keep you by my side And keep you from walkin' out the door.

There are several intertextual references that interact. Morphine is referred to as a
“medication” and the allusion to physical pain is a metaphor for intense emotional pain. He invokes the moral model of addiction that relies on faith to overcome one’s use of substances and which is consistent with the Alcoholics Anonymous steps to recovery. There is an interdiscursive relationship between medical and moral models of addiction.

The notion of intertextuality need not apply exclusively to written text Gubrium & Holstein (2009). Instead, all forms of narrative may be analysed in relation to the immediate context and external influences. Discourses can be interpreted in regard to whether they seem to be internalised or represented as public ideas; internalised discourses are portrayed as taken-for-granted assumptions, whereas public ideas may either be explicitly articulated as a social discourse, or presented as “common opinion” or a “socially accepted view” (Strauss, 2005).

Cues to identify individual assumptions give insight to which discourses have been internalised to the speaker, as well as what aspects are assumed to be a natural aspect of the social context (Strauss, 2005). Assumptions can be identified when the speaker provides evidence to support their statement. Assumptions can also be identified when two topics are discussed in relation to one another without the speaker making explicit how they are linked. Omission of details communicates that there is an assumption of shared knowledge that does not warrant elaboration. Finally, an evaluation of the situation being narrated conveys underlying assumptions, such as when a story is told in a way that is meant to convey shock or irony.

Interdiscursivity describes the combination of multiple genres and multiple discourses in spoken language (Chouliaraki & Fairclough (1999). From this perspective, “a research interview will inevitably be polyphonic – replete with the use of many voices, words, and discourses that structure the conversation” (Tanggaard, 2009, p. 1499). Therein lies the possibility for individual voices to be ascribed with autonomy and validity, though produced by a single narrator (Bakhtin, 1984).

Voice. Voice includes words, phrases, narratives, and ways of speaking that are partially unique to the speaker and partially “borrowed” from the sociocultural environment (Jones & Norris, 2005). While speakers may draw on words, intonation, and
phrases from social, cultural, and institutional contexts, they simultaneously transform them and present context-specific meaning.

Interdiscursivity, then, weaves together multiple voices (Chouliaraki & Fairclough, 1999) and can establish rhetorical ordering and flow between their different discourses:

Discourse representation does not just bring different voices together, it combines and orders them in a particular way, for instance setting up hierarchical relations between them so that one voice is used to frame another or to inflect another. And the various forms of representations (‘direct speech’, ‘indirect speech’, ‘free indirect speech’, etc.) Are resources for effecting order — for instance, while direct speech generally commits you to the words which the other actually used, indirect speech allows you to translate the words of the other into your own words. (Chouliaraki & Fairclough, 1999, p. 153)

Multiple voices can be embedded in a single narrative. In an interview with Don Gabriel (a Mexicano man in San Lorenzo Almecatla) narrating a 17-minute account of his son’s murder, at least 20 distinct voices were identified (Hill, 1995). Thirteen of these voices were identified through the reported speech of others (i.e., ‘You,’ he tells me, ‘Sir, are you the father of the young man?’ I tell him, ‘Yes.’”) (Hill, 1995, p. 106). Five types of “self-laminations,” such as “neutral narrator,” “evaluator” and “father” were distinguished. Don Gabriel used two languages, Spanish and Mexicano, in his story. Furthermore, shifting intonation (i.e., cantante or “singsong,” and desperate or “high pitch voice breaks”) “cast a shadow” on the immediate voice (p. 117).

Voice systems are “the field for dialogue and conflict, where authorial consciousness attempts to dominate and shape the text through its chosen voices” (Hill, 1995, p. 109). Strauss (2005) notes that there are several ways that conflicting ideas — and I would suggest “voices” — may be performed. First, multiple voices can be compartmentalised, such that they are presented (for the most part) as unconnected and the speaker may not be aware of the contradictions. Compartmentalised voices are likely to be expressed in contexts that are distinct from one another. Second, conflicting voices may be demonstrated in an ambivalent manner; the person may be aware of inconsistency between ideas, but the conflicting discourses are closer in temporal proximity, and the person may use more hedging devices, such as pausing, sighing, or saying “I don’t
know.” Third, the person may demonstrate integration of conflicting voices. There is a logical flow of ideas, and the speaker draws selectively on multiple discourses, intertwining and blending them in a way that maintains a consistent position even when the ideas do not agree with the perceived social opinions or norms. For instance, in a hypothetical example, a person might describe that her father was angry at finding out that she had smoked marijuana but her friends just laughed at her for getting caught. This invokes multiple voices of “father” and “friends” and implies that the person undermined her father’s opposition to drugs by framing her error as “getting caught” instead of “smoking marijuana.”

**Speech genre and register.** Speech genre and register can have implications for the social construction of a concept through language and to inform analysis of interdiscursivity in a narrative. Speech genre is “a type of text or talk, ... verbal activity or communicative event” (van Dijk, 2008a, p. 148). Speech genres include shared features of language (i.e., journalistic genres) and stratification of language (i.e., professional language):

> It is in fact not the neutral linguistic components of language being stratified and differentiated, but rather a situation in which the intentional possibilities of language are being expropriated [italics added]: these possibilities are realized in specific directions, filled with specific content, they are made concrete, particular, and are permeated with concrete value judgements; they knit together with specific objects and with the belief systems of certain genres of expression and points of view peculiar to particular professions. Within these points of view, that is, for the speakers of the language themselves, and these generic languages and professional jargons are directly intentional … the intentions permeating these languages become things, limited in their meaning and expression; they attract to, or excise from, such language a particular word — making it difficult for the word to be utilized in a directly intentional way, without any qualifications. (Bakhtin, 1981/2008, p. 289)

Genres do not tend to be comprised of features that are distinct from other genres (van Dijk, 2008a). In this way, genres are largely defined in terms of the contextual features, including the setting, participants, type of activities, and cognitive basis. A genre may also be defined according to the structure of the text or talk, such as features of turn allocation, time control, interruptions, topics permitted, and formality of style.
Registers are linguistic or grammatical *dimensions* of genre (van Dijk, 2008a). Certain grammatical features may be identified as being more frequent in certain contexts and characteristic of a particular genre. For example, formality of lexicon, verb tense, pronunciation, and sentence complexity differs from informal conversation, newspaper accounts, and board meetings. The notion of register may be comparable to the idea of *social languages* as presented by Bakhtin (Thatcher, 2006). Social languages are described as historically situated and represent social diversity through speech types that are stratified through dialect, age demographics, political slogans, and authority (Thatcher, 2006).

Register involves being able to determine, often intuitively, how to appropriately convey oneself verbally in specific settings (de Beaugrande, 1993). For example, individuals use distinct registers when they talk to their friends compared to when they talk to their doctor. One of the features for analysis is to determine the extent to which a person adapts their discourse to fit within particular situations (de Beaugrande, 1993). Register can be used to establish solidarity or dominance. An example of dominance may be to use terms and intonation that convey a sense of prestige. In a similar way, register can establish “insider” and “outsider” status. For example, people who attend Alcoholics Anonymous (AA) may greet someone by saying, “Do you know Bill?”, one of the founders of AA, to demonstrate insider status as an AA member. There are certain words and ways of talking, such as the tempo and use of slang or jargon, that can include or exclude others.

**Decontextualisation and recontextualisation.** The significance of recontextualisation emerges throughout the process of the analysis.

A critical method of discourse analysis ... can show how technologisation of discourse is received and appropriated by those who are subjected to it, through various forms of accommodation and resistance which produce hybrid combinations of existing and imposed discursive practices” (Fairclough, 2010, p. 127).

Recontextualisation is the process through which meanings are selectively transformed as language is appropriated from one field to the next, and can be differentiated through an analysis of discourse, genre, and register. “Recontextualisation of meanings is also
transformation of meanings, through decontextualisation (taking meanings out of their contexts) and recontextualising (putting meanings in new contexts)” (Fairclough, 2010, p. 76). Taking this notion one step further, it has been argued that a change in the discourse does not only change the meaning, but the object loses its previous identity and becomes something new entirely (Meyer, 2001).

As discourses gain salience and dominance in a particular field, these discourses have an influence on ways of talking, thinking, and acting (Fairclough, 2010). As a result, the meanings associated with certain concepts can form areas of contention, and there may be discursive strategies to oppose the meanings that propagate or constitute what is considered to be acceptable. Fairclough (2010) proposes:

Not only the potential for struggle within the recontextualised context to inflict or deflect the colonising effect through forms of appropriation, but also the potential for struggle over forms of appropriation between social groups pursuing different strategies with the recontextualised context, which might include for instance struggles over identity which are germaine to whether and how a new discourse is inculcated in new ways of being. (p. 77)

Accordingly, one of the questions being addressed in this research project is how the research participants conform to or oppose dominant discourse and meanings of drug use using an analysis of recontextualisation. A critical inquiry of discourse needs to attend to aspects of discursive practices where recontextualisation is evident, as well as instances when it is absent and dominant discourses are reproduced.

Each of the linguistic features described above has distinct implications for this particular research proposal. One of the questions being explored is how people talk about their engagement in drug use. Attention to intertextuality and interdiscursivity can provide insight regarding the sources that influence how a person comes to know and talk about their own engagement in an activity. Similarly, acknowledgement of social genres and social languages can provide indication of the contexts and institutions that influence the construction of knowledge. For example, it may be possible to distinguish “counselling talk,” “popular culture,” and sociocultural factors in a narrative account.
A critical analysis that is intended to identify multiple discourses in a narrative account is an interpretive endeavour because no pre-existing list of social discourses from which to base a comparative analysis exists. Chouliaraki & Fairclough’s (1999) example of a critical discourse analysis distinguishes five discourses in a section of the narrative accounts, including: official (policemen), life world (cop, hoods), literary (perpetrators), feminist (a huge, strong man), and political opposition (uniformed + thugs/hoods) (p. 57). This “hybridity of discourses” was further analysed in terms of a form of interaction that was mediated by the way the discourses were presented, demonstrating not only how types of discourses are interpreted, but also the implications for how the construction of knowledge and achievement of action are interpreted.

Another challenge of a discourse analysis is the identification of intertextual, or interdiscursive, features. In a research paper, for example, authors are responsible for clearly indicating the sources that contribute to their thinking about a particular topic. This is not so in everyday discursive events. As noted by Bakhtin (1981/2008) it is possible that a person may explicitly use phrases such as “she said,” “people say,” “it is said,” “everyone says,” or “I heard” to explicitly identify a source of text or talk. Frequently identification of interdiscursive features requires an interpretative analysis that attends to fluctuation between linguistic features, such as lexicon, grammar, voice, and genre.

2.3 Recontextualisation and Flipping the Script

In this section I propose that there are conceptual similarities between recontextualisation and “flipping the script.” Recontextualisation is a term used in the academic field of discourse analysis while flipping the script is a colloquial term that has connections to “urban culture.” By applying script flipping as an analytic tool, it may be possible to draw on a concept that has been identified by the cultural group who is the focus of the research and interpretation.

E. Summerson Carr (2011), while conducting an ethnographic research project at an American addictions treatment centre, observed that clients are expected to learn to talk about certain topics in certain ways. She problematises the belief that words provide
access to *inner truths*, a commonly held assumption that forms the basis of typical counselling approaches. Therefore, she suggests that, regardless of a person’s beliefs or actions, they learn to present themselves as the “proper” type of client who uses the proper words, which affords them access to resources such as shelter and food. She termed this process “flipping the script.” In some cases it seems that the scripts become internally persuasive, while in other situations the person is able to say the “right” words while continuing practices that are contrary to what they say. For example, a person might be able to describe how they developed “insight” to the need to commit to the process of recovery, yet in practice continue to use cocaine on a daily basis.

Flipping the script was acknowledged to occur in funding proposals, committee meetings, and policy development. In order to increase the internal persuasiveness of proposed changes to practice or requests for funding, a rationale was developed drawing on scripts that held authority despite inherent philosophical contradictions. It was proposed that “script flipping” entails the “trumping of a rhetorical component” that involves responding with a critical awareness of power relations in the setting. It was also proposed that script flipping involved an aspect of “volitional reframing of identity” (Carr, 2011, p. 220).

Carr’s (2011) use of the definition of flipping the script demonstrates, at its core, the concept of recontextualisation. She recognises that “people can act politically by strategically reproducing — rather than simply resisting — ideologies of language” (p. 19), but uses the term to mean two separate acts. First, she notes that people produce forms of talk that make it more likely that they will access certain resources and services. For example, during a previous interview, Nikki (a research participant) had explained her life was recently “transformed” by a man she was romantically involved with who, also a recovering alcoholic, encouraged her to seek treatment for drug use. Nikki later laughed and stated, “Girl, don’t you know, I flipped a script on you?!” (p. 18). Carr (2011) realised that when Nikki was on probation from an addiction program, she formulated a narrative account that could influence re-entry into the program, obtain social services, and prevent her children from being removed from her care. After Nikki’s acceptance to the program was terminated, she constructed a narrative with an intention
to achieve different ends. In this way, it can be seen that the person speaking recognised the type of talk that was expected in order to achieve a particular outcome, which meant purposefully fabricating an entire narrative account.

Carr (2011) also discussed the term “flipping the script” to portray the manner in which events or circumstances are not fabricated, but certain terms are adopted and integrated in order to achieve a desired outcome. Again, she presents this idea in multiple ways. For example, she describes a board meeting where certain terms and constructs were adopted into the program description that contrasted the values espoused by the organisation. By integrating certain terms and ideas into the program description, it is more likely that the organisation will receive funding from the government agencies. She also describes this in regard to some the recipients of the therapeutic interventions:

Flipping the script was a matter of perfectly reproducing therapeutic scripts, in both their generic form and textual context, with one big exception — script flippers did not match their spoken words to their inner signifiers (i.e. their thoughts, feelings and intentions). (p. 191)

Flipping a script was not a reflection of a person’s own beliefs, but “an acute, highly attuned know-how … of how one’s words aligned with the desires, intentions, and motivations of those who listened” (p. 193).

Carr’s work is significant in that it brings to the forefront the notion that people do many things with words, not just reflect their own opinions, beliefs, and thoughts. Learning to talk about personal drug use in a certain way is often perceived as evidence that the person has learned new ways of thinking and is interpreted as therapeutic progress. As a result, the person may be rewarded with positive reinforcement in therapeutic contexts, may be awarded custody of their children, and may be found to satisfy court-mandated counselling. Alternatively, a person who does not consistently conform their talk toward therapeutic expectations may be labelled as “difficult,” “manipulative,” “precontemplative,” “in denial,” and “non-compliant,” to name a few.
The term “flip the script” gained its use in reference to freestyle rap or hip hop music (Robert, Bell, & Murphy, 2008). The discursive practice of flipping a script is to “appropriate and modify an ‘old’ or historical concept to produce something new” (Robert, et al., 2008, p. 337). To also consider the colloquial use of the phrase, I turned to the Urban Dictionary (2012). The Urban Dictionary is an online collaborative website where contemporary meanings of urban discourse is defined and discussed. The top three entries were:

1. “To do the unexpected. To deviate from the norm.”
2. “Commonly used in rap battles, it means to take what somebody said against you and to use it against them.”
3. “[T]o gain control in a dialogue that is being dominated by another person so that you are now in charge.”

It is important to note that the ways in which flipping the script can be enacted may vary depending on the context. The occurrence of script flipping is particularly telling because it bears to question what it is about “the nature of the social and institutional relations that require the acquisition and maintenance of practices like flipping the script” (Carr, 2011, p. 223).

I assert that the urban culture meanings of “flipping the script” are closely related to the meanings associated with recontextualisation. Both are discursive practices used to appropriate the words and concepts of a dominant discourse and strategically transform the meanings and associated ways of being, acting, and thinking. Carr’s work sets the foundation for the data analysis that is presented in this thesis. The context of her research was a formal addiction treatment centre in the United States, which is much different from the context of this thesis involving Canadian participants who do not identify a reason or need to attend counselling, and who rely very little, if at all, on the supplemental social services. Nevertheless, there is a common thread of negotiating discursive practices of personal drug use among multiple dominant societal discourses.

Adam Mansbach (2001) holds a Masters Degree in Fine Arts and is the founding editor of the hip hop journal, “Elementary.” In the lyrics to his song, “notes from under sound,” he uses hip hop to reflectively express the discursive practices embedded within
hip hop as an expressive form. He demonstrates the idea that people who perceive themselves to be in social positions that hold less respect or authority make explicit attempts to dominate discourses through discursive means of recontextualisation. In these lyrics, Mansbach starts by indicating that there is a “schism” (or a gap) in relating between people in the hip hop culture and the “nons” (p. 66) or, in other words, those located in the non-hip hop culture, particularly in formal bureaucratic contexts. People in the hip hop culture are not expected to be the group that conforms to general society. In response, Mansbach says, hip hop acts by “recontextualizing” language (p. 67), “cross-pollinating ideas,” (p. 67) and it “recycles everything” (p. 69). It means holding your ground, even in the presence of your “idols” (p. 69). Hip hop is constantly progressing, and can gain the upper hand given the slow pace of everyday “talk” (p. 69). Hip hop is a discursive practice that breaks free of “any & all attempts to define[,] explain [and] categorize” (p. 69). It is a way to “talk over” (p. 69) authoritative discourse, rather than an attempt to “talk to” (p. 69). Hip hop gives voice to all who choose to engage in it, hoping for, but not expecting, an enlightened truth. At the same time, because hip hop is viewed as an insular, isolated community that a mainstream audience may make little effort to understand, there is an awareness of a political action, such that “the devil listens in” (p. 71). The voices expressed in hip hop are heard and are recognised to have potential influence within authoritative and dominant discourses.

Recontextualisation potentially contributes to understanding the discursive practices of people or groups who perceive themselves to be positioned outside what is considered to be socially acceptable. It can act as an alternative to feeling silenced, which will be discussed in the next section.

2.4 Silence and Silencing

The ways in which a person presents him or herself to others — through action and words — are influenced by the context and the need to perform successfully in society. Achievement of social status, respect, legitimacy, access to resources, and maintaining convivial relationships with others often requires one to be able to assess the “proper” ways of talking, acting, and thinking, and to be able to portray oneself in a way that will be viewed as appropriate by others.
In general, there is an attempt to present an “idealized impression” of oneself, which is achieved by “accentuating certain facts and concealing others” (Goffman, 1959, p. 65). However, if a person is discredited in one aspect of their life, such as being found to conceal a particular activity, the implications can extend to other aspects of his life as well (Goffman, 1959). It is therefore important for an individual, or even social networks, to attenuate against disclosure of information that would discredit or disrupt the impressions that are intentionally conveyed. Tact, actually, plays a role, such that the outside observer may act in an uninterested, uninvolved, unperceiving manner as a form of social etiquette (Goffman, 1959).

To maintain harmony, interpersonal interactions additionally involve particular implicit codes of conduct that limit or constrain forms of confrontation or disagreement:

Each participant is expected to suppress his immediate heartfelt feelings, conveying a view of the situation which he feels the others will be able to find at least temporarily acceptable. The maintenance of this surface agreement, this veneer of consensus, is facilitated by each participant concealing his own wants behind statements which assert values to which everyone present feels obliged to give lip service. (Goffman, 1959, p. 9)

The form of consensus that is established will differ between contexts and depends on who is present.

Nevertheless, a person who feels an obligation to act a particular way in public may feel a sense of shame or guilt when their beliefs do not correspond. This may be experienced as a sense of isolation or alienation of self that is in response to a contextual circumstance, rather than an individual fault. Erving Goffman in 1959 gave as example the tension that some women felt to “act dumb” as a way to attract men.

The notion of silencing builds on this. Silencing can be viewed as an active and socially constructed practice “arising from and producing acts that make it easier for certain entities (individuals or groups) to speak and be heard in their preferred form while at the same time making it more difficult for others” (Thiesmeyer, 2003, p. 3). Silencing occurs in response to social and political evaluations regarding what is considered acceptable and unacceptable, and can by performed through discursive practices by limiting, removing, or undermining the legitimacy of another person’s use of language.
It is important to realise that silencing does not produce “silence;” rather, other discourses are used in replacement (Thiesmeyer, 2003). Silencing “seeks to assimilate, filter and replace the unwanted discourse rather than erasing discourse altogether” (Thiesmeyer, 2003, p. 13). There are simultaneous practices of silencing and censoring unwanted discourses, while acceptable discourses and sources of knowledge and dissemination are identified and reproduced (Thiesmeyer, 2003). Foucault (1978/1990) drew attention to the presence of discourses of resistance and silent discourses, affirming that through analysis of the contradictions and tensions evident in social and individualised language, the meaning of a concept begins to take shape.

This perspective on silencing can reinforce the importance of performing a critical analysis on discourse to uncover hidden aspects of narrative accounts. Analysis goes beyond attending to what is said, shifting to how it is expressed and the purposes it serves.

2.5 Language as a Political Practice

Language and the way it is used affect how a concept becomes known, what is considered worth knowing, and subsequently how people act. This principle can be extended to not just how concepts are constructed, but also how one’s self is presented and enacted in interpersonal contexts. “The writer is a ‘subject in process’/sujet en procès, a carnival, a polyphony, forever contradictory and rebellious” (Kristeva, 1998, p. 324). Steinar Kvale and Svend Brinkman (2009) suggested, “the social world is developed through contradictions, discursively, and materially” (p. 227). These perspectives also demonstrate that discourse can inherently affect the potential for change and transformation.

Susan Philips (2000) expounds on the power of language” to create reality. First, she suggests the structure of a language is seen to contribute to a culturally distinctive worldview. Second, the social construction of reality may occur through discourse in face-to-face interaction. Third, she describes how social historical processes both shape
and are shaped by language. In an unequal distribution of control over the production of discourse, members of powerful social groups and institutions have “more or less exclusive access to, and control over, one or more types of public discourse” (van Dijk, 2008b, p. 90). These members include, for example, professors, doctors, journalists, lawyers, and politicians (Philips, 2000; van Dijk, 2008b). The unitary meanings and definitions produced by authoritative groups appear to be grounded in reality and reason, which functions to mask arbitrary divisions (Bourdieu, 1982/1991). Discourse can also construct reality when particular texts become embedded in performance and reproduced in cultural and ideological practices (Philips, 2000).

Language is not a system of fixed norms, but takes on new and concrete meanings in a given context and illustrates “a ceaseless flow of becoming” (p.66). The linguistic form employed by a speaker is not a “stable and always self-equivalent signal”; rather “it is an always changeable and adaptable sign” (Vološinov, 1929/1973, p. 68). Furthermore, “we never say or see the words, we see and hear what is true or false, good or bad, important or unimportant, pleasant or unpleasant, and so on” (Vološinov, 1929/1973, p. 70). In this way, one can consider that language is continually “becoming” in terms of how it is used. However, it is also “becoming” in the sense that it constructs social concepts, and is used to influence or produce knowledge, ways of being, and ways of acting. In considering language as a “ceaseless flow of becoming,” social constructionism can be viewed as a perpetually “unfinished” process.

Discourse can be both reproductive and transformative (Chouliaraki & Fairclough, 1999), perhaps particularly in regard to issues that contradict predominant social values, beliefs, or stigmas. This form of analysis corresponds with Kvale & Brinkman’s (2009) definition of discourse analysis:

Language is used to create, maintain, and destroy different social bonds, and is in line with the postmodern perspective on the human world as socially and linguistically constructed…. It shares with pragmatism an emphasis on the primacy of doing, of practice, of actions performed in the here and now. (p. 226)

The complex processes of social constructionism require the researcher to consider the ways in which knowledge and concepts are socially constructed and how the socially constructed nature of language influences how those concepts are talked about or
communicated in the research context. Bakhtin’s work places emphasis on the social factors that contribute to language production, including the importance of recognising that concepts are constituted within social dialogic interactions. Recognising that the research interview forms a context of interaction will have important implications for the performance of analysis. In the remainder of this paper, a methodology and analysis will be developed to explore discourses of addiction.

The role of critical theoretical practice is “to unpick the relations which constitute social practices and so identify the mechanisms which produce antagonisms and struggles, also making explicit its own position in these struggles” (Chouliaraki & Fairclough, 1999, p. 27). Critical social science is furthermore marked by an interest in emancipatory knowledge. Critical social inquiry is not intended to identify appropriate alternative practices, but is to identify possibility for change, including different ways of understanding and different ways of acting (Chouliaraki & Fairclough, 1999). Critical constructionist inquiry invites possibilities, recognises its own constructionist potential, and questions what is proposed as “known” or what is “best” for another (Hosking, 2008).

2.6 Discursive Narrative Methodology

In this section I outline a methodology that combines narrative and discursive methodologies. Narrative and discursive constructionism share common processes. Ontologically, both narrative and discursive constructionism view knowledge, ways of being, and action as constituted relationally, interactively, and through discourse. Andrew Sparkes and Brett Smith (2008) say we are “active, socially constructed beings who live and lead storied lives” (p. 296) and “live in story-shaped worlds” (p. 295).

Epistemologically, narratives and discourse are the means through which social reality is constructed through language. The individual is both the site and subject of discursive practice, such that language both constructs knowledge and provides access to subjective and situated experiences (Richardson & St. Pierre, 2005). Narratives act to constitute subjective realities and to guide social action (Sparkes & Smith, 2008). There are multiple, often contradictory discourses that influence a person and contribute to a shifting and contradictory subjectivity (Richardson & St. Pierre, 2005). In this way,
subjectivity is not viewed as stable, fixed, or rigid.

Narrative methodology that draws on features of the discursive interview for elicitation of discourse was implemented for this research. The narratives elicited in this research were designed to elicit personal accounts of drug use and permit extended discussion with minimal directedness from the interviewer. Narrative accounts are, themselves, discursive practices (Chase, 2005; Marvasti, 2008; Sparkes & Smith, 2008). From one perspective, the process of narration constitutes an interaction in which the concept is constructed (Sparkes & Smith, 2008). At the same time, interviewees are expected to adapt their use of language to the cognitive and sociocultural context of the interview (van Dijk, 2008a). The narratives elicited for this research project were obtained in an interview setting by a female PhD student using electronic recording equipment; the subsequent analysis and findings have the potential for being published and read by others. These are just some of the factors that may have an effect on the discourse produced in the interview context.

Three assumptions were significant to the selection of a narrative methodology. First, it was assumed that there is not a unitary, fixed, authentic self because a human subject is “never a whole, is always riven with partial drives, social discourses that frame available modes of experience, ways of being that are contradictory and reflect the shifting allegiances of power as they play across the body and the mind” (as cited in Kvale & Brinkman, 2009, p. 225). This perspective questions the potential for narrative methodology to distinguish a particular meaning, and requires a non-unitary perspective of identity. “Human subjects are not just integrated through narratives, but also fragmented” (Kvale & Brinkman, 2009, p. 225).

Second, narratives were not considered to be temporally or historically bound by a particular event, or even by a particular person. Using a discursive approach permits a form of narrative that exceeds boundaries of temporality, individual, narrator, and audience. A person’s own narrative account can be influenced by events that occurred historically, and might contain an awareness of potential future implications resulting from their discursive practices. The narrative practice of speakers has been recognised to extend beyond being “overtly ‘about’ some ‘content,’ such as what happened when,
where, and to whom, but ... they somehow make public the covert underlying presumptions that organize the worlds in which the speakers live” (Hill, 2005). Accordingly, attempting to determine the narrator’s own viewpoint should not be the intended purpose of interview (Tanggaard, 2009). The central analytical unit is not a bounded and static self but rather the diverse discursive repertories spoken by persons within particular social settings; that is interviewing provides a context for “revealing how language ‘makes’ people and produces social life” (Tanggaard, 2009, p. 1513).

Drawing on Bakhtin’s work, Tanggaard explained that a research interview is essentially polyphonic, such that multiple voices, words, and discourses are embedded in the dialogue. Furthermore, in an interview context, the interviewer is not the only audience influencing what is said. The narrator was expected to produce accounts that are addressed to external audiences, anticipated readers of the research, and to themselves. “The question of audience is always relevant to intertextuality” (Fairclough, 1992, p. 208).

Third, narratives are “socially situated interactive performances ... produced in this particular setting, for this particular audience, for these particular purposes ... [to] explain, entertain, inform, defend, complain, and confirm or challenge the status quo” (Chase, 2005, p. 657). The story that is told is flexible, variable, and the narrative account is shaped as a product of the interaction. One aspect of the analysis includes the processes of narrative production and processes of interpretation within the discursive interaction of the interview.

Interviews neither provide access to information nor describe a person’s experience; rather, experience and meaning are rendered through a narrative account using language, and the telling of a narrative account is viewed as a performance (Parker, 2005). The production of narrative accounts is an actively creative process through which the narrator produces a version of self, reality, and experience (Chase, 2005). Accordingly, the purpose of narrative research is to analyse how “selves” are constructed through narrative practice, how personal experience is made sense of in discourse, and how meaning is communicated (Chase, 2005).
For the purpose of this research, narrative methodology is implemented in a way that can reveal multiple discourses of drugs and drug use embedded in an individual account. One of the assumptions is that the concept of *addiction* may be refuted, refused, and negated. In the interview context I explicitly attempt to avoid a “therapeutic” style of interaction, professional jargon, and interpretation.

Analysis of addiction discourse is also challenging when one considers that society portrays the predominant discourses of addiction as a truth, and individuals subsequently learn to interpret their actions according to these truths. An analysis of individual narratives of addiction, therefore, must include a form of analysis that recognises and accounts for the influence of public narratives of addiction, as they are represented formally in medicine and law practices, and informally in media, family, and businesses.

This approach to narrative methodology diverges somewhat from the purpose of the narrative research proposed by other researchers who describe fully formed narratives as including an abstract, orientation, complicating action, resolution, and coda (a perspective that returns to the present) (Riessman, 1993). “Narratives provide an important means of access to the interiority of individuals’ personal experiences, selves, and identities independent of our theories” (Sparkes & Smith, 2008, p. 298). Narrative methodology has also been implemented in an attempt to “see how respondents in interviews impose order in the flow of experience to make sense of events and actions in their lives” (Riessman, 1993). In this way, narrative accounts are a context where retrospective meaning-making can be organised and conveyed (Chase, 2005).

The discursive narrative methodology applied in this research project distinctly shifts away from a focus on *meaning* or access to *experience*. This is not to refute the potential for narrative methodology to provide access to this form of knowledge, but rather to shift the focus of analysis for this particular project. Using a discursive narrative methodology alters both the way in which the interview is conducted and the focus of analysis. The focal point shifts to *how* languages or discourses are used to effect or convey a perceived meaning; though this does not mean that analysis of meaning and experience are completely absent. Meaning and experience, in this way, are viewed as
constructed, relational, processes, rather than as individual, subjective phenomenon.

An important feature of narrative methodology is the elicitation of narrative accounts. Some researchers may request “a story with a beginning, a middle and how things will look in the future” (Riessman, 1993). Sometimes the research participant is presented with a storyboard, which outlines typical topics that may be relevant to the development of a story (Riessman, 1993). However, these strategies may, perhaps unintentionally, shape or limit the form of discourse or content provided by the research participant. Primary considerations for this research project include facilitating narrative accounts that are as fluid as possible, with as few interjections from the researcher as possible. The researcher was expected to refrain from using words that convey values, judgements, interpretations, and professional jargon. The discussion was not restrained by temporal boundaries or boundaries of individual experience or knowledge.

Ian Parker (2005) suggests that an interview based on the theoretical work of Bakhtin may incorporate a dialogical, carnivalesque flavour open to resistance. It is also proposed that interviewees may be asked to explicitly identify the sources of their ideas and to openly acknowledge contradictions embedded in utterances (Kvale & Brinkman, 2009; Parker, 2005). In discursive research interactions, it is important to attend to variation in responses, techniques should invite diversity, and interviewers are considered to be active participants (as cited in Kvale & Brinkman, 2009, p. 156).

In order to facilitate opportunity for inconsistency and contradiction to emerge, the interview must be sufficiently long and there should not be a perception of feeling rushed (Strauss, 2005). Questions need to elicit a variety of discourse, including narratives and opinions. The interview should engender a stream of consciousness style that progresses under the direction of the interviewee. Finally, in order to provide a context for the interviewee to disclose emotional topics, the interviewer needs to present herself as friendly and nonjudgemental.
2.7 Study Design

**Participant recruitment.** Ethics approval was received from the University of Western Ontario. (See Ethics Approval, Appendix 1, p. 203). The initial plan was to recruit 12–15 research participants in Ontario and Manitoba by placing advertisements in municipal newspapers in selected Southern Ontario cities to provide access to a large number of participants across a small geographical region, but this proved too costly. Instead, the advertisements were conducted through Kijiji, a free web-based classified site. Kijiji was determined to provide a viable access to participants because it is a forum where some Canadians acquire and distribute drugs, and there is also a classified section for volunteering for research projects. The geographical area for recruitment was expanded to Northern Ontario and Winnipeg, Manitoba for convenience in relation to the interviewer’s place of residence. Recruitment was also conducted through informant sampling and by poster advertisement at the University of Western Ontario. (See Recruitment Letter, Appendix 2, p. 206).

On the Kijiji website, it was possible to ascertain that the poster received hundreds of visits over a period of four weeks. Overall, 11 people responded to the call for participants. One person was not interviewed due to scheduling difficulties, one contacted me after recruitment ended, and three others did not follow up after being provided with the information letter.

Recruitment was based on self-report of meeting the inclusion criteria.

Inclusion Criteria:
- The person engages in the use of a psychoactive substance (i.e. opioid, hallucinogen) on an approximately daily frequency.
- The person is 18 years of age or older.

Exclusion Criteria:
- The person has attended addiction counselling.
- The person has attended a 12-step self-help group.
- The person has received a clinical assessment for substance use.
If an excessive number prospective participants were interested, a selection process was expected to be implemented that would consider variety in age, gender, types of substances used, and community location. However, no selection process was necessary.

Occasionally the research team faced questions about what constituted “recreational substance use,” which was a term used on the recruitment letter, or what constituted addictions counselling (e.g., attending a methadone program). It was decided that if the person responded to the poster, they had subjectively determined that they satisfied the criteria, which would be sufficient. Furthermore, the purpose of the study was to better understand how people who used drugs, approximately daily, spoke about drugs. The classification of the drugs as “recreational” was essentially incidental; it was a marketing strategy to attract a target audience rather than a research variable. Peers who were known to drink alcohol or do drugs on a regular basis reviewed the advertising poster and provided feedback for revisions. Through this process, the term “recreational” was recommended. In addition, a sentence was omitted which stated that many people who use drugs might feel stigmatised and not able to talk openly about their drug use. One peer said that the sentence was somewhat offensive since it pre-assumed how he was expected to feel about his substance use. The poster used the term “substance use” instead of “drug use.” One of the reasons was that during conversations with people who used certain “substances” I found that different terms were used. For me, this became most apparent during a trip to Cusco, Peru, where I met many people who considered certain “substances” to act as “spiritual guides.” I believed that to neglect the spiritual aspect of substance use and to assume that people who use psychoactive substances conceptual that substance as a “drug” would inadvertently exclude a segment of the population who could contribute to understandings about drugs and drug use.

**Sample size.** Due to the large amount of data collected within each interview, it was decided to stop recruiting after the sixth interview. This research project was designed to be part of a doctoral study; therefore, duration for data collection and analysis was necessarily constrained. This study was intended to uncover concealed discourses of addiction and to locate these discourses within social contexts that inform health
professional education. As such, this study is more likely to benefit from depth of narrative interviews facilitated by a strong interview rapport than by a breadth of number of participants. Furthermore, the form of discourse analysis required multiple readings and collaboration with the members of the doctoral committee. Twelve to fifteen participants were expected to be the upper limit to allow for integrity of data analysis, but it became apparent that six interviews were more feasible. Six participants provided sufficient diversity of gender, location of residence, type of substance, age, and culture.

Data collection consisted of narrative accounts collected through a qualitative interview process. A narrative methodology with discursive interviewing strategies was implemented. It was expected that research participants would partake in narrative interviews of 60–120 minutes, potentially followed by one or two narrative interviews of 30–60 minutes. Instead, one interview was conducted per participant because each interview provided large amounts of data. The length of interviews varied from 90–300 minutes. Interviews ended naturally or in relation to another deadline (e.g., a personal obligation or expired availability of the meeting room).

Interviews were generally conducted in private meeting rooms in public locations, such as a library. The research participants signed a consent form. (See Blank Consent Form, Appendix 3, p. 207). The narrative interviews were audiotaped using a digital recorder. (See Semi-Structured Interview Guide, Appendix 4, p. 210). This research was designed with an attempt to stand somewhat apart from assumptions and models that typically inform health professional education in regard to working with clients who use drugs. Therefore, the interview intentionally excluded questions that would be typical of a health-related addiction assessment, such as history of use (age of first use, frequency of use, amount used) and history of origin (family members’ history of drug and alcohol use). The interviewer also refrained from using a therapeutic style of interviewing that is focussed on reinforcing suggestions of ambivalence and directing the interviewee toward increased commitment toward decreasing their drug use. In other words, the interviewer attempted to remain neutral and not direct the conversation toward an evaluation of what was being said.
The opening narrative invitation tended to be a variant of “What brought you here today?” This statement acknowledged that the research participant responded to the research recruitment for reasons that may not be known to the researcher and opens the possibility to discuss the topic of substance use from multiple points of reference. To facilitate ongoing narration, the interviewer smiled, laughed, nodded, and used vocalisations like “mm,” “hm,” or “mmhm.” To obtain clarification or to explore a topic in more depth, the interviewer typically reiterated what was said, incorporating the words actually used by the research participant, and asked as a follow up question. This strategy was intended to limit interpretation and redirection, while providing a means to facilitate in-depth narration.

The researcher also requested clarification by checking interpretations of what the person said, and giving opportunities for correction. Parker’s (2005) useful examples of prompts to facilitate dialogue — such as, “How would you describe that to someone who knew nothing about it?” and “Can you go through that again, giving some examples/different examples?” — were also used. With a focus on interdiscursivity, the researcher explored these particular aspects in more depth. For example, the participant was asked about how he or she had spoken or would speak about this subject to another person, such as a friend, a child, or a health professional. The participants were also asked who they would like to read their interview. These strategies were used to develop insight to the invisible audiences that may have shaped the discourse produced.

Transcription. Gail Jefferson’s (2004) detailed form of transcription provided the basis for a transcription method to enable the critical analysis of the discourse. Parker (2005) recommended including an indication of who is speaking, emphasis, interruption and overlap, unintelligible portions, and relevant observations or descriptions of occurrences. Discourse consists not just of words, but pauses, interruptions, and non-lexical expressions such as “Mm hm” (Mishler, 1986). For example, the phrase “you know” can be used to achieve and manage shared knowledge (Potter & Hepburn, 2008). Furthermore, transcription methods were selected to ensure the accessibility, or readability, of the transcription.
Confidentiality. Audio recordings were stored electronically and labelled according to the order of the interview (e.g., Interview #1). In terms of utilization of the data gathered, any information that could make participants identifiable (personal life trajectory, particular events or places, a combination of characteristics) was omitted or changed to protect their identity. The descriptions of the participants were made in a collective form, and the socio-demographic characteristics of a participant were not linked to her/his narrative.

In order to protect participants’ identity all the information about them was listed in a coded manner and destroyed as soon as it has been processed into the research data system.
Protection of confidentiality:

- The data was coded using pseudonyms and kept separate from the master list of research participants;
- The master list was kept in hardcopy (a paper copy) in a locked filing cabinet at the interviewer’s domain; and
- The interviews were maintained as electronic audio files and stored as encrypted transcribed copies on a portable laptop that required a password for access.

Any files with personal identifiers (e.g., audio digital recording) were destroyed immediately following the completion of the study data analysis. Other anonymous data will be kept for a maximum of 5 years on CDR in a locked cabinet at the University of Western Ontario.
Chapter 3

3 Analysis

The analysis is organised into three sections. In Section 1 the notions of “hiding” and “disclosing” are distinguished, and discursive practices explored. Section 2 focuses on the ways in which individuals negotiate how to talk about drugs depending on the perceived context. Section 3 presents interpretations regarding how the research participants discuss the integration of drugs into their lives, and how drug use is framed in relation to social acceptability.

3.1 Introducing the Research Participants

As was mentioned, the research participants responded to the call for participants which stated: “This study will provide an opportunity for individuals who use one or more substances or drugs on a regular basis (approximately daily), to confidentially discuss their own experiences and ideas about substance use.” The term “recreational” was used once in the call for participants, but this was not in any way defined or evaluated as an inclusion criteria. As will be seen in the following introductions to the research participants, there were many individual differences in drug use, including types of drugs used and circumstances related to the drugs use. Please note that the names of the research participants have been changed, as well as all the names of people mentioned during the interviews.

Paul. I met Paul in a public library. He was a 21-year-old, wearing a designer jacket and ball cap. He set up his computer and requested that I turn off my cell phone. He later expressed surprise that I pulled out a low-tech, silver-flip cell phone that I borrowed from my mother, expecting instead that a Canadian doctoral student would holster a modern, high-tech touch-screen smart phone. Yet, Paul also defied the preconceived ideas I might have had about someone who self-identified as a key member of a Canadian illicit drug organisation. He took steps to ensure his anonymity, noting that he had colleagues in the library for protection, and threw in bits and pieces of information that he had attained about me, such as where I live, where I’ve travelled, and even what
year I graduated as an occupational therapist; certainly all the details readily accessible on the Internet, yet nevertheless acting as a warning. Paul entered the study as a person who uses Ritalin, for which he has a prescription. The prescription assured a legality to its use. However, he noted that Ritalin is essentially “legalised meth.” Paul spoke very little about his own drug use, focussing more of the discussion on his role in the “organisation.”

**Joshua.** I met Joshua at a university meeting room. He was a 25-year-old who planned to graduate from a health professional Masters degree within the next few months. He stated that he saw the interview as an opportunity to “reflect on” his “habit” of smoking marijuana “chronically,” or in other words, on a daily basis. He was in a relationship and his girlfriend had been asking for a specific date for when he would quit smoking marijuana. He was looking ahead to a career as a registered health professional and expressed concern that smoking marijuana did not coexist with societal notions of what it means to be a “professional.”

**Haylei.** Haylei was a vivacious 30-year-old woman who spoke with a melodic New Zealand lilt. She said she could not imagine not being able to smoke marijuana daily. She smoked cigarettes and drank alcohol occasionally. She entertained with stories about childhood experiences of becoming aware of her father smoking marijuana and the prevalence of marijuana in the community where she grew up. She regaled with stories about past experiences of trying a multitude of other drugs, including over-the-counter caffeine pills to a “glop of something” from a cousin who was selling drugs and had a freezer like a “Hunter S. Thompson suitcase.”

**Jenna.** Jenna was a 34-year-old woman who owned a holistic wellness business. She was in a long-term relationship and they had a young daughter. Before signing the consent form, she asked for clarification that Child and Family Services would not be informed of her participation in the study. She smoked marijuana daily and quit for a period of time when she was pregnant. She found that marijuana helped her to “be in this world,” as well as to be “calm” and not “judge” others as much. Marijuana helped her “hear the heartbeat of the Earth,” and to better appreciate the beauty in nature.
**Sean.** Sean was a 35-year-old man who owned his own business and worked from home. He was married, with two young sons. He described that he smoked marijuana daily, and found it “helps motivate” him to be stimulated with certain tasks at work. It also helps him to appreciate certain activities more, such as watching a movie or going for a bike ride with his son, and to alleviate boredom during mundane tasks like household chores and working out. He occasionally drank alcohol and used MDMA (3,4-methylenedioxymethamphetamine – the active ingredient in ecstasy) and, more infrequently, did cocaine and “mushrooms.” He described the ways that his use of drugs had changed over time and was highly context dependent; “a time and a place thing.”

**Sharon.** Sharon was a 51-year-old woman who had three adult daughters and seven grandchildren. She requested that the interview take place in her home since she felt more comfortable in her home than in public settings. As I entered the house she immediately offered me iced tea and showed me the piles of prescription medications she had lined up in anticipation for the rest of the day, including morphine. She also reported smoking marijuana daily. For years at a time when she was younger she used cocaine and acid. She also “cooked” and sold crack for a period of time. She spoke hurriedly and rocked constantly in a rocking chair, clicking a pen, and became emotional several times, proclaiming, “I’m broken.”
3.2 Section 1: Disclosing and Hiding

In this section the notion of “hiding” is distinguished from “disclosing” drug use. On one hand, the belief that hiding drug use is a sign of a problem has become a rhetorical device in addictions discourse, as demonstrated by this online news release:

If the pattern of [drug] abuse continues, they eventually become trapped in a vicious cycle of using drugs, hiding the fact, lying about using and even stealing to support more drug use. At each turn, the addict is committing more dishonest acts and with each act is creating more damage in their life and relationships… (Smith, 2009, para. 5)

Lying and hiding drug use are categorised to be the same as stealing, evoking the image of an internal drive to do something that is morally wrong in order to satisfy intrinsically motivated desires to engage in drug use.

Yet, because “deviant activity is activity that is likely to be punished if it comes to light, it tends to be kept hidden and not exhibited or bragged about to outsiders” (Becker, 1963, p. 168). Therefore, there seem to be contradictions as to whether people who use drugs “hide” their drug use because it is a “symptom” of addiction, or a reflection of defective morality, or because they are attempting to avoid a form of “punishment.”

This section is divided into four parts. The first part includes an analysis between the ways in which the term “hiding” are used to convey concealment and disclosure, depending on the intended meaning and context of the use of the word hiding. Practices of “non-disclosure” are discussed in the second part. Non-disclosure is intended to reflect the idea that people may not explicitly hide their drug use, but at the same time, they may not explicitly or indiscriminately disclose their drug use, or even disclose their opinions in regard to drugs. As Joshua put it, “How can everyone know and no one know? Well, that’s because no one talks about it.” The idea of “discovery” is explored in the third part. Within the complex practices of non-disclosure and if no one “talks about it,” how do people come to know that other people do or have done drugs? Finally, in contrast to hiding, the notions and value of “openness” and honesty are interpreted in the fourth part.

Hiding—distinguishing between concealment and disclosure. The first part of this analysis addresses the apparent contradictions in the narrative accounts whereby the
research participants speak about *not hiding* their drug use, but at the same time convey not openly disclosing their drug use. The tensions between these seemingly conflicting positions are explored. In particular, the hidden aspect of drug use is discussed in relation to concealment and non-disclosure. Several means of discovery of the drug use of others are presented. Finally, the notion of openness is described.

The research participants frequently discussed the hidden nature of personal drug use during interviews, even without prompting (i.e., being asked who they could talk to about their drug use). Hiding drug use requires actively “not disclosing” personal drug use verbally, not being seen to do drugs, and not being identified as high. On the surface, it seems that some research participants express contradictions between their assertions about “not hiding” their drug use and their actions to not disclose personal drug use.

Joshua and Sean in particular demonstrate this apparent contradiction. Joshua explains that he considers being honest and not hiding what he does from others to be one of his intrinsic “traits.” Later in the interview he describes not only having to “hide” his drug use, but draws on the image of Osama bin Laden to clarify how he feels positioned socially. He states, “Cause that’s why I have to hide it, that’s why I have to feel like I’m Osama, bin Laden with my like, uh:m: my weed habit.” A perceived conflict exists between Joshua’s espoused identity and his perception of the dominant beliefs and norms in Canadian society. By drawing parallels between smoking marijuana and Osama bin Laden, Joshua conveys that his need to hide his drug use is driven by his perception that he would be portrayed as an evil person by a dominant, powerful group, and also that he would be actively pursued and hunted. Additionally, he conveys an inherent expectation that a majority of the population would revel in his demise or passively accept whatever punishment is bestowed upon him. This image captures a deep-seated, embodied experience of distinguishing between right and wrong, and good and evil.

Hiding drug use is viewed as undesirable. Joshua indicates that hiding his drug use is comparable to having to hide a part of his personality: “And that’s part of like-, that pretty well my personality? Is like I do:n’t, I try not to hide anything. From anyone. Like honesty’s really the best policy.” Similarly, Sean describes that he does not want to “feel” as though he is “hiding” his drug use, and that having to hide drug use could be a sign that
he is doing something he should not be doing:

Sean: But yeah. I don’t wanna do a drug and then like, you know feel like I’m hiding it or anything like that like. If I- you know then that would- to me that would be a sign that maybe I, I shouldn’t be.; it’s not a good thing

Later in the interview, Sean relates his experience to the main character in the television series, “Breaking Bad,” and describes sometimes feeling as though he has a secret “second life.”

Sean: (describing the main character in the television series Breaking Bad) Yeah, and you know he’s always very torn. You know because he’s got, you know he’s got this whole, second life that he’s gotta.; keep, keep hidden and, keep ah, secret to himself, so. Yeah, there’s certainly a.; a- a level of connection there? But ah:.

Niki: The, the hidden life? Kinda part?

Sean: Yeah. The hidden aspect of it like.

What initially appear to be contradictions within Joshua’s and Sean’s narrative accounts can be interpreted as consistency that shares common ground. Both Joshua and Sean voice intrinsic values of not wanting to hide aspects of themselves. Sean draws on a dominant discourse that presumes hiding a belief or action publically is a “sign” that it is wrong.

This is distinct from how Joshua and Sean convey their perceived realities of “having” to hide drug use. They apply linguistic strategies to indicate that the need to hide is not based on an intrinsic desire, but in response to extrinsic factors. They use a more passive form of the verb to hide, incorporating terms such as “have to” and “gotta,” and avoid progressive linguistic features. The “hidden” aspect is more in relation to the situated position of drug use in society rather than a trait or choice of the person. The conflict between the intrinsic value to be honest and extrinsic forces that require one to hide may cause the person to feel discomfort, guilt, or frustration. Guilt and evasion are not rooted in the act of doing drugs or a personal belief that his or her actions are wrong, but in response to a perception that drug use is judged to be wrong by others.

There also seems to be a distinction in lexical meaning between hiding as concealment and hiding as disclosure. Concealment of drug use from certain people in the person’s life is sometimes interpreted as indicating a problem. Sharon’s statement
portrays this point when she explains that several years ago her partner had quit doing drugs and she continued despite her promise to the contrary, explaining: “And I- of course I buy my wee:d, and hi:de it. ‘N oh, you know when you gotta hi:de things from your family it’s like, it’s crazy.” In this example, Sharon’s statement differs from Joshua and Sean; she seems to believe her need to hide the fact that she was doing drugs is active concealment of something she “shouldn’t” be doing. In this case, it seemed that her partner quit doing drugs and expected the same from her.

Sharon also describes hiding her marijuana when she was younger, living in her parents’ home.

Sharon: like my mom, would walk in my room and she’d go, “Do you have pot in here,” I’d go “Uhhh.” [shaking head, no] And you know, or- but- we had a trailer in between the house an’, so I tied a, a bag, with a shoestring and I’d put it in the long grass and I’d shut the window.

Niki: Ah:

Sharon: So, it wouldn’t smell, in the house. So, she never, you know after that it was like okay I’m not, I know you can smell it. So … and I never told anybody I stashed it there. Not even my friends because my friends woulda went and stole it. They would’ve. They were all, into pot ‘n.

Sharon indicates that she actively concealed the location of her drugs to prevent her mother from smelling it, and subsequently got in trouble; and she concealed the location of her drugs from her friends, who she believed would steal it. In these ways, Sharon portrays hiding as an evaluation of the potential consequences and as an active decision to conceal her actions from others.

Hiding as not disclosing drug use is a passive approach and seems to be more of an undesired social obligation. It is not necessarily based on the person’s belief that the drug or their use of the drug is “bad;” rather, it is the recognition that it is “socially unacceptable” to other people. As Joshua states above that he “has” to hide his use and is made to “feel” as though he’s a despised criminal.

Joshua demonstrates the negotiated position of balancing between the idea of hiding and disclosing. He explains,

Joshua: Uh:m, I don’t know how many people do: smoke it, uh:, or know I smoke it chronically? I don’t- I don’t advertise it, but I don’t- ‘n like I said I don’t hide it. ‘N as I said either, so.
Joshua distinguishes in this quote that he doesn’t “hide” his drug use, but he also does not “advertise” it. In this way, the act of not openly disclosing personal drug use is not viewed to be the same as hiding it. The significance of the distinction will be explored throughout the remainder of this section of the analysis.

**Verbal practices of non-disclosure.** Several discursive practices are portrayed regarding the disclosure of drug use. Research participants indicate a caution regarding disclosure of personal drug use and the drug use of others. There is an awareness of potential consequences of disclosure of particular drugs to particular audiences. Practices of non-disclosure can be interpreted from a broader social perspective whereby another person’s drug use may not be directly acknowledged or discussed by others.

Sean: yeah I wanted to, smoke a bowl ‘n y’know smoke some pot at some point and I was, I was really close to asking [my dad] if he mi:nded or even if he wanted to: …And ah, but I never did and I kinda, you know and I’m, I’m probably glad that I, that I didn’t, you know just say it right out to him

Niki: Sure.

Sean: because then it’s out on the table and then [laughing voice] now we gotta talk about it. You know whereas I was glad I just sort of like left it to the side.

There is a shared assumption between the research participants that the majority of Canadians have tried drugs. However, it is assumed that many people may not disclose their drug use due to associated stigma regarding drugs and drug use. Jenna provides an example of this opinion in the following quote:

Jenna: ‘Cause I’v- I’ve learned over the years, that, more people than not. Smoke pot. Whether or not they want to say, it out loud, because of whatever um, you know, bad connotation that goes with it? They don’t, you know not a lot of people share, that, you know they might be a pothead.

Jenna indicates that “saying out loud” one smokes pot can be perceived as equivalent to declaring oneself to be a “pothead.” Each of the research participants has different beliefs about the meaning of the term “pothead” and whether it does or does not apply to them. Nevertheless, Jenna raises the issue that knowing a person smokes marijuana daily brings up assumptions and connotations depending largely on the other person’s judgments.
It is generally assumed that on a daily basis people are expected to present themselves in the non-drug-using role unless they find out, through typically indirect means, that the other person uses drugs or is accepting of other people using drugs. Jenna points out that drug use is a private issue and not disclosed openly in public: “Yeah, like I don’t, m-make it public news to new people that I meet unless, [inhales] you know there’s an opening for it. Um, I guess it’s more like one of those private things that people, you know.”

Haylei describes informal situations when knowledge of another person’s drug use was acquired.

Haylei: [2] U:m. [3] You just kinda [laughs] \figure it out.\ Like,
Niki: Yeah?
Haylei: Say you’re at th: the bar: out on the deck. It helps if you’re a smoker because you know what it smells like, and it. You smell it. And you look and “oh it’s those people,” and, um, or you hear people, you know you’re over at someone’s house and someone’s talking about, ice fishing with these people ‘n. They were smoking or whatever. So you just sort of, \figure it out. Or you’re over at a friend’s smoking and someone shows up. And like, “oh they do too,” like.

As Haylei describes it, there are certain contexts where one might feel more open to use drugs and, in this way, public disclosure is demonstrated or enacted within certain boundaries.

Caution toward verbal disclosure of personal drug use extends to not disclosing other people’s use as well. In a way, verbal disclosure of drug use can be considered a protected discursive activity. Joshua asserts that other people, particularly his classmates, are unlikely to talk about the fact that he smokes marijuana because it would implicate them as well. He states “like I- I know people that smoke are never gonna say anything, because if they- they don’t wanna be: associated with it too, right? People don’t wanna talk about it.... No one, is open.”

Haylei, on the other hand, portrays the implicit restrictions regarding verbal disclosure of another person’s drug use as “social etiquette.”

Haylei: Well, and it’s not something that I want to like openly discuss in public? Like I don’t need everyone know:ing? But the people that know: know? [2] And it’s like [2] [breathy] \I don’t know it’s just, [1] it’s just sort of

Haylei: [laughs]
Niki: Unwritten,
Haylei: Yeah.
Niki: Social,
Haylei: It’s just sort of like the social etiquette of [laughing] smoking weed.

In the quote above, Joshua sheds light on an important issue. One contradiction that seems to come up in the interviews is the conflict between assertions that the majority of people have done drugs and an overarching belief that others view drug use as socially unacceptable. In a way, the perpetual non-disclosure of personal drug use and the drug use of others may limit the presence of discourses that counter the dominant assumptions about drugs.

Belief in the need to suppress disclosure about drug use can become deeply embedded in a person’s discursive practices. Joshua notes during the interview that it was difficult for him to talk candidly about drugs because it is unfamiliar to be in a setting where one can talk openly and without risk. It can also be hard to put aside thoughts of potential negative outcomes associated with disclosure of drug use.

Joshua: There’s a certain nervousness. Even, even- I know you’re not ah:mm, like I have a certain nervousness around you without me- about, well even about your own, interpretation of me as a person too. Right? That’s why I’m- I’m having a little word finding problems too. It’s not, like, you know what I mean. I have a little, heightened level of anxiety right now. Just, talking about it. ‘Cause it’s not something you can talk about to people. You can’t be open like this [quietly] most of the time. Right?

Joshua elaborates on the difficulty of openly talking about personal drug use in regard to the context of the interview.

Joshua: it’s hard to talk about this, like you know what I mean. It’s, I [chuckling] even peop- like my friends. I told a couple of people I was doing this. It was like “Are you sure it’s not a set up.” You know what I mean. It’s like, I n- I never thought it was a set-up, but like, for a second though I [chuckles] Wh-what is it? What if it is a set-up? [laughing voice] I just picture my world crumbling around me. [laughs] Oh. I’ll my-, I’ll just walk into the room with all my teachers, waiting.

Looking back at the news release stating that people who use drugs will “lie” or
hide their use, it becomes evident that this may not be a question of morality, but rather a need to avoid the experience of negative consequences that might be associated with other people learning that someone uses drugs. Joshua’s account of imagining his “world crumbling around him” might not be far-fetched. As a student in a Masters level health professional program who will be seeking employment, it is possible that he could encounter barriers and difficulties if it became public knowledge that he smokes marijuana every day.

Paul was in a unique position because he is affiliated with an organisation that is involved in national and international illicit drug distribution. He implies that there are many people at all levels of society who do drugs. I clarified with him this position.

Niki: So, what’s your thought? Because, there are a lot of people who do drugs right?
Paul: Absolute.
Niki: All different variety of drugs,
Paul: Absolutely.
Niki: ah most people, don’t tell one another [chuckles] that they’re doing it.
Paul: Of course not.

The questions I posed were intuited by Paul to be rhetorical and to not require further elaboration. In addition, the lexical selection of affirmations were definitive terms, such as “absolutely” and “of course not.” When he is asked his opinion about why, if there are so many people who do drugs, people do not talk about it, Paul notes “[2] the problem is, it’s so taboo.” This includes the selling of drugs, as well as the use of drugs. He explains, “And, it’s pretty much what I’m doing is, everything that I’m doing, is, it’s shunned by today’s society.”

Discursive practices of non-disclosure may furthermore be taught and learned. Jenna talks about her friends who taught their son to not disclose his parent’s drug use in public settings. At the same time, this teaching was done in a way that protected the child from having to lie. While the child was able to truthfully use the word “smoke,” the fact of drug use remained undisclosed.

Jenna: And, so they just always explained it to him that, and he’s now eight and he knows all about it. You know and like yeah “mommy and daddy like to, have, a joint once in a while” and he knows to not say that in front of other people. Like he just says “a smoke.” So it could be any
kind of smoke, right? But, i- they educated him very early on, that it’s not socially acceptable. You can’t, just say to like your teacher at school, like yeah, mommy and daddy like to smoke drugs. Like, you know. Or marijuana, or a joint or something like that.

The preceding example displays an interplay between telling the truth and working within the boundaries of what is considered socially acceptable. Haylei, in her example, provides a somewhat truthful account in terms of discursive content, but alters linguistic style and prosody to maintain a sense of telling the truth. She holds onto a notion that she is being “open” and “honest,” but in a way that continues to restrict knowledge of her drug use to others.

Haylei: like I have told my parents, but probably in a way that they never got it? Because they’d be like, “What did you do on Saturday?” [growly] \"Well I did five hits of acid.\" [1] And they’d be like, “Oh yeah right.” [chuckling] [1] So it was like \Well, I told- just\ told you. I did acid."

Niki: [laughs] I’m totally honest about this.
Haylei: Yeah, I’m being totally honest with ya. [1] You’re choosing not to believe me. [chuckles]

Haylei makes a point that there may be a different “stigma” attached to different types of drugs. Therefore, a person might disclose one type of drug use, but not another.

Haylei: yeah I don’t think there’s such a stigma. Whereas like I haven’t told my parents that I’ve like, done acid. Or I’ve done mushrooms. Or like that’s none of their business. But, that I smoke pot, they don’t, [1] it’s not the end of the world.

Similarly, although Sean’s wife is aware that he smokes marijuana, he does not disclose the extent of his drug use to his wife. In regard to cocaine, he states:

Sean: and, I keep that a little bit quiet from her and, you know. She knows it, to a degree; and, you know she used to, you know, be around us all the time when we would do it, and, stuff like that.

Similarly in regard to MDMA, he says, “But now, you know I don’t do it that often and, you know in- in my mind I think she just sort of politely: you know turns a blind eye to it and.” In this account, it is unclear whether Sean’s wife is aware that he uses MDMA and “turns a blind eye” or if, through non-disclosure, she does not know.

The extent of non-disclosure of drug use is determined in relation to the speaker’s perception of the audience. For example, drug use is often not disclosed to health
professionals or to people who work in law enforcement. Haylei recounts a story about talking to a police officer at a social gathering.

Haylei: I was, like, hammered. S- or like not high at all. But I started bugging him, and I was like, you know, like “What do you think about this crime, and what do you think about this crime? And I was like, “What do you think about coke?” And he’s like, “oh,” I’d’n, “it’s bad stuff!” And I was like “what do you think about Turkish hashish?” He’s like “Oh capital offense you’re goin’ to jail.” [laughing] And then that was the point, I’m in my head I’m like, “shut, up.” Like, “He knows, he knows.” You know like, [2] just walk away.

There are also certain circumstances when it is recognised that drug use would be viewed as less acceptable, even among people who use drugs. Jenna resumed smoking marijuana during her pregnancy on a weekly basis.

Jenna: And the midwives didn’t know that I was smoking pot. [laughs]
Niki: [laughs] You didn’t want them to know.
Jenna: [laughing] No. Nobody knew but me.
Niki: [laughs]
Jenna: Well and [Kyle]. He knew. [laughs]

Sean mentions several times in the interview that he has not openly discussed his drug use with his parents, though there were several times when he contemplated doing so.

Niki: [1] And your- your parents know?
Sean: Y-
Niki: Like your family?
Sean: Good question. [touches lips; looks away from interviewer for most of the discussion relating to his parents] Ah:: [1] [speaking slowly] I would think, that they know. [chuckles] I would think that they don’t know, to the degree: or to the regularity that I smoke pot. Ah:m. [1] Yeah like, the amount of-, yeah, it’s hard to say.\ Yeah I- I’ve, I’ve kept it from them.

While on one hand there is a protective approach to assume that the other person does not do drugs or is opposed to drug use, there is also a constant evaluation of the expected response of the audience.

Practices of “non-disclosure” were also viewed to occur on a larger societal level, such as in relation to news coverage. Sharon describes an incident when she heard on a radio station that a man in her local community had been charged with cocaine
possession. She contrasts the fact that his name was not mentioned in the local paper, while her name had been mentioned when she had faced drug-related charges. She attributes the difference in news coverage to the social status and financial resources of the individuals in question.

Sharon: But they didn’t say it on [the local radio station] did they. No no no.
Niki: O:h.
Sharon: No no, [Curtis Lambert]’s name never came up. My name was in the paper. If I got caught with a line [of cocaine] I’d be in jail right now. I would be. But because, people have money, and are willing to donate, [higher pitch] “I’ll donate, ten grand to this and I’ll never do it again sir. Please keep my name,” they get away with it.

The research participants give examples that can be interpreted as complicit perpetuation of non-disclosure. In this way, people do not ask about drug use and do not acknowledge indications of drug use. Haylei gives an example of how the observer sometimes acts to reinforce the hidden nature of another person’s drug use. By not “putting it on the table,” it can remain “hidden.” Haylei describes growing up:

Haylei: [1] I don’t know it was, [1] it wasn’t, like in our face but it wasn’t really hidden either? So it was like my parents don’t smoke, but there’s like packages of zigzags [brand name of rolling paper] everywhere? [chuckling] \And then, you like, find weed, and just [softer] \put it\ back and pretend you don’t see it,

This portrayal is consistent with Goffman’s (1959) description of tact as social etiquette that perpetuates silence about a phenomenon.

Sean also gives an example of a time when it was quite likely that his mother would have noticed that he had been smoking marijuana. He looked for a sign that would indicate to him she noticed, such as a knowing, perhaps conspiratorial “smile.” She gave no indication of noticing, which continued to restrict any open discussion. Sean seemed to seek affirmation that his mother accepted of his drug use, looking for a smile rather than the alternative option of a “scowl.” Not acknowledging the drug use with approval could be interpreted as a signal of disapproval; and rather than instigating a disagreement, both parties left the knowledge of drug use unspoken.

Sean: And I remember, once, this past summer. I had ah [chuckles] \I was out in the car just,\ doing some running around like, shopping. And I’d smoked in my car. And I just [chuckling] wasn’t thinking. [chuckles] \And then my mo:m, was waiting for me like. In the driveway. They-
they’d got there a bit before me.\[laughing\]

Niki: \[laughing\]

Sean: And I just for some reason hadn’t [chuckles] hadn’t thought about the fact that, “Shit. I’m, just smoking pot. In my car. I’m gonna stink. Like”

Niki: Right.

Sean: “pot. And now I’ve gotta give my mom a hug. Like, [chuckles] right away.” She never said anything but I, I find it hard to believe that she wouldn’t know. [laughs] She wouldn’t have noticed the smell. But she didn’t, she didn’t, ah crack a smile or, you know, anything. She didn’t

[unintelligible]

Niki: She didn’t give you any hints.

Sean: [speaking loudly] Any- any indication of whether or not she knew or not so, who knows. Maybe she did ‘n I don’ know. But. You know. Yeah.

Similarly, Sean notes that his colleague is aware that he has used drugs. However, he prefers that the knowledge is not in the foreground of attention in their working relationship.

Sean: You know it- it is what it is. But that being said yeah I wouldn’t like, you know remind him or broadcast it and

Niki: Oh sure.

Sean: And we work together so I don’t need him, thinking about “oh yeah, [Sean] smokes pot you know, possibly every day so,” [chuckles]

Niki: [laughs]

Sean: [laughing voice] “therefore he’s high sometimes when he’s working.”

Niki: [laughing]

Sean: You know that kinda thing so.

Niki: He might not very cool with that?

Sean: Yeah he might not think it’s, might not think it’s too cool.

**Discovery.** In circumstances where drug use is not openly disclosed, discovery of someone else’s drug use generally occurs in circumspect ways. There are several ways that the research participants describe the “discovery” that other people use drugs. Knowledge about who uses drugs seems to be frequently discovered by being in settings where drugs are being used. By being in a setting where drug use is determined to be accepted and acceptable, shared enactment of drug use is possible. At other times, the knowledge of drug use is an accidental discovery, such as through a casual comment, finding pictures, or coming across drugs or drug paraphernalia. However, discovering that someone likely uses drugs does not invariably lead to being able to talk about drugs, and not talking about drugs is perpetuated.
Occasionally—but not commonly—there is open, verbal disclosure. Jenna describes that it is important for her to know another person’s perspective on drugs before discussing it openly.

Jenna: [inhales] a couple weeks ago I was over at friend’s house … and, so [Lynn] is asking us these questions like, you know, ah:, you know “where do you think you’re gonna be in five years” and “if you were gonna be arrested, what would you be arrested for” and you know it’s just stuff like that and so she’s asking these questions and she’s like “what’s your guiltiest pleasure.” So, I’m thinking, “pot.”

Niki: [laughs]
Jenna: But I’m not gonna say it. Like I know [Lynn] smokes pot but I don’t know about this other girl right?

Niki: [laughs]
Jenna: [laughing voice] So I’m not gonna say it. [laughs]
Niki: [laughs]
Jenna: [laughing voice] So I’m like “Ok. Chocolate ice cream.”
Niki: [laughs] Chocolate ice.
Jenna: [laughing voice] Or ice cream in general. [laughs] And uh,”
Niki: [laugh together]
Jenna: And then, uh:, [Lynn] says, like, this- you know “coffee.” ‘Cause she’s like off coffee now. And then the other girl goes, [high pitch, soft] “uh:, Pot. With a little bit of tobacco inside.” [laughing voice] And we’re all like [loudly] “Ah! I love it! The same!”

Niki: [laughs]
Jenna: You know like [loudly] “thank you for opening the door for us.”
‘Cause we’re all like [deeper voice] “I’m not saying it.”

…

Niki: [laughs] But no one wants to be the first to say it.

Jenna makes clear in this story that there is a risk in disclosing personal drug use if you do not know the other person or his or her opinions about drugs. However, awareness of the perspective or practices of the other person “opens the door” to more open discussion and personal disclosure.

Interestingly, it seems that many of the research participants “know” whether or not their parents had used drugs, though in many cases they had never had a direct conversation about it. Their parents, or friends of the parents, may have alluded to past experiences, but there was often not open conversation.
Niki: So you, you know that there’s stories that your *mom* had, had to have smoked at one point.

Haylei: [whispering] \Ye:s.\n
Niki: Yeah?

Haylei: But I don’t know, really, like she just makes comments, like she was a hippy, [2] and like she’s, [1] we don’t really talk about it. [4] But, like I know she has.

Sean seems to have some knowledge about the fact that his dad has smoked marijuana in the past and even an idea of his dad’s past experience. However, the knowledge seems to be based on a vague impression, as he uses the words “what I get from it” to indicate this assumption on his part. In this example, he discusses a situation when he and his dad were drinking together and Sean contemplated asking his dad if he would mind whether he smoked marijuana or to even join in.

Sean: And he *doesn’t* really any more, and it’s just never really been his thing, is kinda the per-, you know, kinda what I get from it.

Niki: Yuh.

Sean: You know, just kinda, used to make him tired and stuff like that and I:, that’s a common thing for a lot of people who smoke pot. And ah, *but* I never *did* and I kinda, you know and I’m, I’m probably *glad* that I, that I didn’t, you know just say it right *out* to him.

Niki: *Sure.*

Sean: *because* then it’s out on the table and then [laughing voice] now we gotta talk about it.

Children are taught from a young age that drugs are “bad,” which contributes to children not being able to talk about them, particularly to authority figures such as parents.

Since drug use is largely concealed, familiarity with drugs often occurs accidently. Haylei tells a story of how she accidently came to realise not only that her parents smoked marijuana, but also that other people knew about it. This realisation came as a shock to her as a child.

Haylei: my mom was breastfeeding [my brother, Kieran]. And she asked me to go get her a pair of *socks*. ‘Cause we were going to like the big, community barbeque after the [laughing] *possum hunt.*…a big community, get together. But I went- and I, think I went, in my dad’s drawer, and there was a bag of weed in there. And I, ca- went back and my mom’s like “where’s the socks?” I’m like oh- I think I went back and got the socks and she’s like “what’s wrong? Tell me, what’s wrong?” I was like [crying/laughing voice] “I found *weed!*”  

She’s laughing. And she’s like [firm, calm voice] “What?” [higher pitched, panicky voice] “I think I found weed!” And she’s like [laughing] [firm, calm voice] “Go-.” She’s like “Go get what you found. Go bring it to me.” So I bring it to her and she’s like [firm, calm voice] “Yes that’s weed.” And I’m like [higher pitched, panicky voice] “You’re going to go to jail!” And I was like hysterically crying and she’s like [firm, calm voice] “We’re not gonna go to jail.” She’s like “Wh- what do you want to do.” And I’m [higher pitched, panicky voice] “we have to get rid of it.” And so c- I remember I climbed up- it was like a mission ‘cause I didn’t want to drop the bag. And I climbed up on top of the [chuckles] dog house, to like dump it over the fence?

In this story, Haylei relays that she was terrified her parents might go to jail, as she had learned in school. However, the biggest shock was that her mother was able to talk openly with a friend about the incident, revealing a hidden network of discursive openness that included laughter and not fear.

Sean recounts a different experience when his father realised that Sean had drugs with him.

Sean: well couple of years ago; a bag of pot fell out of my ah, fell out of my pants’ pocket [touches right pants pocket]. When I was in the boat fishing with my dad and, and my son [Bryce], and my aunt. And my dad saw it and, you know he looked kinda disappointed.

Niki: Yeah?

Sean: Yeah. Yeah he was like, you know he was jus’ like, “I am so surprised” or something like that. And he was just

Niki: Ah-

Sean: you know, kind of. An’, and I was surprised that he was surprised, to be honest like,

Niki: Huh.

Sean: that was. Y- i- i- th- the way it kinda happened was ah, afterwar- you know. As he saw it, and ah, I was putting it away and [whispering voice] ah, he’s like “oh I’m- I’m\so surprised” or, “shocked,” or something like that. An’ I, I was honest. I’m like “Really?” like, [chuckling – almost sarcastically] “you’re that surprised?” like.

[chuckles] You know “I’ve kept it a secret?” because I didn’t think that I’m that s-. You know I wasn’t going over the top to be sneaky about i;
you know, for the last 10 or 15 years like, just because I wouldn’t talk about it like, you know I’d go to [a high school friend]’s house and smoke pot for two hours and then go home like.

Sean: [chuckling] ‘Surely,’ ‘Surely’ they could figure that out ‘r. But I guess maybe, maybe they, didn’t obviously. Because it was, to some degree a surprise or. Whether or not he was just, trying to not notice it or, anything like that.

In this story, Sean’s father expresses disappointment and Sean is not sure if the disappointment is because he smokes marijuana, or because he is carrying marijuana in the presence of his son. Regardless, his father’s expression of disappointment does not open an opportunity for further discussion. Sean seems opposed to the idea that he may have been hiding his drug use, and holds his parents somewhat responsible for not knowing by not attending to the signs and not asking about it.

In a way, it can be seen that, discursively, drugs and drug use are frequently silenced. It is not only hidden discursively through non-disclosure, but it is also in many contexts a discursive taboo. This idea aligns with Foucault’s (1978/1990) description of censorship as an enactment of power by:

affirming that such a thing is not permitted, preventing it from being said, denying that it exists. Forms that are difficult to reconcile. But it is here that one imagines a sort of logical sequence that characterizes censorship mechanisms: it links the inexistent, the illicit, and the inexpressible in such a way that each is at the same time the principle effect of the others: one must not talk about what is forbidden until it is annulled in reality; what is inexistent has no right to show itself, even in the order of speech where its inexistence is declared; and that which one must keep silent about is banished from reality as the thing that is tabooed above all else. (p. 84)

**Openness and honesty.** The research participants value being open about their drug use, but seem to struggle with a perception that open disclosure would frequently not be received well by the audience. Openness is portrayed as a possible means of contributing to individual and social well-being. The term, “openness,” seems to mean being able to disclose personal drug use. Discussions about openness and honesty are embedded in complex discursive acts that involve interdiscursivity.

Sean expresses feeling bad and dishonest when his father noticed the marijuana that was in Sean’s pocket.
Sean: You know you never; you never feel good when you, sort of catch your parents off guard.
Niki: [laughs]
Sean: [laughing voice] \or even let them down a little bit right? So:
Niki: [laughs] Ye:s.
Sean: You know and I probably felt ev- you know maybe even a little bit more bad because, that I hadn’t been honest with them. You know it just feels like you, you know I’d be more comfortable if I could just, be honest with them and, you know talk to them. Like [eye wide open, eyebrows raised] my mom drinks wine [deeper voice] every day, like you know why can’t, you know and there have been times when it’s been, you know we’ve had, you know several drinks together, and, where I just wanted to mention it and just, you know. Didn’t. And you know glad that I didn’t. You know. But in the same sense, you know [chuckling] \I wanna be myself\ and, and be honest about, you know sort of what’s on my mind and stuff, so.

Initially, Sean separates the fact that he felt bad about the incident related to drugs by assuming the passive voice and attributing it to more general circumstances such as “catching your parents off guard” and “letting them down even a little bit.” He then narrows his feeling of guilt to not having been “honest with them.” He modulates the idea of “not being honest” with the terms “probably,” “you know,” and “maybe,” which indicates the topic is controversial; he also uses the term “you know” frequently when indicating that he wishes he could be more honest with his parents, which can be interpreted as a strategy to indicate a common opinion with the listener (Strauss, 2005).

Sean draws on a seemingly typical position of comparing marijuana to alcohol when he voices a hypothetical argument toward his mother. His words, “why can’t,” imply that he was questioning her apparent position against smoking marijuana every day although she drank alcohol every day. Sean indicates that he has frequently wanted to disclose his drug use to his parents. During situations when they were having a few drinks together, not only were his inhibitions reduced slightly, but this also provided a parallel activity — drinking alcohol — as a relatable context. While he is glad that he did not disclose his drug use to his parents, non-disclosure creates a separation where he is not able to be “myself” and be honest about “what’s on my mind.”

Most of the research participants express a desire to speak more openly about their own drug use. Honesty about one’s own decisions, thoughts, and actions — as described
above by Sean — is intertwined with self-identity or a part of “who I am.” Honesty is portrayed as important, aligned with being able to genuinely be himself or herself.

Jenna: Well, I just you know for me I feel like honesty is the best policy and even though it may be uncomfortable. To be honest sometime and to be truthful about something it really is the best thing, because, you know then everyone knows where they stand. You know you’re not lying, you’re not faking it with someone and you’re not real.

Jenna portrays honesty as a necessary element for creating real connections with people. For her, not being honest is akin to lying. She also admits that being honest can be “uncomfortable.” Sean alludes to this when he discusses being “too open” with friends who do not smoke marijuana.

Sean: So I’m a really open book. [laughs] Obviously. And ah, and I might be a little bit, [exhales] [quieter] I don’t know, yeah I, I might be a little bit too open with my, pot smoking habits. You know for people who, you know who are friends but, you know, who don’t smoke pot. But I’m still very open about it. Because it just feels like, at least then I’m being open and honest. If I’m being, [unintelligible] I call it, like kinda, wearing my emotions on my sleeve or- you know just being a very open person. And then if you’re always just being open and honest, [exhales] then, I don’t know I just think it’s the proper, sorta approach to take, as compared to, sometimes bending this or, you know hiding my own, my real self. [gestures with right hand toward heart]. In certain ways. You know just- just being myself and if being myself means, that I like to smoke some pot, you know while I’m playing some cards with buddies, you know, yeah I’ll, smoke some pot. Like I’m not gonna,

Niki: Right.

Sean: it’s not gonna hide it from you, it’s one thing, that I don’t like. The idea of like, you know doing a drug, ‘n you know I sample other drugs here and there but, nothing really too ah, too serious. But yeah. I don’t wanna do a drug and then like, you know feel like I’m hiding it or anything like that like. If I- you know then that would- to me that would be a sign that maybe I, I shouldn’t be; its not a good thing. And yeah if I’m comfortable with it and, I’m okay with that decision. So.

In this quote, Sean says being open about his drug use and not hiding it is “being myself,” and “wearing my emotions on my sleeve.” He draws on the belief mentioned earlier that “hiding” drug use is the “sign” of a problem. Yet, Sean seems to question his openness about drug use with friends, as he says in the final lines of this quote, “And yeah if I’m comfortable with it and, I’m okay with that decision. So.” This statement seems to
indicate that if he is comfortable with his own drug use, he is “okay” with his decision to use in front of friends who might feel uncomfortable about it. The idea of “hiding” drugs in this section seems to be in relation to other drugs that he “samples.” He seems to see drugs on a hierarchy with “serious” drugs being more problematic.

The commonality between the two sections might be interpreted as Sean evaluating the impact of his own disclosure of drug use based on the audience. While his friends might feel uncomfortable, Sean determines it is more important for him to be able to disclose the types of drugs he uses and to be able to use drugs openly in particular settings. Doing drugs and talking with his parents about doing drugs holds more risks. In a way, Sean has had these discussions with his parents multiple times in his mind, and would like to avoid the expected outcomes of actually carrying it out.

Being able to be open and honest is also associated with feeling less shame and stigma about one’s own choice to do drugs. Having to hide one’s drug use made it seem or feel wrong. It can also influence how a person chooses to engage in social activities and can contribute to isolating one’s self from others. This was discussed by Sharon who said, “If I could just smoke, as much marijuana all day long as I want- I could possibly you know a joint or, and not have to hi:de it? I’d probably would feel better. And be more open, and get out.”

In the previous quotes, openness and honesty were interpreted in respect to the impact on the individual. Being honest about drug use means being honest about one’s thoughts, decisions, and actions. Therefore, not being honest can make a person feel guilty and contribute to a sense of doing something wrong. This can impact how the person who does drugs relates to their friends and family, and the sense of genuine relationships. The research participants express a desire for people to know and respect them, regardless of their choice to do drugs.

Being able to openly talk about drug use is also portrayed as having a social and pragmatic value. Given the hidden nature of drug use overall, as previously stated, discussion about open public disclosure is presented as hypothetical and imaginary. Hiding personal drug use may contribute to individual feelings of guilt and
simultaneously perpetuate problematic social circumstances. In the following quote Jenna responds to a question regarding her position on the legalisation of drugs. Jenna’s reply focuses on the impact that legalisation would have for reducing the need to hide drug use, reducing the need to hide any problems that develop as a result of drug use, and reducing the sense of “shame” associated with these aspects.

Jenna: So, I think, h:ow would I see the world if drugs were, legal. I think we would see a lot less crime. I think we would see a lot less abuse. Of substances. Because if it’s if it’s there and you can do it if you want to, then, then no one’s there to say [deeper voice] “Oh you’re bad.” You know. An- and then you would be more, h- um, [I] we would be more aware of if there were, problems. You know if- if someone was spinning out of control, and not able to function and do what they need to do in their everyday life, then it would be noticed and they wouldn’t be shamed for it and try to hide more? From it? It would just be like [softer voice] ”Listen. We see that you’re having an issue. Let’s try to help you.” You know, instead of “oh my god you’re bad you need to put in, detox, and you my god you need to go through therapy because you’re just fucked up.” You know [laughs] like, … and people wouldn’t feel, the need, to hide. So much. You know, and be shameful. Because you’re holding onto that shame. Because you’re doing something that makes you feel good. But if you’re holding shame around it too because you know how other people think, will, perhaps think of you, then, that’s not doing your body any good. You know, any kind of shame isn’t doing your body any good. So. Yeah. [I] Two thumbs up.

Jenna addresses the idea that the illegal nature of drugs contributes to the concept that it is wrong to do drugs, that it is wrong to do “something that makes you feel good,” and that you are “bad” and need corrective, therapeutic intervention. Instead, Jenna suggests that open knowledge of drug use would facilitate the opportunity for informal social supports to be aware of and prevent the development of drug-related problems. She also asserts that if there were more open discussion about drugs, there would be potential for more open discussion about underlying situations and circumstances that are contributing to problematic addiction.

Jenna: and, ‘n yeah, some people can, get into a bad situation where they are abusing drugs and, and that they can’t draw the line and, and have a regular life. It can happen. Probably can happen to anybody. Depending, your emotion state. But, it doesn’t mean it has to be that way. And maybe if we had, uhm, maybe if we were more open, in our society to finding solutions? We wouldn’t necessarily ignore little, uhm, little things that become big things. You know like, if someone has an
emotional hurt. And instead of it being dealt with, the people around them, don’t know how to deal with it. So they ignore it. And then the person feels ignored. And, useless. And that it’s all their head and maybe that they’re crazy. And, so how can I find something that’s gonna make me feel like I’m not those things? Well this substance makes me feel like that. And, well then I’ll just keep using it. And depending on how severe the trauma may be, or, or the feeling or emotion of of segregation, you know, th- the substance will make you feel closer and closer like you have something to rely on. And then that’s where, bad addiction comes in. Because you can really be addicted to anything.

In this quote, Jenna suggests that drugs can be used to soothe emotional pain or past experience of trauma. The drugs might mask the pain, yet eventually the drug use may result in problems. The person is then in a position of not disclosing both the emotional unrest and the drug use. Joshua also discusses how open discussion about drug use could reduce the risk of negative consequences being experienced. In fact, open discussion and honesty can provide the foundation for teaching and education about how to do drugs in a way that limits the risks.

Joshua: but when I come to him [my dad] and asked him you know “Is it a big problem” and he says “It’s not a big problem” and, uh:, and he would give me advice like “If you’re gonna, if you’re gonna study high:, take the test high:,” and stuff like that which, I was- it was almost joking but, it’s- that’s how: ah:, if you look at any studies about studying, it’s a:ll about your environment. And your state of mind. So:, it makes sense. I mean if you: if your state of mind i:s high when you’re studying, then you should be i- r- recreate that as much as possible. And o- obviously there’s limitations. You- you can’t get stoned out of your mi:nd, kn- know what I mean and just, pass out.

Several of the research participants specifically address the impact of openness and honesty toward children. Children are often shielded from drugs and drug use, or they are given one-sided messages that “drugs are bad.” Some of the research participants challenge these messages as well as the social implications. Jenna asserts that it is acceptable to disclose drug use to children, provided they are taught to understand the reasons behind the drug use. For Jenna, drugs are used with “intention” to facilitate various ways of being in the world. As she says: “I don’t think, it’s, I don’t think it’s bad as long as you’re really honest. About wh-what it does and what you’re doing with it.”
Haylei also thinks that it would be beneficial to be more open with children. She found that learning about drugs occurred abruptly, at a particular age, and the messages she received from programs such as D.A.R.E. (Drug Abuse Resistance Education) were very fear based:

Haylei: ‘Cause I know I had a very sheltered childhood and I was twelve years old playing with Barbies and Then, all of a sudden it’s like, there’s drugs and there’s sex and there’s all these terrible things and, “Argh!” The world suddenly is a very scary place.

The implications of openness about drug use and the education of children is a theme that will be discussed in more depth in the next section.

The sense of an implicit social obligation to keep one’s drug use hidden is an important topic arising from the interviews. At the same time, there is an impression that the social perspective of drugs is based on unbalanced information and knowledge. Joshua explains this stating, “I think it’s important to realise that, part of my, m- part of the reason I don’t think it’s that bad is ‘cause I, don’t, align myself, with the, the views, the current views other there, that, it’s bad.” He further states, “like everything, around me hiding what I do: is based on, lies. [1]Which is unfortunate to me.” This also means that there are few legitimate social positions from which the dominant perspectives of drugs can be challenged. In fact, this research project seems to be a means toward achieving that end.

The analysis reveals what initially appears to be a contradiction between individual claims of not hiding drug use contrasted with indications that the research participants do not discuss their drug use openly or indiscriminately. However, further analysis demonstrates that the term, “hiding,” can mean either concealment and non-disclosure, depending on the context. Concealment, or lying, is viewed as problematic, whereas not disclosing drug use is necessary in most social settings to reduce the experience of problems. Discovery of the drug use of others is generally accidental or indirect, though occasionally explicit. Being able to talk openly about drug use is generally presented as desirable and beneficial to reduce feelings of stigma, to provide a foundation for education about drug use and effects, and to create spaces for people to talk about problems they may be experiencing.
3.3 Section 2: Negotiating Spaces of Discursive Openness

Section 1 of the analysis focussed on the complex positions that people took in relation to an espoused value of not hiding their drug use and being open about it around other people. At the same time, discursive openness was shown to be a negotiated space depending on the audience. In Section 2, this negotiated space will be explored in more depth in regard to three themes: 1) associated risks, 2) educating children, and 3) confronting social discourses.

Associated risk refers to the idea that disclosing personal drug use is viewed to be associated with particular undesired consequences, and people discuss drugs and drug use according to these perceived consequences. A second negotiated risk pertains to the education of children; in this part, the contradictions between what people do and what people say will be explored. In addition, alternative perspectives on what constitutes appropriate education are presented by some of the research participants. Third, the narrative accounts reveal how the research participants respond to perceived social discourses in regard to drugs and drug use.

**Disclosure and associated risks.** As was mentioned in the previous section, hiding drug use is posited as an indication that a person is doing something wrong. It was argued that concealing and not disclosing drug use may be a response to awareness that the audience would perceive the drug use as wrong. A reluctance to disclose drug use reaches beyond feeling judged or misunderstood and is a response to the potential for negative consequences. In this section, several examples are provided to indicate the research participants’ awareness of the potential consequences.

Concealing drug use is almost viewed as a necessary evil. According to the participants, concealing drug use is important to ensure personal success in contemporary Canadian society. The person who is publically exposed to drugs runs the risk of facing very real negative consequences.

Jenna: [higher pitch] \Well because you just never know. And especially in today’s society like people just [inhales] y- they can go o:ff, \ you know and like I was saying to you [earlier], like my biggest fear is that someone is going to call, u:m, child and family services on me.
Joshua describes what could happen if people find out he smokes marijuana daily. He explains, “If it got out, you know, I’d be: you know, I’d be number one, to, get kicked out of the program or, ah: not hire list [chuckles] you know what I mean?”

Joshua describes the entangled perspectives of not hiding yet not disclosing. Hiding drug use is seen to directly affect the person’s life. In this case, effective hiding limits the number of negative consequences. It can also be noted that Joshua states that he is “protecting” himself from the “misconceptions” of others. The negative consequences are not believed to be a result directly from the effects of the drugs, either on school or life, but to result from the perceptions of others.

Joshua: I don’t hide it necessarily, unless it’s gonna affect my life. I don’t hide it from people so, I mean obviously the school, ‘r ‘r anything like that. People don’t know. Um, as best I can I want to keep it from them. Just be- and mainly and I think I mentioned on the phone, when we talked on the phone is just because I know that- the misconceptions associated with, with ah, with marijuana and uhm, [clicks tongue] and I wanna protect myself from that.

Joshua says that drug use becomes a “problem” not based on the effect of the drug on himself or his performance, but based on how others evaluate it. Furthermore, the reason it is a problem is that it changes the other person’s perception of the person who is doing drugs.

Joshua: if I went to a prof and I told my prof, that they saw me smoking a joint, I don’t think they’d be: upset or surprised. If you told them that I smoked weed every day, or on a chronic basis, then at that point I think it becomes a problem. Right? For them. And that changes their perception of me.

Jenna shared similar views, suggesting that people would not take her opinions seriously if they knew she was high.

Jenna: you know I don’t want people to know that I’m high because, a lot of people have a different view of, you know “oh you can’t function” or “whatever you’re saying is not really coming from you” or you know what I mean, people have judgments? Against it. As we all have judgments. Um. [clears throat] But, I don’t know what theirs are.

Sean indicates that a concern of his is the implications for his children if the parents of his children’s friends became aware of his drug use. He describes what might
happen if other parents find out that he smokes marijuana.

Sean: just because I’m okay with it, you know, some parents who might think it’s really ter-, you know, not a proper thing at all. And then, you know, them, to not want their kid to play with my kid. Like nah. Nah I, not

Niki: Ah yeah.
Sean: getting into [chuckling] anything like that. Like.
Niki: Yeah.
Sean: That’s not cool. So.

Paul responds to a question about why, if so many people use drugs, they don’t come together to make changes:

Paul: The problem is is that, they feel that they’ll get shunned. That’s really what it comes down to. In, in human, in human nature, they’re always yearning to be wanted. You’re always wanting to be loved. If you pull, any type of love, or any time of friendship, whatsoever from a person? It’s like taking away their ribs. You’re gonna kill them. You’re gonna make them go absolutely insane. Um, a lot of people, have medical conditions because, they’re not wanted, or they don’t feel they’re wanted. And some of the people are just so, I guess, over-consumed with want and love,

Joshua is concerned about people’s opinions of him.

Joshua: You know I’m not afraid of no- I’m not afraid of, like of, going to jail or anything- I’m not afraid of all those things. I’m more afraid of, of people, changing what they think of me just because of that. I’m afraid that their misconceptions are gonna change their view of me. You know and I wish I could just change their misconceptions really.

Paul, at the time of this interview, was one of seven at the head of a national organisation that sells drugs. He alludes to the fact that while living in Ottawa he learned that many politicians were purchasing and doing drugs, which required “discretion” on his part. In this way, he exemplifies the loss of credibility associated with people who use drugs.

Paul: I think this is actually one of the very few years I won’t actually be voting.
Niki: You won’t be voting?
Paul: [quietly] No. No. With the political parties? And the amount of, once you get into this business, and you find out about,
Niki: Oh.
Paul: And it’s like, you’re like, you’re, you start doubting and you’re like, “Really?”
Niki: [chuckles]
Paul: “You take this type, [2] you take this type of thing, and yet, you’re having problems, and you wanna run a country? [2] N::o.”

Many of the consequences associated with drugs are social and legal. The legal consequences apply to growing or producing, selling, possessing, and doing drugs. Being charged with drug-related offenses can contribute further to the social consequences.

Jenna knew a man who works as a contemporary artist, and who also grows marijuana.

Jenna: But he also, you know, made growing pot an art form. ‘And, he had cross-eyed pot. [laughs]

Niki: [laughs]

Jenna: [laughing voice] \You would smoke it and then you’re like, “Argh, too strong.”\

Both: [laugh together]

Jenna: But, you know, that was really, for him, he’s a family man, like house in the Beaches, and you know uhm, would never, no one knew that. That he did that you know and it was really hush hush, and it’s like, it’s like people need to be afraid, of doing that sort of thing.

Sharon also emphasises the need to hide her marijuana use from a legal perspective.

Sharon: Because I’m not doing anything wrong in my life anymore. I don’t have to hide anything. Well, other than that little bit ‘a pot. But like I say, I don’t, you know anybody could come in my house at any time and not smell it. Um, that’s the only thing. I’m totally terrified of getting caught. With pot. Because I know I need it. I do. If I don’t have a p- my pills, I’m gonna be smokin’ pot. ‘Cause it does make you relax, it makes you wanna eat, it, it does help.

It is possible to interpret concealment and non-disclosure of drug use as a means to minimise the potential for negative consequences. There are limited ‘safe’ spaces or circumstances in which one can disclose personal drug use and yet the person who does drugs is criticised for hiding their actions.

Educating children. Educating children about drugs is an unanticipated topic that emerges during the interviews and elicits several contradictory voices and discourses. Limitations on the open discussion of drugs and drug use is perceived to impact the education of children.
During the first interview that I conducted for this project, Sean mentioned that there were several occasions when he contemplated disclosing his drug use with his parent but was ultimately glad that he did not. I was curious about how this would impact his own relationship with his children in regard to drugs, assuming that he would have planned to create a context where his own children could talk openly to him. I was therefore surprised at his response to my question about how he would talk to his own children about drugs.

Sean: you know and just, really just trying to curb it, early on, so there is no grey area for example. Because maybe to a:, you know, a t-, 13 year old kid, y-, you know to say one is okay and, you know the others are bad or something like that, would just maybe be too confusing.

Sean’s desire to smoke marijuana daily and use other drugs daily, as well as being able to disclose his use more openly and honestly with his wife and parents seems at odds with the position he takes as a parent himself. In the context of the interview he cites a peer-reviewed journal article by David Nutt (2010), who categorised MDMA as having less potential for harm than riding a horse. Yet, in portraying drugs to his children he proposes that there should be “no grey area” which would allow for certain drugs to be classified as good and others as bad.

As a result of this discussion I included a question in all subsequent interviews about how the research participants would talk to children about drugs, be it their own children, younger siblings, or children generally. Children developing awareness of drugs through formal and informal means is a topic that comes up spontaneously in several of the interviews without prompting.

Two topics about educating children will be addressed in this section. The first topic is that although the research participants seemed to value open discussion about their own drug use and drug use generally, this did not always translate to open discussion with their children. Sharon, for example, had three grown daughters and seven grandchildren. She used drugs in the presence of her children when they were growing up and seems to have an awareness of what drugs her own children have tried, which she relays during the interview.
However, while she used drugs in front of her own children and talked to them about using drugs, she says she will not do the same in front of her grandchildren. One reason for this might be that her children would not permit her to see her grandchildren if she exposes them to drugs. Apparently, Sharon had used marijuana when her young grandson was near, as he has recognised the smell in public settings.

Sharon: So. [sniff] Now it’s like, well, okay I got seven grandchildren, the other three are comin’. I’ll hide ‘n my pot, I’ll never have my house smellin’ like that again. Because, [Rachel’s son, Xavier] Xav- he didn’t know what it was, but he, knew that I smelt like that, at times.

Niki: Right.
Sharon: So it’s not something I want my grandchildren to, you know

At the same time, Sharon says that she would like to educate young people about the risks associated with drug use. However, she would be ashamed to tell them that she still smokes marijuana.

Sharon: I- I wouldn’t wanna have to admit in front of those kids that I still smoke it. So I wouldn’t wanna, I would never. I would hav- but then I’d be lying. And I don’t like lying.

Niki: Right.
Sharon: I don’t. I don’t feel good about it.

In this quote at the same time Sharon voices shame about admitting drug use to children, she desires being able to smoke as much as she wants every day without feeling shame.

Sharon: I have quit every drug you could possibly think of, except for marijuana. And one day I’ll probably put that down but. Right now I can tell you I don’t want to quit it. Just the little that I do, I don’t want to give that up. Because it’s in between the pills, and it, it’s, I’ll tell you something e- I’d rather smoke a hit of, marijuana than take a morphine. Because it just settles me down. [1] I would. If I could just smoke, as much marijuana all day long as I want- I could possibly you know a joint or, and not have to hide it? I’d probably would feel better. And be more open, and get out.

In a way, Sharon is caught in a Catch-22. She is lying if she does not admit to doing drugs, which is contrary to her espoused values; yet if she admits to doing drugs, she would feel ashamed. The shame is not directly associated with “doing drugs” as something that she considered to be bad, but based on the social position of drugs as illegal and unacceptable.
Paul discusses educating his younger siblings and anticipated future children about drugs from a variety of viewpoints. First, he indicates that he would advocate the business of drug distribution to his children.

Paul: I’m going to be to the point here, about whenever I do have children, that, I’m gonna definitely condone this industry with them. But, I think that they should kinda know: the truth about it from someone that lived it first-hand.

Second, he states that if his younger siblings approach him about using drugs he will “show” them people who use a variety of drugs and let them make their own decisions. He demonstrates consistency between what drugs he would use himself and what drugs he would view as acceptable for his siblings to use. Furthermore, his approach to deterring his siblings to not do drugs was not based on a discourse of whether drugs are good or bad, socially acceptable or not, legal or illegal; rather, he observes that there are circumstances that would make a person more likely to want to do drugs, so he wants to support his siblings to achieve their goals and have satisfaction in life without drugs.

Paul: It depends on the type, and depends on what they want. Because what I would do first is I would show them the sides of both. I would show them people that use it, or show them people that don’t. I would not let them use something that I wouldn’t use.

He elaborates:

Paul: It’s- it’s not like I would say “No.” I’ll make it so that, you never do that. Because I’ll say, “You know, so and so,” or, “This person,” or, “I can give you a list of people that, like who- have died from this” and, I’d tell ‘em, “It’s a killer drug.” If he came and talked to me and said, “I wanna do weed.” “And you’re telling me this why?” You know it’s like, it like what- I could get it for him, but I would never do it for him. But, I don’t think that really, I don’t really think that I would kind of, properly get them to the point of, of- where they’d, where they would want to.

The fact that Paul does not incorporate legal discourses into the drug education of his siblings may be because he works outside legal boundaries for his business on a daily basis. For him, legal discourses may hold less credibility or weight in terms of shaping decisions and behaviour; conforming to legal norms may be viewed from a perspective of more fluid or arbitrary boundaries.
Third, Paul draws a parallel relationship between discursive openness about drug use with other topics that are often considered to be “taboo.”

Paul: and I know for a fact like, with, with my kids, they’re gonna be raised up in a family, how I was raised up where, [1] there was no such thing as off limit topics. If you wanna bring up sexuality, we’ll talk about that. In length. Any way you do it. I’m not gonna turn around and lie to my kid and say, [nasally voice] \The stork brings them.\ you know. It’s, it’s such, a normal way of life. And, everything we do, in, as humans is, is shunned.

Jenna makes similar distinctions. She portrays educating children about drugs as akin to learning about sex and sexuality.

Jenna: it’s all teaching and learning right? Like when is, why is someone too young to learn about sex. You know we’re sexual beings, we have sexual parts, shouldn’t you know that from the beginning. You know, why does it have to be [nasal voice] \“ok, now that you’re fifteen, let’s teach you how your body works.”\

Some issues or topics may be viewed as taboo in society, and children are protected from these topics through non-disclosure or even untruths or fables — such as the idea that babies are delivered by storks— until a certain age.

Jenna and Paul both propose open dialogue with their children, and a commitment to avoid outright lies. Jenna initially hid her smoking from her daughter until she realised that her daughter was noticing and mimicking what was happening around her. Jenna voices a need to educate children instead of telling untruths.

Jenna: I remember when [Clara] was pretty small, [clicks tongue] three or four months, and I was over at my buddy’s house and we were out on the deck and, he ah, passed me a joint. So I’m like [higher pitch] \I’m like “yeah sure.”\ And so, I grab it, I’m smoking and she’s watching me and I’m like “Aoh, I shouldn’t- I shouldn’t do this. Like she’s watching me.” And he’s like [high pitch, shouting] \“She’s 4 months old.” And I’m like “Yeah. but she, like, they get it.” You know it’s not like she doesn’t get it. And so he’s like “Oh, don’t worry about it” and so I just, turn my back you know and. [laughs] Keep doing it, just turn my back.

Niki: [laughs]
Jenna: [chuckling] \She doesn’t see me, like actually putting it to my lips.\ [mimics smoking] Um, but the reality is, she knew. [1] Even when she w- she couldn’t talk yet but, she would see a lighter come out and she would go [demonstrated bringing 2 fingers of one hand to pursed mouth, exhaling with puffing sound and pulling hand outward from mouth].
From Jenna’s point of view, it is important to be truthful, but also to educate children regarding the meaning or reasons underlying the choices and actions regarding drug use.

Jenna: Like my sister for instance was, crazy partier. And she had a child very young. And uh, [clears throat] when he became a teenager he asked her you know “Do y- did you ever smoke pot? Or do any drugs.” And she lied and said no. And I was going, psht, “what are you doing? Why don’t you just be honest with him?” And she’s like “cause that’s gonna make him feel like he can go about and do it. Because I did it.” And, I’m like “Well, explain it to him.” And she’s like “well I have, but I can’t give him that up.” And for me I just don’t wanna lie; to my kids.

There seems to be a tension between telling the truth about one’s own drug use as condoning or encouraging another person’s drug use, and the value of being honest.

Haylei notes that she felt shielded from knowledge about drugs until a certain age. As a result, she feels as though she went from living in a protected environment to living in the world as a “scary place.”

Haylei: So I think in a way, [1] to take stigma away from things that you protect things, from children. And although you have the right to be an innocent child, th- it’s like this whole world opens up to them at an age, and it’s scary. Whereas if, you’re open and talk about things and they know about it, then it’s not such a novelty.

She advocates for children to learn more about drugs from a younger age, and for a move away from scare messages like those in the D.A.R.E program. She states, “Yeah. That was like, that was the D.A.R.E program put the fear of death in me. Like, you- you will go to jail. And you will end up, overdosing in the hospital.” She suggests that part of the dissemination for this research project could be a children’s book, stating, “Something that just, [7] I guess shows the world of drug use, not necessarily drug abuse.” In this way, Haylei implies that current drug education portrays “drug abuse,” and that there is a realm of “drug use” that is absent from drug education discourse. For example, when asked how she hopes this research information is used, she says:

Haylei: [1] I would like um, I would think like for teenagers? And young adults. That maybe; [3] to give them an idea of what they’re getting into: Before they, they do it? S- to- ‘cause I’m sure you’ve gotten a whole bunch- a realm of stories and experiences that are good and bad.
Haylei also thinks it is important for parents to have information about drugs so they can feel more comfortable talking to their children and perhaps preventing problems from developing.

Haylei: and parents too. That maybe, like even people my age that may be, um, [1] have never and will never. But if they’re like that and their kids probably sure are. So, [1] that it’s not all bad. And if you find, you know if you found, weed in your kids’ drawer, you don’t have to freak out. They might not have smoked any of it yet.

In the previous quotes, Haylei draws on dualisms of use and abuse and good and bad to portray what she thinks is missing from drug education and from the ways that parents respond to their children. She subtly indicates that the person and voice of parents and educators has authority over the person and voice of children and youth. She states that parents might find drugs belonging to their children, which implies both monitoring of one’s child and a parent-centred response. Haylei, on the other hand, suggests it is important to first listen to what the child has to say before providing a stock parenting reaction of “freaking out.”

Like Haylei, Sharon also wants to share information with young people. She believes that it’s important to draw on real experiences that people have had in order to understand the possible risks associated with drug use.

Niki: So you’d like to tell kids,
Sharon: Yeah.
Niki: not to be
Sharon: No.
Niki: using drugs at all.
Sharon: Look. I have no teeth.
Niki: Mm.
Sharon: You know why? Because I did acid. Or I did drugs. And I have no teeth because of it. And, I was a lower class. I was- I wasn’t middle class. I was on welfare. Um, and a lot of these, Indian people, pardon me:, are f-pumping Oxys into them. And then pumping Oxys through their breast milk. And, th- the baby’s aren’t standing a chance, n’either. You know and I think if the children were, made aware of it now and talked to by someone who looks like me? Not someone who’s in a suit, or, Somebody else:. You know, um, I mean I’d be dressed nice. Wouldn’t be goin’ in my cut offs [indicating the pants she is wearing]. You know what I mean I got nice clothes but, talking to these people and really being earnest with them about, the fact that prescription drugs, is not the
way to go:. Um, there are herbal medicines that work. And there’s exercise. And mindset. If you set your mind, to getting better, and tell your body, “I want to get better:, let’s go for a walk,” your body will listen to you. Your brain will listen to you. I know it will. I’ve been there. I have quit every drug you could possibly think of, except for marijuana.

Sharon’s message, based on her interpretation of her own past experiences and her evaluation of her current circumstances, is to deter young people from doing drugs. Unlike Haylei, Sharon attributes several aspects of her life, such as “having no teeth” and “being on welfare,” to drug use. However, her message opposes the dominant perspective that is proliferated and attributed authority by the AA model of addiction, which states as Step One, “We admitted we were powerless over alcohol — that our lives had become unmanageable,” and as Step Two, “[We came] to believe that a Power greater than ourselves could restore us to sanity” (Alcoholics Anonymous World Services Inc., 2012). Whereas the AA model emphasises personal powerlessness and a reliance on a higher power to restore the person’s afflicted “sanity,” Sharon proposes “herbal medicines,” “exercise,” and “mindset.” Sharon draws on external resources, and emphasises the “mind” being able to tell the “brain” and “body” how to act.

The second topic refers back to the first quote in this section. On the surface, it seems that there are conflicting beliefs about drugs and drug use. Do the interview participants hold conflicting beliefs about the harms of drugs that they minimise or deny in regard to their own use, but want to protect their own children from? Do they actually believe that “all drugs are bad” and simply fabricate justifications for their own use? On deeper analysis, I propose that the research participants may construct distinct, and even contradictory, discourses about drugs and drug use for themselves and their children. However, the constructed discourse is shaped by their differing roles of being an individual in society and being a parent in society. As an individual, the person evaluates the possible risks associated with his or her choice to do drugs. As a responsible parent in society, on the other hand, the role is to shield their child from negative consequences and to teach acceptable and moral behaviour as conforming largely to social norms.

Sean and Joshua demonstrate the most apparent contradictions in regard to their anticipated approach toward their children and their own choices and actions. Admittedly,
both state that they had not thought about this before, so their responses were instinctual. Interestingly, both Sean and Joshua state they would not tell their children about their own drug use at least until they were older and no longer living at home. They also say they would not allow their own children to smoke marijuana, for example when Joshua says it’s “my house my rules.”

In the following quote Joshua says he expects he would not tell his children that he smoked marijuana until they are older. This is consistent with dominant discourses of drug education for children that propose children are not equipped to know about drugs until they are a certain age.

Joshua: and I don’t want my kids to smoke weed. But if they do, uh, [1] like I’m never gonna tell them that, what I did. N:
Niki: No?
Joshua: That’s just gonna influence them to do it more. Right? Uh, at some point, at some point I will. Like when they’re older, like, by: twenty:, something like that. When they’re out of the house. I’ll tell them the truth. Uh:, and there may be an appropriate time, depending on how mature they are.

In addition to telling their children to not do drugs and not disclose their own drug use, Joshua and Sean also imply that they would not establish a context where their children could openly discuss drugs with them. For example, Sean describes what he would do if he “found out” his child was doing drugs, and Joshua describes what he would do if he “caught” his kids doing drugs. Using the terms “finding out,” “catch,” and “suspect” indicate that it is expected that the children would be hiding drug use from their parents. Sean and Joshua do not indicate that they would ask their children about drug use or invite their children to come to them with questions. Sean, for example, uses the term finding out, which implies he would not have established a relationship that allows his son to disclose drug use. He says, “And, but yet, yeah if it, if it eventually came, to finding out that, [inhales] you know, him and his buddies, you know, smoked [chuckles] \joint\. You know:, at a party:. Like, what are you going to do?”

Joshua explains that he has no intention to talk about his own drug use with his children and it seems unlikely that he would directly ask his children about their drug use.

Joshua: I wanna try ta’, stay apart from them. But if I ever, catch them with it or: suspect hear anything or know that they’re doing it, which I mean I
I think I would, I w-o- I think I- I do know I’d see the signs. Uh:m, just from my experience. But, uh-I dunno.

While Sean and Joshua are both outspoken about the position that marijuana should be legalised, both refer to research indicating that marijuana is not known to be a risk to health, and they both indicate they want to be able to talk more openly about their drug use, they nevertheless both reproduce the very situation that they criticise. This might be interpreted as Sean and Joshua prioritising being a “good parent” and helping their children act “properly” within socially accepted parameters. As Sean says:

Sean: [quieter] and ah, but yeah do I want, you know my kids to know like that I, smoke pot, you know, here and there, on a, on a somewhat regular basis, like? No, not so much because, i-, yeah. It’s just [chuckles]. But then again, you know part of me thinks yeah I don’t want them to know it all, but then, you know, there’s also part of me, you know when we were talking about like comparing to boo:ze, and like yeah, I can let my six-year-old mix me a rye and coke like. I taught him you know,

Niki: Oh: yeah.
Sean: [chuckles] \“pour it into the shot glass.\”
And that’s perfectly okay. But him knowing that I, you know for example smoke a little bit a’ weed like. Isn’t allowed. Right? ‘Cause it’s-, you know from a so:cial, from a social perspective, it’s ‘cause one’s illegal and one isn’t. But. you know if you want my [chuckling] \honest opinion\, yeah, I don’t even think it’s, you know, that terrible. You know. An’ and especially in, in sort of relation or in comparison to other things, so.

In this way, Sean contrasts the relative social acceptability of alcohol, to the point that he could teach his young son to pour appropriate proportions, to the social unacceptability of even small amounts of marijuana. The distinction that he draws between alcohol and marijuana is based on its legal status. He voices discontent that marijuana is not “that terrible” “in relation or in comparison to other things.” However, ultimately, he feels the need to defer to the legal status of drugs.

Sean: you know part of being the, the, you know current, social, situation, you know maybe not even, just what I think, but, you know what society, thinks, you know and just, really just trying to curb it, early on, so there is no grey area for example. Because maybe to a:, you know, a t-, 13 year old kid, y-, you know to say one is okay and, you know the others are bad or something like that, would just maybe be too confusing… You know, from a legal point of view, it is illegal. So [chuckles] \you know,\ that,
Niki: Yeah right.
Sean: that, that’s a pretty, clear-cut, you know, what’s allowed and what isn’t allowed.

An analysis of the discourse, in this section, shows that Joshua’s and Sean’s “father” voice reinforces discursive silencing and replicates legal discourses, despite narrative accounts of experiencing these laws and practices as insufficient and a source of personal conflict and discomfort. The authoritative social discourse may ultimately be determined by the legal status of drugs; and as the protective parent in a role of authority, this may be perceived as acting responsibly to enforce legal action. The legal discourse may be viewed as the most authoritative source, so when a person who is aware of and holds multiple conflicting discourses is put in the position of having to choose one, he or she may feel more secure in reproducing dominant discourses and practices.

This analysis regarding the education of children is significant to the field of health professional education in several ways. I would propose contradictions between personal beliefs and action in regard to protecting children underlies the legal and health systems in Canada. Despite the fact that a person may hold beliefs that counter the dominant discourses, the enactment of counter-discourses may be restrained due to a lack of contemplation regarding the options of enactment, it may be a protective instinct to encourage others to live within social norms, it may be a habit of practising non-disclosure, or a number of other factors. It does highlight significant challenges pertaining to changing social practices.

**Confronting social discourses.** The research participants directly confront, or challenge, social discourses regarding drugs, drug use, and addiction in several ways. Discursive practices that indirectly confront social discourses will be described in the final section of the analysis. The research participants frequently refer to social misperceptions and misrepresentations of drugs and drug use as disseminated through media, formal education, and research. Jenna asserts that drugs are misrepresented as being “all bad.” She insinuates that there is a broader understanding that is not as prominent.

Niki: if there are things that you think, you wish kinda people could understand better? About drugs.
Jenna: Mm. [2] Just, the hype is not, [1] the hype that it’s all bad, is not the truth. Of it. You know. I th- and this just goes more about everything, not just drugs. That you can’t believe everything that you’re told.

The media is identified as a source of social misconception. For example, Joshua provides examples of how marijuana is depicted falsely and “unrealistically” in terms of the effects of the drug and the stereotypes that people who smoke act “stupid” and engage in criminal behaviour.

Joshua: any- any commercial about, marijuana like has been, usually depicted like weird. Like I that I mentioned earlier that’s- that’s: you know y-they would- sort of any depiction of marijuana is, is messed up. Like even, even things that we sort of associate, with our own culture like people who smoke weed like, uh.; movies like Half Baked and How High. All the Cheetch and Chong movi:es. Uhm, elic:it a stupi:d, ah:: dumb, guy.; like, not aware of the surrou:ndings, and, not- know what’s going o:n, and even like, criminal behaviour:r,

Joshua explains, “The depictions to me:, like are they-? They’re not realistic but, and they- noth- like nothing’s depicted realistically.”

Although the research participants voice an opinion that the drugs they use are frequently depicted unrealistically, some media portrayals nevertheless inform their own beliefs about drugs that they had not used. Haylei had sampled a variety of drugs, yet she reports there are some that she would not try, and that much of her knowledge of these drugs comes from movies.

Niki: So what’s um, what’s is it about Trainspotting that, that ah, kinda spoke to you, or?

Haylei: [2] I think just I liked-, I mean I really liked that movie. Like all those movies. But, it was so: gritty, and dirty? And, j:ust:, na:sty like the worst of the worst and as bad as it can get. And, you’re still scrou:ng to stay in tha:t. Just like, no. I don’t [inhal:es] I don’t wanna do that with my life. [3] So, and I guess, probably what I, know about, a lot of drugs I haven’t done is from movies:. And I jus’, didn’t like what I saw:.

Paul notes overlap between how drugs are portrayed by the media and the passive receptiveness of the public. He asserts that the media takes information about drugs out of context and has a powerful influence on what the public believe and how they act. In this way, the public perspective of drugs and drug users is shaped in a certain light. He states, “and that brings me again to the media, where they use clips of everything, out of context.
It’s, [1] so, it’s so, mind-boggling.” Paul elaborates and describes the media portrayal of drug use as being guided by a select “few” who have influence over the beliefs and actions of the general public.

Paul: And, that’s that bad with it is that, it everything is self perceived to the point of where, only a few, tell the masses what to do. We’re too, stupid. I would say stupidity is worse for, for the world, than drug users are.

Paul demonstrates the extreme nature of how drugs are portrayed, stating, “Like, if you look at it, we paint everybody as all the drug users being, crazy people. Kinda, killing everybody. [2] W- We’re not.”

Jenna suggests that the portrayal of drugs by the media is an intentional attempt to control individuals.

Niki: What you would like people to understand better about drugs. [laughs] ...

Jenna: Yeah, so maybe it’s just not, it’s not as bad as it- as it’s portrayed in the media. You know and maybe that, the media makes it worse than it is. Not, W

Niki: What do you think that’s about?

Jenna: Ah well I think that’s about control.

Niki: Control.

Jenna: I think it’s about control. I think it’s totally about, um, keeping people doing what you want them to do. Instead of what they want to do. And, ot- and getting other people to police other people. With harsh beliefs. You know what I mean? So, if you were really dead set against drugs, and I shared with you, that I smoke pot, you would work really hard to convince me, that I was doing something wrong and I had to for the sake of my child for the sake of my family, stop this because I am harming my life. And then, depending on how severely you believed that thought, you would implement, uhm, something; that would go farther like calling the cops or calling, ahm, child and family services and taking my daughter away because of your belief system. Not about, and it wouldn’t have anything to do with how I ran my life and, or anything like that but it would be because of your belief system and, and I think that’s, w-w-what this is all about, you know we’ve created these, strong beliefs and these strong ideas within people without them even having to think about it? Like do I really believe that or have I just been told that so many times that I believe that.

Jenna’s argument was reminiscent of Foucault’s (1978/1990) analysis of surveillance as it pertains to sex:
Through pedagogy, medicine, and economics, it made sex not only a secular concern but a concern of the state as well; to be more exact, sex became a matter that required the social body as a whole, and virtually all of its individuals, to place themselves under surveillance. (p. 116).

Jenna asserts that control is enacted over individual drug use by the establishment of particular belief systems in society; view that are perpetuated by the media and enacted by individuals. Jenna uses script flipping when she says, “taking my daughter away because of your belief system.” Jenna is strategic in her selection of words. She does not say, for example, that her daughter might be taken away because she used drugs; rather, her child could be taken away because of someone else’s “belief system.”

The education system is a forum where children in Canada receive early exposure to authoritative discourses of drugs. As was mentioned earlier, Haylei says the D.A.R.E. program taught to her in the school system also presents many fear-based messages. She explains “Yeah. That was like, that was the D.A.R.E program put the fear of death in me. Like, you- you will go to jail. And you will end up, overdosing in the hospital.” Despite evidence about its ineffectiveness — it does not prevent drug use in the short-term or long-term — the D.A.R.E. program continues to be promoted (Rosenbaum, 2007).

Some of the fear-based messages about drugs are actually based on potential consequences associated with drug use and possession. As Jenna mentioned earlier, there is an expectation that people who have problems with drugs need to be subjected to therapeutic intervention. There is also a legal, punitive discourse that Jenna describes as “backwards.” “But we’re still in this, this backwards way of thinking where we need to punish people. ‘No, you were bad, you were wrong, you shouldn’t have did that.’”

Paul’s perspectives about misunderstandings about drugs were also related to the sale of drugs. He suggests that the clandestine nature of drug sales facilitate the perpetuation of a belief that there is excessive risk and violence associated with it.

Paul: If, if we were to the point of where, [1] w-we made it more, o:pen, and more believable? People would understand that it’s not, everything is not violent about it. It’s, a product. Tha- tha- that’s really what it comes down to. Anytime there’s a, there’s a demand like it’s supply and demand. If executed rightly, there’s no risk. There’s no risk. You deal with it.
In the preceding quote Joshua indicates historical and political factors that impact how marijuana is conceptualised. Joshua reports feeling that he needs to “avoid” the constructed “misconceptions” that are actively shaped and fuelled by dominant sectors of society. He also cites flawed research trials supporting the position that drug use causes brain damage to support his position that the construction of drug use can be considered as propaganda.

Joshua: a lot of the research surrounding the bad effects of marijuana and, a lot it, that was created, was government ah, funded. A:h since, for a long time. And every time that the re- every time that results showed no negative effects, and it just gets thrown out. Ah any time there are negative effects shown, there’s there’s flaws in the methodology, I mean one point there’s one study that said that, it killed brain cells. And what they did was they hooked up, monkeys to, ah:, to a gas mask for five minutes with pure smoke. I mean that, and no oxygen. So all the studies that it’s gonna kill your brain cells, if you’re not getting any oxygen for five minutes they just suffocated these monkeys. That’s all they did. And they didn- and that’s and they did that to prove, something that wasn’t true. Uhm, and that’s, and tha- and there’s lots of research out there. And I mean and the propaganda behind- it, h- has, ha- create these misconceptions.

Sean goes so far as to claim that the way drugs are presented is part of a broader form of “propaganda,” rooted in United States legal initiatives and Christian movements, that classifies all drugs as bad.

Sean: Uhm. Yeah and, you know, I do think there is a certain level of, you know maybe, propaganda. You know sorta, bad press that, say marijuana gets, because, yeah I, I just ah, they just kinda have it classified as, you know because it’s illegal it’s bad and, you know, ‘n maybe in the Unit-., in the Uni-, from the United States like, maybe there’s, you know there’s obviously a large Christian, sort of push, on certain things. And if they kinda have it in their, you know their agenda that-, that drugs are wrong, and they’re just grouping all drugs together? [clears throat] ‘n I don’t, necessarily think that’s ah, that’s true? To be, to be grouping, you know, marijuana as the same as heroin? Like, no. [chuckles] It’s not. [chuckles]

Joshua elaborates that the way marijuana is portrayed has changed over time in relation to political and historical situations.

Joshua: So that I mean it’s ah changes every time. And it’s different things. Because before you say it’s gonna make you aggressive it’s gonna make you steal, or not. And now you’re saying it’s gonna make y- apathetic.
Not do anything. And then you’re gonna be a Communist. So there’s that propaganda behind it, is fuelled, like I said all these misconceptions that- that, I ha:ve to avoid because, of of, of my different vie:ws on- o- on marijuana. Compared to what society has, has been led, led to believe.

When asked about how he thinks the information gathered in this project should be used, Sean advocates for “proper information” that is researched, in contrast to information provided by the media.

Sean: you know I, think ah, [speaking slowly] \you know knowledge on the topic for a general society, is ah, you know is, is probably important, \[speaking slowly] \for, for us to have, \on any topic. Whether it be, pot or, [chuckles] whatever. Social assistance housing, you know, pick a topic. I just think knowledge is important for people. So, if it ah, you know, helps, somebody have, you know, like an educated perspective, and an analysis o:n, on dru:gg, or a ha:bit, or something like that. Then yeah that, that’s the proper information for them to ha:ve. That’s been actually researched and thought out instead of just some, random, like, you know, media comment, or you know some, some person on CNN whose, whose ah, you know, talking about something, so.

Niki: Sure. So kind of um, yeah, the general public,

Sean: Yeah.

Niki: needs to, have a more balanced,

Sean: Yeah. Yeah. If it’s just information for, for people to know, then, I think that’s fine.

Joshua summarises his position by stating that he does not align himself with what he perceives as the dominant “current views” about drugs. By not being “aligned” with current views, he is in opposition and feels a need to “defend” himself. As he says, “perception is reality,” and therefore he feels the dominant reality is that his actions are wrong.

Joshua: But uhm, I think it’s important to realise that, part of my, m- part of the reason I don’t think it’s that bad is ‘cause I, don’t, align myself, with the:, the vie:ws, the current views other there, that, it’s bad.

Niki: Right. [1] Yeah so it’s important for you to be able to explain that and,

Joshua: Yeah. And justify that, I guess.

Niki: [chuckling] And justify it.

Joshua: I even ha:te having to justify it. Like and I shouldn’t have to, ‘n don’t want to. I mean justifying it, ah alone is, is kinda it shows: that it’s, a bad thing. It doesn’t, it’s not true, but that’s just- that’s reality. That’s- perception i-is reality. Right?
In this section of the analysis, I focussed on some of the ways that the research participants overtly argue against specific examples of how drugs are portrayed in the media, in education systems, and through research. These representations influence societal beliefs and perception. These examples may reveal how the research participants interpret what are the dominant discourses pertaining to drugs and drug use. Accordingly, personal accounts of drug use may also be interpreted to implicitly respond to these positions at other points of the interview.
3.4 Section 3: Integrating Drugs into a “Successful, Functional Life”

When asked about her interest in the research project, Jenna replied:

“Well, from what I know you’re looking for people who, use substances, more regularly than, most. And um, and still have a, healthy functioning life... For people who can integrate, um, you know the use of th- substances. Like for me, its just pot. You know, I smoke pot. Um, and- and I have a very, successful functioning life. So h- you know, how can you do both. This is how.”

The accounts of drug use provided in the interviews were certainly not intended to suggest that drug use is unambiguously associated with a successful, functional life. However, there is a perception that it is possible to do certain drugs in ways that can minimise problems or even enhance aspects of the person’s participation in various activities and enhance appreciation of certain experiences.

This section is divided into three main parts. The first part portrays that by not disclosing personal drug use the person may be preventing or avoiding certain problems or negative consequences; accordingly, non-disclosure can be viewed as a social achievement. The second part explores the discursive practices used to construct drug use as socially acceptable. This part includes a more in-depth analysis of individual accounts that appear to be constructed in response to diagnostic criteria of substance dependence and substance abuse. The third part describes the discursive practice of flipping the script as it pertains to notions of drugs and pushing.

Non-disclosure as a social achievement. Developing an understanding of the function of non-disclosure from the vantage points of people who do drugs is very important. A majority of the theory, research, and media representations in regard to drug use view the act of hiding drug use as a sign that there is a problem. This opinion is based on several assumptions. The first assumption is that the person’s words reflect their “inner reality” (Carr, 2011). This assumption holds that the person is willing and able to describe his or her own knowledge and beliefs. In addition, there is a prominence given to the words as representing meaning. In this way, prosody and other linguistic features that are used to interpret meaning are not understood to be hold equal weight in the expression of
meaning. For example, throughout the interviews, Sean conveys ambivalence about his wife’s acceptance of his drug use.

Niki: And so you’re saying your wife she teases you about it. Does- is um is- is that generally how she approaches it?

Sean: U:m. Yah- N-. [exhales] I-it’s a good question. It’s ah:, it’s a balance of both. And- and when she:, me:ntions it or: teases me about it. [sip of water] It won’t, you know it’s neve:r ah:, you know, you know mean or malicious or anything like that. ‘N now she’s actually, you know gotten to be more comfortable with it in the last couple a yea:rs, and just realized that yeah it’s, it’s not a negative thing for me really and, and she’s okay with it- and we work at home so, so she sees me and stuff like that. [quietly] \and ah:\, but yeah, Generally:, what would I say? No she’s- she’s okay with it. She understands. She ah:, she knows that it- it actually helps me with work a lot of times and helps motivate me to work.

In this quote, Sean’s concluding statement is “Generally:, what would I say? No she’s- she’s okay with it. She understands.” At the same time, through his tone of voice, sighing, halting, selection of words, use of negation, and repetition he conveys ambivalence to the listener. By focussing on the words a person says — which is typically taken to represent “meaning” in counselling settings — it might be possible to interpret this excerpt through the psychological theories of denial, minimisation, justification, and rationalisation. Interpretations that define a person’s discursive practice as denial, minimisation, justification, and rationalisation function to negate the person’s own capacity or capability to speak for themselves or to understand themselves. Everything the person says is therefore suspect and unreliable. The truth can only be ascertained through access to inner psychological realities, and the person’s own perspective, conveyed semantically, is not to be trusted. Similarly, family members who do not acknowledge the problematic nature of drug use are also said to be in denial, co-dependent, or “an enabler.” In a sense, this process of labelling and attributing authority to specific interpretations can act to “silence” dissenting voices.

The general assumption that the content of what a person says necessarily reflects of their knowledge, opinions, and beliefs furthermore assumes that people are able to fully express their meanings verbally using English words and that they will choose to disclose the full range of their understanding. However, Carr (2011) explains that “[t]he
self is an actor who is radically dependent on where, when, with whom, why and under what circumstances she acts” (p. 223). From this point of view, the enactment of self, including the discursive enactment of self, is dependent on the situation. Successful enactment of self involves metalinguistic awareness, which is “the practiced ability to read the range of authorized, acceptable discursive possibilities within an institutionalized set of recursive linguistic practices” (p. 194). Therefore, metalinguistic awareness contributes to the discursive enactment of self. The person, implicitly and explicitly, considers the context of “where, when, with whom, why and under what circumstances she acts” (p. 223) and selects discourse in response to what is considered authorised and acceptable and what are the desired outcomes of the interaction.

Depending on the anticipated and desired outcomes, the person may conform or act in defiance to various degrees. For example, in these interviews it is possible to identify instances when the research participants conform to a higher academic style of language as compared to a colloquial style of speech. They also demonstrate conformity to Canadian views of morality that are centred on family values and a Protestant work ethic. Given the critical perspectives presented regarding the dominant view of drugs, this was rather surprising. However, this may be an enactment of metalinguistic awareness with the goal of constructing an image of the person as a moral agent, thereby implicitly positioning their choice to do drugs as external to debates of morality. In this way, it may be that under different circumstances — such as a discussion about public funding for child care, maternity leave, or work-life balance — the interviewees may have presented a more liberal perspective about the value of work.

Similarly, when a person who does drugs is talking to a health professional, a legal representative, or their employer, they will disclose information about their drug use in particular ways. For example, when Joshua speaks about feeling nervous during the interview, he attributes this largely to the interview providing an unfamiliar experience of being able to talk about drugs extensively. Even with friends he feels unable to disclose his “conflicted” feelings about doing drugs, particularly because he is a student in a Masters level health professional program.
Joshua: I can’t even be open with most of my friends because, th–they don’t know; that I’m, con–conflicted. Like even the friends that smoke weed all the time like, I couldn’t tell them that I think that they’re in a lower [chuckling] socioeconomic status. Like I can’t tell them they haven’t succeeded in life and all this stuff.

After the interview, Joshua described, “it felt like I was having a conversation with myself.” At the same time, in preparing for the interview, Joshua says he made a list of things to talk about but believed that it focussed on advocating for drug use. He frequently redirected himself away from an advocacy role during the interview and apologised since he assumed this was not the “purpose” of the interview or the research.

The third assumption is that disclosure is a desired “good.” In fact, as demonstrated above, disclosure about drug use is fraught with perils. In a way, non-disclosure of drug use is a necessary factor to contribute to achievements in other aspects of the person’s life, including interpersonal relationships, employment, community involvement, parenting, and one’s criminal record. Disclosure might mean loss of relationships, unemployment, loss of credibility in the community, loss of child custody, and having a criminal record that could impact employment and travel. These effects are possible even if the drug or drug use does not negatively impact the person’s performance. The capability of a person to not disclose drug use can therefore be viewed as a social achievement.

The next part of the analysis explores several ways the research participants discursively construct their drug use as acceptable. This will be followed by an analysis of recontextualisation.

The construction of drug use as socially acceptable. I have heard addiction theorists joke that substance dependence is the only psychiatric disorder that a person can get from arguing with their wife. A kernel of truth here deserves exploration, and is relevant to the analysis. A review of the criteria for diagnosing substance abuse and substance dependence reveals that substance dependence includes only two criteria that are directly attributed to the physiological effects of the drug, namely, tolerance and withdrawal. The criteria include activities associated with drug use as not being able to control intake amounts or the presence of socially undesired consequences, including
legal problems and interpersonal problems. In fact, a diagnosis of substance dependence does not require that one of the *symptoms* include withdrawal or tolerance. Therefore, for the person who meets two criteria for substance dependency, the development of conflict with one’s spouse regarding drug use can, in fact, lead to the person satisfying the criteria for substance dependency.

Returning to the current criteria for substance use disorders in the DSM-IV and the ICD, note that many of the *symptoms* associated with substance abuse and substance dependency involve identification of problems in social roles, responsibilities, and obligations. Drug use is considered problematic when it is identified to interfere with performance at work, school, home, interpersonal relationships, to takes place under risky circumstances, and/or that causes legal problems. Moreover, evaluation of what constitutes a *problem* is subjective. As stated by Reinarman (2005), “what is taken as empirical indicators of an underlying disease of addiction consists of a broad range of behaviors that are interpreted as ‘symptoms’ only under some circumstances” (p. 308).

From this point of view, it can be proposed that judgement of the perceived impact of the substance on the said *problem* is also subjective. For example, Joshua describes arguments between himself and his girlfriend about his drug use and her giving him an ultimatum to quit or they would break up. Joshua is hesitant to yield to an ultimatum and argues the merits of marijuana in relation to its minimal health risks and harms. One might consider that Joshua’s drug use creates an interpersonal problem in his life; but when one considers the bigger picture, he and his girlfriend are looking toward graduating from a university program and are contemplating their next life steps. They come from different cultural backgrounds and have different goals. For example, she is not sure she wants children and plans to work and travel abroad, while he expresses a willingness to travel, but a preference to remain in his home town. He is also interested in having a family while she expresses a desire not to have children. One could imagine that the problems in the relationship may be rooted in life circumstances, long-term compatibility, and divergent visions for the future. Arguments pertaining to Joshua’s use of marijuana may provide a tangible topic to focus the dispute, but may not be the core of the issue of the conflict.
Recognising that the problems associated with substance use require evaluation and identification by a person (e.g., either the person doing the drug or an outside observer) and occurs in relation to social contexts (e.g., work, school), it can be understood that people who use drugs need to constantly negotiate all aspects of their drug use. In this analysis it is proposed that the research participants actively demonstrate a negotiation regarding how they *talk* about drug use in various contexts in order to minimise the risk of negative consequences. Given that drug use is often viewed as wrong, bad, and socially unacceptable (and not to mention the fact that it is illegal), in order to protect oneself from the development of “problems” and the identification of symptoms many of the facts about drug use need to remain undisclosed. What is often described as denial, minimisation, neutralisation, and justification can be interpreted as a discursive means to avoid judgement and the construction of disordered behaviour. As will be described, the drug use itself may not be viewed to have a negative impact on work, school, or legal status. However, if a professor, employer, or police officer became *aware* of the drug use, this awareness could lead to actions being taken that would have negative consequences for the person who is doing the drug. As a result, the analysis of the interviews will focus on how the research participants achieve successful enactment of their drug use through discursive practices.

An analysis of intertextuality and interdiscursivity emerges as a means to interpret discursive practices. In this part of the analysis intertextuality can be interpreted through incorporation of the criteria to diagnose pathology. This is not to assume that the research participants have direct knowledge of the diagnostic criteria, but that the criteria are authoritative enough for the research participants to address them throughout the interviews.

The criteria for the diagnosis of abuse and dependence can be categorised as the pharmacological effects of the drug (e.g., tolerance and withdrawal), impaired self-control (e.g., using more than intended and unsuccessful attempts to reduce use), imbalanced use of time toward drug use (e.g., increased amount of time, decreased time in other activities), using despite associated physical and mental harm, and problems in the areas of acting safely, role fulfilment, interpersonal relationships, and adhering to laws.
During the analysis it was found that the research participants indirectly address the concerns that make up the diagnostic criteria of the drug abuse and drug dependence without being prompted. One reason for this might be that the interviewees were aware that the interviewer is a registered health professional and addiction counsellor. In addition, the research is located in the health professional education field, and the word *addiction* is in the study title. However, given the spontaneous disclosure about the health-related content, that it is embedded fluidly within the talk, and that there is evidence the person thought about it and talked about it in the past, it seems unlikely that the immediate audience was the sole influence. When referring to topics that correspond to the diagnostic criteria, the interviewees sometimes described how they fit the criteria as an indicator of a problem and evaluate whether or not their actions met the criteria. In another way, the interviewees sometimes challenged the relevance of the criteria and provided evidence that there are factors which are insufficiently captured by the criteria — for example, that drugs can contribute to health and well-being, or that drugs can enhance productivity.

For the most part, the participants did not dispute the validity of the diagnostic criteria as being appropriate indicators of drug use being problematic. This is consistent with Becker’s (1963) observation that narrative accounts by people who engage in deviant activities “tend to contain a general repudiation of conventional moral rules, conventional institutions, and the entire conventional world” (p. 39). One exception is in response to “legal-related problems.” The research participants acknowledge that their use of drugs is illegal. However, they tend to blame the fact that they are engaged in an illegal activity as a fault of the law and associated upper-level bureaucratic decision-makers, rather than any wrong-doing of their own. As Joshua explains, “And again, if it was not- not illegal then I wouldn’t be, doing illegal, ah activities ‘n.”

Haylei notes that police officers are “just doing their job” and should not be blamed for the laws they are expected to enforce:

*Haylei:* [chuckles] like if the cops, [chuckles] you know caught me with something, I’d be like “Here it is.” You know why, why make it, difficult for them? They’re just doing their job. It’s not their fault it’s illegal. I mean I’d rather them go, catch coke dealers and, meth dealers,
but, [1] should my time come, [laughs]
Niki: [laughs]
Haylei: I’ll deal with that then.

Sean conveys an opinion shared among the research participants that select people in positions of authority establish laws. Yet, the existence of a law and the need to enforce the law are not viewed as necessarily being relevant to guide personal choices and actions:

Sean: sure it’s a rule and it’s a law, [laughs] but that doesn’t necessarily mean I have to agree with it and, and think it makes, sense in the long run. It’s just, you know people, people at the top who have made the decision for whatever reason.

Interestingly, several of the research participants do drive vehicles while they are high, despite knowing this is illegal:

Jenna: and I can still drive my car, and [laughing] \you know what I mean.\ [sing song voice] \I know I’m not supposed to,\ but
Niki: [laughs]
Jenna: I feel, I’m better you know. I’m more attentive, [laughs]

While the research participants who drive while high do not seem to see this as problematic for themselves, they do view this as problematic if performed by others:

Sean: as much as, I think I’m a, probably a, perfectly, good driver, maybe even safer [chuckling] \’cause I go really slow.\ [laughs]
Niki: [laughs]
Sean: [laughing voice] \Maybe a little bit more careful when I’m on it, but there,\ there are times when you, you know, just aren’t as attentive, and not as paying attention, so. As much as it can help you times. You know, do I think it’s right for everyone to be out there [chuckling] \smoking some pot ‘n driving? Like, no no no.\ [laughs]
Niki: [laughs]
Sean: Just because it works okay for me, doesn’t mean I think it’s a good ah, you know a good norm.

Sharon reports that she does not drive when she takes her prescribed morphine, which she explains acts as a limitation to participating in social activities.

The research participants express a stance that many of the illegal activities associated with drug use are inherent to the nature of illegal markets. If the drugs were not illegal the costs would be less, and there would be fewer crimes related to accessing sufficient financial resources necessary for purchasing the drugs. Paul says that crime
related to drugs may be a result of the illegal nature of drugs: “And, … again with- like-w- making drugs illegal and stuff, they involve more crime. They involve, higher prices. Higher price mean more crime. Because they can’t afford to buy it.”

Joshua expounds the inflated value of drugs in relation to the illegal nature of drugs:

Joshua: Which is funny because like if you think about weed is more expensive than gold right? Because it’s a- and it’s all based on the fact that it’s uh, uh, prohibited right? Prohibition drives up prices. I-it’s a black market, it’s illegal so you have people t- to do: illegal things. It’s crazy how, that it’s, worth more than gold.

Note also that the illegal nature of obtaining drugs means that people seeking to purchase drugs have a higher potential to be in dangerous situations, such as meeting up with people they don’t trust, being in more dangerous areas, and being offered or exposed to drugs that are considered to be associated with higher risk for harm:

Joshua: but, [2] I’m not gonna lie, smoking weed has exposed me to: people that do a lot of drugs. Uhm, [1] I don’t know if legalising it would change that. I think it would. Decrease that. Uhm,
Niki: Sorry, decrease the?
Joshua: My exposure to,
Niki: Yeah.
Joshua: people that do o-, I don’t know if it would. I think it would because it would-
Niki: Oh to other drugs.
Joshua: Yeah. Different drugs. Ahm. I’ve been exposed to a lot of bad things and I I-I-I, one decision could have changed my life, pretty badly but.

Joshua also states, “the reason [marijuana]’s a gateway drug is because it’s prohibited. So you’re, you’re exposing people to other drugs because dealers don’t just deal, one drug.”

Regulation of drugs that are currently illegal is proposed as a strategy to reduce the health risks associated with drugs:

Haylei: [12] But I think, you know so on the flip side that if it were legal and accessible, it would be like, well my hope would be, it would be like the liquor store, where it’s packaged and it’s, contents are known and, it’s, y- you know you’re not getting some, crap that’s not, what they say it is. Where, it would be a safer way. You wouldn’t accidently end up doing PCP.
One way that the research participants express their opinions about the legal status of drugs is to compare illegal drugs to legalised commodities and behaviours. Comparisons are frequently drawn between illegal drugs and prescription medication, or illegal drugs and alcohol:

Niki: Hm. Do you find, um, like for you, do you see much of a difference between drugs that are legal and drugs that are illegal?
Sharon: No.
Niki: No.
Sharon: No. Actually, drugs that are legal are worse. Than the marijuana. [louder] \Because I’m telling you, I don’t crave, my marijuana. \ I crave, my morphine.

Sean compares marijuana to alcohol several times during the interview:

Sean: You know how alcohol is legal, and a lot of pot smokers just think you know, it’s just so ludicrous you know the thought of, throwing someone in jail for, you know, smoking, you know, a herb plant, that happens to get you a little high. You know, compared to; you know, the endless, endless social problems in my opinion, from booze. ‘An-, you know. And th- that’s how [chuckles] that’s how m- I think me ‘n lots of people who smoke pot sort of have that level of, sorta justifying, it. You know people who [deep, growly voice] \ drink wine every day, you know have three glasses of wine every day, and that’s, socially, [chuckles] you know [deep voice] \ no problem at all. You know ah,\n
Parallels are also drawn between other activities that are viewed not only as socially acceptable and legal, but also with more generalised patterns of consumption.

Jenna: [chuckles] We’re all addicted to food.
Niki: [laughs] You need it to live.
Jenna: Right? We need it to live but we use it in, in a bad way in our society. You know especially with, making bad processed foods. Like that’s a bad addiction. People who- an’ an’ that’s f-free and easy on your shelves to go and buy chips and pop and high fructose corn syrup and, have more have more even though, scientifcally been proven to cause cancer. So, why are we pushing that on people? Why isn’t soda pop, illegal? When, it’s a harmful substance. It can cause dementia, it can cause cancer, it makes, your DNA, go wonky. So, why is, why is that ok? To use.

A relatively large amount of the research data is constructed as a response to the legal nature of drugs and the implications for the individual, and Canadian society, generally. Legal discourses dominate an authoritative position, such that parents will
uphold the legal discourse with their own children, choose to suppress their own opinions and not disclose their own drug use. Advocating for legalisation of drugs is a challenge in these situations since there is a parallel need to not disclose one’s own drug use from the public eye.

Paul describes that by locating himself in Ottawa some of his clientele are politicians. In this quote he highlights a disconnect between personal choices and upholding the law, as well as the implications for not disclosing personal use publically:

Paul: A- and most people would be outraged, if they found out that, a huge percent, a huge percent of their tax money’s going towards ah, [indicating quotation marks with fingers] illegal, with quotations marks, drugs that they say is horrible, but yet they’ll turn around and tell you. [louder, deeper voice] "Nope. That’s horrible. Can’t do it.” But, [quieter voice] they come home, they take ’em.

The research participants indirectly discuss their drug use in relation to the DSM-IV criteria of substance dependence, which, I suggest, allows them to demonstrate an awareness of what constitutes problematic drug use, to present an informed evaluation of their own drug use, and at times to challenge the suitability of the criteria to understand the experiences of drug use. The discursive practice can be interpreted as providing a means to frame drug use as socially acceptable. In the remainder of this section the data is organised in the categories of tolerance and withdrawal, self-control, time, physical and mental health, acting safely, role fulfilment, and interpersonal relationships.

_Tolerance and withdrawal._ Tolerance and withdrawal are only described occasionally across all interviews. Personal accounts regarding the presence or absence of tolerance and withdrawal are rarely presented. Sharon describes the development of tolerance, saying, “And, what happens is you need a bigger rock, you need a bigger rock you want more ‘Ah let’s do it again. Let’s do- let’s buy one more.’” Jenna describes the loss of tolerance, stating, “So we, do a little toke. [laughs] And, and it’s true because when you stop you get like [blowing out] bphew\ like blasted away right? Like you get super high so you don’t really need a lot.”

Sharon reports experiencing withdrawal while in jail:

Sharon: I went to jail for six weeks. Okay so, I went through withdrawals, by the
I was done my withdrawals, I was ready to have a hoot. Like let me outta here. I wanna have a hoot. I wanna have a, drag off a joint.

Joshua notes the absence of withdrawal during an overseas vacation:

Joshua: And I wasn’t afraid, of going s- five weeks, or six weeks without it. And I never ever tried to get it while I was there; I never felt any signs of withdrawal. But, like the studies show that they’re not gonna g- you’re not gonna, I mean it’s a habit.

Self-control. Self-control refers to the concept of impaired self-control, including using more than intended and unsuccessful attempts to reduce drug use. Occasionally during interviews there is recognition that drug use had periodically been uncontrolled and problematic. Sharon suggests that she had experienced times while immersed in drug use when she seemed to lose a sense of volition until the drugs were used up. She speaks about the fun of being in the moment and high on cocaine, in contrast to the “now” of coming down when the cognisant realisations begin to assume clarity:

Sharon: And I have, seen what cocaine has done to me. So. And [loudly] \It’s a great high.\ Oh yea:h.

Niki: Yeah?

Sharon: Whoo hoo hoo! Ya:y! For the moment. After four hundred and fifty dollars is gone, and n- now you’re coming down and you really really feel, you do get that guilt? You get that. “h:uh! If I didn’t do all that coke, I’d have that money I could go drinkin’ maybe buy some groceries. Some cigarettes.”

Haylei reflects that she is able to have mushrooms (psilocybin) in her house and isn’t tempted to take them. However, she says she has “no control” with marijuana and if she has it in the house, she can’t resist smoking it:

Haylei: And I still have some left. So I’m like, mm they’re just in there. Like I don’t need to, those can be put away.

Niki: [laughs]

Haylei: They’re not like

Niki: Mushrooms you’re good at putting away.

Haylei: Yeah. I can, just put those away. [1] But, [1] [chuckles] \\

The idea of a lack of control is sometimes adapted in a humorous way. Frequently, the research participants express a sense of control. One of the ways that personal control
over drug use is described is in relation to the idea of whether the person feels a “need” for the drug, compared to a perception that drug use is a rationalised choice.

Joshua tells about a friend who approached him when he first started smoking marijuana, advising him to maintain “control” over his smoking and Joshua acknowledges the truth in this observation. Now, he has been smoking daily for a “long time,” “enjoys it,” and believes that he has established control:

Joshua: Uhm, but h-he was right. Like I ha-, like I wanted to smoke it all the time and, I didn’t really have control over it I really enjoyed it? Uhm, and I still do:, ah, not that I c- I have to smoke it. And, and I have been smoking for:, for a very long time. Almost every day.

Sean finds that he is able to establish appropriate boundaries for his drug use depending on his changing responsibilities and circumstances. For example, the need to attend his son’s recreational activities where other parents are present:

Sean: But ah, yeah. Yeah wanting to reduce it and and, you know that helped me, r-really slow down because even if it was, you know two or three hours before like, [Bryce’s] hockey game for example. You know I didn’t want to be remotely, high or under any influence or anything like that so. [inhales] That was, ah you know kind of a good thing to just, slow it down and, and change it up at different times.

Although Sharon notes there were times when she lost control over her use of cocaine, she also describes being able to quit doing cocaine completely. While she describes herself as “weak” in regard to drugs, she was able to exhibit her control over exposure to situations where drugs would be present. She explains, “I had to disassociate myself. From the people that, were doing it because I was weak. I knew I was weak. Because had I stayed I would’ve, spent my grocery money and got high, and drunk.” Sharon also states that she quit doing acid suddenly, after “I had, one, l- really bad, and very last trip in my life.”

Paul mentions having been “addicted,” which suggests a loss of control, but was able to stop using those drugs that he believes he was addicted to without accessing addiction-related counselling. He explains that when he first got involved in the business of selling drug he inadvertently became addicted, but seems to have quit without much fanfare. He describes, “When I first got into it, I was not looking. To: become a user or,
become addicted to anything or anything like that. Which, thankfully nowadays, I’m not addicted to anything, which is great.” Paul gives an indication that he became “bored” with the effects of drugs. He states, “All the other ones are kind of, [2] they get boring. They get very very boring.” This is quite contrary to the notion that once a person uses drugs, the drugs become overwhelmingly alluring.

Jenna notes that drugs can be used with “intention,” or a specific reason. This insinuates that drugs can be used purposefully, suggesting an element of control and strategy:

Jenna: You know everyone uses it for, [inhales] everyone uses any kind of drug, for a specific reason and if you are doing it just to tune out? Then, you know that’s what you’re gonna get. But if you use it with intention, It becomes more of a sacrament.

The notion of need comes up frequently. In one way, some of the research participants reproduce discussions with people close to them regarding to arguments about using the term need. For example, Sean describes a typical conversation with his wife when he tells her he wants to smoke marijuana, such as before going to the movies: “And ah, and then she would say like [higher pitched voice] “well if you need to.” I’m like ‘well I don’t need to like, I’m just being honest. Like I’d, that I would like to.’ [laughs]”

Joshua portrays a similar conversation with his girlfriend:

Joshua: if I said that to my girlfriend she would like, you know she would go “[exasperated sigh],” you know “you need- you need it to get chill. You don’t need weed- you don’t need weed to get chill.” And you don’t need weed to get chill. I don’t ne- I never said that. But, it, does make you chill, like, [chuckles] [higher pitch] you can be chill without it, yeah:.

There are frequent hesitations in the narrative accounts, which seem to indicate an awareness of the audience and the perceived meanings associated with certain words. In the quote above, Joshua hesitates twice following his use of the word need, as indicated by the “-” symbol. Similarly, Sean both hesitates and corrects his use of the word need when he describes, “like, you know if-, if we need to smoke pot, after, hockey or, [quieter] need to.”
In the next quote, Joshua distinguishes what he perceives to be the difference between need and choice. A portion of his account reflects a typical interaction he might have with a friend. Discussions with his friends are embedded with shared meanings, which Joshua finds necessary to explicitly explain and clarify to the interviewer. For example, to his friend he could respond “I can’t say no,” but to the interviewer he needs to clarify, “But no, you can say no. That’s a joke.” He adds emphasis to the words “can” and “joke” to reinforce the idea that he is able to exhibit control over his drug use:

Joshua: I try to advocate that it’s not something you need to do, it’s a choice. You know. It’s an easy choice. To make. For us, right? ‘Cause it’s- it’s not really a choice. It’s like, [1] think of my buddy. Would do it. Ask- if he-, if he: it’s like “You wanna come have a bowl?” And it’s- I can’t say no to a bowl you know what I mean [chuckles] \how can I say no right.\ 

Niki: [chuckles] 
Joshua: How- I can’t say no. So I’ll do it right. But no, you can say no. That’s a joke. It’s a joke he has. Like if I really have to do something right now, I would say no. But, I’m not gonna say no ‘cause I don’t have to. 

Niki: Right. 
Joshua: Right? So why would you say no if you don’t have to. 

The research participants do express a need for drugs in a few instances. Jenna describes a frustrating situation when, after several months of not smoking marijuana while pregnant, she wanted to smoke in order to calm down: “I’m just like, livid, and I’m like, ‘I need a fucking joint.’”

Sharon also expresses a perceived need to be able to smoke marijuana. In a way, she presents her need to smoke as therapeutic, despite what “any doctor will say:”

Sharon: I’m totally terrified of getting caught. With pot. Because I know I need it. I do. If I don’t have a p- my pills, I’m gonna be smokin’ pot. ‘Cause it does make you relax, it makes you wanna eat, it, it does help. I don’t, care what a d- any doctor will say. Marijuana helps. I’m here. I’m forty years into it. 

Haylei adopts the language of diagnostic criteria when she refers to “the ongoing battle of, needing and finding drugs.” However, she uses this term while laughing, and it refers more to her perceived incompetence at finding drugs than in response to an insatiable desire for drugs:

Haylei: [1] I would still wanna do mushrooms again. 
Niki: Mmhm.
Haylei: Like I know [laughing] \ I’m gonna do them again. I just have to get some. [laughs]
Niki: [laughs] [2]
Haylei: Ah th-[chuckles] the ongoing battle of, needing and finding drugs. [laughs]

*Use of time.* An imbalanced use of time toward drug use develops, such as an increased amount of time associated with drug use and decreased time associated with other activities. Sharon is the only person who indicates that she perceives she currently sacrifices other activities as a result of her drug use. She notes that she tends to isolate herself, which she attributes more to her prescribed morphine than to her marijuana use:

Sharon: That’s the only, one side of, of taking prescription drugs is that, is you tend to ah, stay in your own little realm.
Niki: Oh yeah.
Sharon: Yeah. You don’t you don’t wanna go outside much you don’t wanna, like if you don’t have to you don’t go. I don’t know. Peopl- I- I guess you isolate yourself a little bit.

Joshua notes that he feels he has “wasted” days when smoking marijuana. However, these are days when he does not think he would be productive, regardless of whether or not he was doing a “drug:”

Joshua: and I’m not gonna say I haven’t wasted any days. Like you know, I was thinking about that today. I was, “Well, I would’ve wasted those days doing other things” so usually when I waste a day just smoking weed all day, it was a day when there’s-, when I woke up and like you know “Today’s gonna be one of those days, gonna do what I wanna do;-, watch a- I could watch movies all day watch like a, marathon of movies on TV., but I don’t do that. You know, I hang out with my friends, I go hang out with, my friends and, smoke weed.

What seems to be a more common way of presenting drug use is to integrate time spent doing drugs with time spent in other activities. Sean uses the term “combinations” to describe selectively choosing drugs to enhance specific activities. He describes, “[inhales] certainly one of my ah, my favourite combinations. Is having a nice smoke and, going out for a nice two hour bike ride.” Also:

Sean: like ice fishing or something like that like. I’ve always said that my favourite combination of like a drug and an event, is, fishing, on mushrooms.
Niki: [laughing]
Sean: It’s just awesome. [laughs]
Niki: [laughing]
Sean: It’s, you know, i-it’s just such ah [chuckles]
Niki: [laughs]
Sean: it just can be such an experience, and, just so memorable it seems like
too Niki it’s really neat like, you know they’re, s-some of the, you know
and it’s just a rare occasion and maybe that’s why it’s such a neat treat.
You know

Paul describes this in a way that can be interpreted as a well-rehearsed sales pitch.
The “craving” is not attributed to the psychoactive properties of the drug so much as the
craving for an overall embodied and situated experience:

Paul: The new term is designer drugs?
Niki: Okay yes.
Paul: That’s really what it is. And, in regards to that, it’s, pretty much your
mood. It’s like you go out and, you have a certain event you wanna
come out to, you for example would probably pick out an outfit and a
pair of shoes for it right? You don’t rea- I guess you could do that too if
you wanna go clubbing but, it’s more so like, y-you figure out w-what
you wa:nt. And you figure out what, what craving I guess you’re
having. And then at that point you fulfil it.

In his work, Becker (1963) found that people who smoked marijuana frequently
progressed to a point of smoking at times that were considered to be “appropriate” and to
not smoke at inappropriate times. He suggests that this is perceived by the marijuana
smoker to demonstrate an element of control over drug use. The research participants
seem to support this interpretation, and determine drug use to be a desired use of time.

Physical and mental health. Some of the research participants indicate that the
drugs they are using do have the propensity to have some negative effects on their affect,
Joshua indicates that marijuana seems to heighten symptoms of social anxiety:

Joshua: I know I have social anxiety. Uh:m, weed doesn’t necessarily help that.
Niki: [1] No?
Joshua: No. If anything it makes it worse. ‘Cause there’s a paranoia- people say
there’s a paranoia from weed, and it’s not um, it’s not that weed makes
you paranoid, but for me weed, ah:; like I said it makes you more
aware of your surroundings, makes you more aware of yourself, as well.
Uhm, so, being more aware of yourself, you’re more aware of your
high, and you’re also aware of everyone around you, and you start
worrying everyone’s- does anyone know I’m high, do I look high, uh:m,
so that- in that sense that can- that can actually create social anxiety, for
me right so.
Sharon reports that marijuana makes her more “emotional.” She elaborates, “And- I definitely think the marijuana makes me more emotional. [sniff] [clears throat] It makes me think about what I’m doing. [tearful] And that makes me emotional.”

More typically, the research participants argue that the drugs they choose do not have any negative impact on their health. In several instances, they feel that the drugs were contributing to their overall well-being. Similarly, Becker (1963) found that people who smoked marijuana frequently compared it to more harmful practices (such as alcohol consumption), and reported that the marijuana effects were beneficial rather than harmful.

The research participants recognise a potential for drugs to impact their physical health, monitoring potential symptoms and evaluating the significance of risks. Sharon compares marijuana to morphine and cigarettes. She indicates morphine is significantly more harmful, stating “These’ll kill you.” Cigarettes, on the other hand, she presents as more likely to be linked to lung disease than marijuana, drawing on personal observation:

Sharon: you know “These [morphine]’ll kill you. The pot won’t.” We don’t know that, I mean ahm, mm. Another thing is, I’ve talked to at least four people that have half their lungs taken out or, and they’re all cigarette smokers. None of them smoked pot.

Niki: Right.
Sharon: I’ve smoked pot for forty years and I still have both my lungs. Yes, I’ve had, I don’t use my puffer as much, ‘cause I quit smoking.

Joshua also worries about the potential effects of marijuana on his lungs. While he reports that he “coughs up… black specks,” he draws on technical, standardised medical indictors of health, such as pulmonary functioning and loss of endurance. He notes that he was enrolled in a health professional program and “obviously” cares about his health, indicating that he would not be engaged in an activity that he perceived to be unhealthy:

Joshua: …we have a lung, a lung ah; ah performance test? Like the; ah; FET yeah. Pulmonary function testing? And I was worried obviously like ah; it was gonna show signs ‘a emphysema or all these things. Ah I had nothing. Like just perfect. Like there was nothing wrong. But it was still cool. And you still worry and ah; I do cough up ah; like black specks sometimes things like that but like ah; no: like si:gs of like loss of endurance, I still work out every day and like obviously people in, who get into [this university program] care about their health. Right. Like eat healthy. I try to be healthy otherwise, yeah.
Jenna draws on the colloquial term, “pick your poison,” which originally referred to choosing which type of alcohol one wanted, but now generally means choosing between two potentially harmful options. Her initial reference to this term indicates a casual use of this phrase that is likely shared among her peers to indicate the perception that everyone has a way of coping or indulging that is potentially unhealthy — be it alcohol, chocolate, or watching TV. However in the context of this interview, she realises the possible interpretation that an outsider might make of relating the term “poison” to “harmful.” Instead, she shifts the position of marijuana from a poison to the relatively more neutral concept of “a plant.” It is natural and “from the Earth,” which is more benign than alcohol that needs to undergo a fermenting process. At the same time, when concluding she acknowledges potential harm to the lungs using scientific terms, but in a manner that is somewhat dismissive, as indicated by saying “of course” and “what-not.” She also does not elaborate, as though the point warrants no further attention:

Jenna: So, who knows what your poison is but, [laughs]
Niki: [laughs]
Jenna: I feel like this- for us, this is not really a poison ‘cause it’s- like it’s from the Earth. It’s grown from the Earth it’s, a plant. It’s not like it’s a fermented, [1] fermented alcohol or, you know, I don’t feel, yeah of course smoke d-does damage your body. Your lungs and what-not. Carcinogenic.

Sean uses several linguistic strategies to present his evaluation of the harms associated with different drugs. In the following quote he states that smoking marijuana “helps me justify that gigantic thing of popcorn that I’m gonna inject.” He constructs an implicit comparison of marijuana as being less unhealthy than theatre popcorn:

Sean: Then yeah. Movie on weed. Yeah. They- they certainly go enough- well together. It helps me justify that that gigantic thing popcorn that I’m gonna ingest
Niki: [laughs]
Sean: into my body ‘n [laughing voice] \b-before the movie even starts, so.\n
This example can also be interpreted as flipping the script, as Sean recontextualises marijuana to be healthier than the socially acceptable activity of eating high-fat, high-sodium, artificially flavoured popcorn. He transforms smoking marijuana to be an equally normal activity associated with watching movies as eating popcorn, and furthermore portrays it as the better, healthier, alternative.
The research participant refer to peer-reviewed literature and documentaries that address the health-related research of drug use. For example, Sean references a controversial paper written by David Nutt (2010), describing the reported negligible harms associated with MDMA:

Sean: And he ranked it on like, it was like four or five different criteria. From like, social perspective or social ah:, sorta, damage, ah, you know physical damage to your body th-
Niki: Ah yeah.
Sean: and the level, of addictivity or, whatever, you would call it. And, in his, in his, words ’r what I saw, was that, based on all the research that he had done and, you know, research that he’d looked into, he said there’s no way MDMA is not, more dangerous, or ‘r is- is less dangerous than riding a horse.

Each research participant also demonstrates that they actively make decisions to not do drugs that they deem have too high of a potential for harm. A few examples are provided here. Jenna describes, “Like I haven’t played with pharmaceuticals. It’s not one thing that I’ve ever gone into? ‘Cause I think that is way more dangerous, in a sense, ‘cause they’re synthetically uhm, milled and made.” Haylei explains, “But it’s not like, [1] I don’t know like I read about meth and, heroin and, coke and all that. And I have no desire to try any of those, or go there.” Joshua states, “and when you go onto the harder drugs, most of them just are degenerates just ‘cause of the effects it has on you:, your life, you can’t, you can’t separate your- the drug from your life.”

One way the research participants address the effects of drugs on health is to assert that the drugs actually improve or enhance their well-being. Paul indicates that by selling drugs he plays a role to “help” people:

Paul: I help people in a different way. I help them kind of, escape the problems that are there. We- we, we try to fix problems, … [interruption at the door]
Niki: You were saying like you’re helping people.
Paul: Oh yeah like, I’m helping them in-in-in a different way. I’m- I’m trying to make them to the point of where, [1] they’re, [3] their goals are more achievable. May it be in a, clearer thinking head, or else in a clouded head which a lot of drugs can cause you. That kinda stuff, yes.

Joshua agrees with this potential for drugs to play a helping role. He says:

Joshua: but, on top of the effects that weed’s a, calming thing, ‘cause it makes you kinda chill ‘r whatever so it, it helps that just to, be in a situations
where- just relaxed, not wo:rrying, you know, so. The psychological aspect it, ah.

Joshua expresses some ambiguity about relying on drugs to play a role in managing stress, but overall he indicates it seems to help:

Joshua: And it’s helped get to where I am, in a- in a sense. Sometimes, ‘Caus- as a coping mechanism. As a passive mechanism I realise that it’s not, the best thing. And I do, I do I have other active coping mechanisms like, if I have a problem, I may smoke weed at-, rel- tim- ah- ah on a- a- to partially relieve, you know any-, s- stress or anything like that.

Acting safely. Driving was touched on earlier. The research participants acknowledge they “shouldn’t” drive while high, but do not evaluate it to be a significant risk. The research participants also seemed to evaluate how to best keep themselves safe:

Haylei: And it’s like I know, how to get, how to keep myself safe? And I always have, been able to do that. I’m very lucky in that way. That, nothing bad has ever happened to me:. Never been rob:bed, never been raped. Like I just, as messed up as I have gotten? I always, keep that wit about me. I just call it my internal homing device. When it’s like “home.” It’s like I’m going home.

Haylei also describes establishing strategies with friends prior to doing drugs in order to keep one another safe, such as a time she and some friends went out to a bar while doing mushrooms:

Haylei: but we made a code word. S’ it was like if anyone, from the group, came up to you and said jellybean, you had to tell someone else, that jellybean has been activated.
Niki: [laughs]
Haylei: And you were getting them out. Take them back to where you started.
Niki: And everyone goes? Or just that one person.
Haylei: No. Just one person goes with them.
Niki: Yeah.
Haylei: So they don’t freak out and take off. But you let them know that someone is freaking, so you gotta get them out. Because it’s kind of like a warning too:, that these [drugs] may be bad.

Role fulfilment. Sharon is the only research participant who says her current use of drugs interferes with her participation in roles. She reports isolating herself and not being able to work. She relates this primarily to her use of prescribed morphine, not her use of marijuana: “I wanna work. But I can’t. And now I’m on all these pills. And I mean the morphine I mean I get right looped.”
Sharon also describes that her current use of drugs contributes to a reduced sex drive and reduces participation in a sexual role:

Sharon: “When I need them, is at night.” You know, that’s when you’re supposed to be havin’ sex. And you’re supposed to be livin’ with-sleepin’ with your spouse. I mean- not me. I’m like “haugaugh.” You know. And I don’t wanna be bothered anymore.

Sharon reports that cocaine had impacted her roles in the past, including paying bills and parenting:

Sharon: so anyway so one day I just woke up and said “ok no more cocaine for me, I can’t do this anymore. I got no money left. [starting to get tearful] My mom’s paying my bi:lls, my mom’s feeding my kids, [more tearful] I can’t even pay my thirty-two dollars rent.” So, [less tearful] I smartened up, [more tearful] I lost my oldest daughter over all of it. [tearful] She ah, one morning she woke up and just called me names and punched my in the face, three times.... So I [tearful] punched her back. And I phoned Children’s Aid.

Sean indicates that marijuana negatively impacted his ability to undertake “bigger projects.” As a result, he decided to change the times that he was smoking:

Sean: like I said if there’s, a big work project that needs to get done or if I’m talking to someone important for wo:rk and, [quietly] \and it’s like, “ah yeah\ I don’t want to be [chuckling] \high for this.”

Niki: [quiet laugh]

Sean: This phone ca:ll or something like that. And then what I’ve fou:nd is, you know when I’d be: high I would just sort of leave those bigger projects, just a little bit to the side like, I would love to think about them and, you know write notes and, and the sorta to-do list on it a:nd, ahm, you know sort of action plan but then like sort of the follow through on it just, just wasn’t as, you know wasn’t what it should have been, so.

He decided instead to smoke at times when he feels marijuana helps him in his roles, such as housekeeping and brainstorming at work:

Sean: if I:\’ll like have a smoke and all of a suddenly I’ll be doing like, housework, and I’ll be kinda like, [breathes in], you know. And I get really like my mind gets going quickly I find it really stimulates my mind like if I ever need to like think of work idea:s or brai:nstorming I I just think it’s awesome.

Paul reports doing Ritalin in order to give him energy to be able to fulfil his roles:

“I still prefer my, [2] [tc] uh my prescription Ritalin? I think that’s probably been the one thing. That’s the one that gives me, kinda the energy to get up in the mor:ning,”
Joshua states he has used marijuana as a motivator to get out of bed in the morning and attend his university classes. He does not claim that the effects of the drugs enabled him to perform his role as a student, but that marijuana acted as positive reinforcement:

Joshua: ah I would use it first year. I’d hate going to class. So I would use it to motivate myself like. I wouldn’t wake up to go to class, but I you know what. Wake up, miserable. I would wake up just to get to smoke a bowl. Right, I’m like, I would wake up and smoke a bowl. And I’m like, I’m already awake, I’m up, I might as well go to class.

At the same time, Joshua describes that he did evaluate the effects of marijuana on his performance in school and work. In this way, Joshua does seem to adhere to the idea that impaired performance of roles is an indication of problems associated with drugs. He seems to use this criteria as a personal indicator to evaluate the his own drug use:

Joshua: It hasn’t affected my school. But I always said, if I smoke weed and it’s gonna affect my, if it started affecting, my life. Started affecting, school, my job. [1] I wouldn’t do it. You know and, it’s done. And it hasn’t.

Sean notes that he feels able to perform various roles while high. In his evaluation, marijuana does not negatively impact his performance of parenting and leisure and, at the same time, it enhances his enjoyment of the experience. He seems to express conflict between a social discourse of drug use being “wrong” and a subjective evaluation of his experience:

Sean: you know there are times when, you know before I’m gonna, take him to the, park for example, or go for a long walk with him ‘r a bike ride. Yeah, I’ll, I’ll have a smoke in the garage ‘n, you know, go, for a, a bike ride with him, ‘n, you know there are times ‘n every once in awhile where I’ll sorta like, you know, “Jeez,” you know, “is this, quote unquote wrong,” you know, “that I’m, you know, getting high before I go for a bike ride with my kid?” But then on the-, on the flip side, I’m like, “well”, you know, “smoking this pot, you know, certainly, [chuckles] enhanced the experience to me.”

Joshua states his opinion that it is not necessarily the pharmacological effect of the drugs that can impact a person’s performance, but the impact of other people finding out and judging them as a “drug addict.” He highlights that using drugs does not correlate with the dominant conceptualisations of what it means to be a “professional.”
Joshua: Like a professional you can-, and they would like expect if like- which kind of funny that expect a professional to go home and have a glass of whiskey right, ‘cause that’s almost like that- that Mad Men mentality, right, that- that [deeper voice] ‘you the guy.’ A business an office guy. Which is okay to go the bar after to have a beer- a bong or- or a smokes a joint, in our culture anyway that that’s, that like that- that disrupts his entire life. Like- It’s just- that changes your entire perception of that person. It’s not just, you know he’s not just doing an illegal substance. He: i:s, a drug addict. Kinda thing. It’s that- puts a label on him. He’s not a professional anymore. Completely gets rid of it.

Joshua summarises his position that drugs do not enhance or affect him, his life, who he is, or his participation in his roles:

Joshua: I don’t thi- I don’t think it, enhances it or- or affects it whatsoever. I am who I am. That’s one of the things why I don’t, consider it that ba:d. ‘Cause I am who I am, re-regardless of w-weed. If I smoke weed every day. It ha- it hasn’t changed me.

Niki: Mnhm. [1] Yeah it sounds like it’s something important to you, is to say;

Joshua: Yeah.

Niki: how am I acting? Is it because of the wee:d or,

Joshua: I’m still me. Like I still don’t-. And that’s ‘cause I’ve had to defend to other people. And I’ve had to do that right?

Niki: Yeah?


Interpersonal relationships. Some of the research participants touch on how drugs have impacted or have the potential to impact their interpersonal relationships. As was discussed earlier, the practice of non-disclosure may serve to prevent arguments related to the person’s drug use. Joshua does describe that his girlfriend wants him to stop using drugs and tells him that she will end the relationship if he chooses to continue doing drugs:

Joshua: ah:, from my gir:lfriend, she’s threatened to break up with me:, gave me an ultimatum. Ah it’s just-. In her eyes it’s ah:, you know if I don’t, if I ch- like I really don’t know what to do. She actually came to me and threatened to me, um, gave me an ultimatum. Like I’m breaking up if you don’t quit right now. Uh:, if I don’t, quit, then, she sees it as me choosing it over her, and, right? But I don’t see it that way? I see it as “You’re making me choose somethi:ng, over you that doesn’t really affect. Our relationship. Other than the fact that you: don’t like it.” And
I, I’ve given her the- and every time she ha- I asked her for specific reasons she doesn’t like it and I’ve given her; evidence against it every time. Specific evidence against it every time. And she- and in the end she said “Oh I don’t like it.” And that’s just how it is so. I lose that argument, so. It’s like we’re just- if she’s gonna give me that choice, like I don’t ever want to be with someone that makes me choose, things like that. But then, I’m conflicted about that too because am I really choosing weed over someone that- like I do love her, And I really gonna, choose that over her? Like what’s more important? Like if she asked me today I-I would have a hard time. I think my answer, at the time would have to be: ah, “I quit.” [laughing voice] To buy myself time, to think about the right answer.

In Joshua’s narrative account, he does not indicate that his girlfriend is opposed to the effects of marijuana on him or their relationship. For the most part, he seems to convey that she is opposed to the fact that he is smoking marijuana regularly.

Jenna describes an experience she had a child when her brother was sent to a treatment centre for drug addiction counselling. For her, drugs can “separate,” which is a literal separation of proximity as well as a figurative separation of caring and understanding:

Jenna: Um, So, when he was sent away it was kind of [whispering] “oh my god.\ You know like, [whispering] ”Drugs are bad.” Like they make you, you know they really separate, and they make your family really mad, and not care- or-or care, but be really frustrated with you that they don’t want to, have an open mind towards you any more. You know they see your substance not you.

Alternatively, Joshua describes smoking marijuana with his brother as a way to spend time together and bond. His brother is terminally ill and not able to drink alcohol, and Joshua finds that smoking together is a common activity they can do together:

Joshua: And it’s something that we do together, it keeps us together, it’s not the only thing that keeps us together, again like I hate saying it that- that way ‘cause then you look at it, “Oh using a drug to be friends,” and it’s not, using it’s, uhm, [3] [quietly] I don’t know\ almost optimis-, not optimising it’s just- it’s ah, something that we do: together

In summary, the research participants were not asked about the perceived effects of drugs on their health and behaviour. (See Interview Guide, Appendix 4, p. 210). Two questions beyond the initial interview that emerged during the research process were: “How would you talk to (your) children about drugs?” and “Could you imagine if drugs
were legal?” These topics had unexpectedly elicited some conflicting positions from research participants early on, and the questions were subsequently included in future interviews. However, the interviews were intentionally designed to exclude questions that were aligned with addiction counselling assessments. Nevertheless, it can be seen that there are many instances where research participants nevertheless respond to the types of topics that are included as diagnostic criteria in addiction-related health practices. In some circumstances the research participants describe their drug use as problematic in a way that was framed by the criteria, while at other times they give illustrations about how they do not satisfy the criteria.

The diagnostic criteria for addiction contribute to dominant discourses about drug use, and therefore the research participants, to a large degree, construct their narratives accordingly. Accordingly, one of the results of eliciting narratives that counter dominant discourse is that is the accounts may be constructed from a defensive (i.e., speaking against a perceived dominant position) and argumentative position. It is not surprising, then, that the narrative accounts can be interpreted as justifying, rationalising, denying, and neutralising. This may not be an indication of a psychological “defense mechanism;” instead, this is a natural discursive strategy to position one’s account against an assumed position and belief system of the listener. To demonstrate knowledge and expertise, the dominant perspective is interdiscursively intertwined into the personal account and structured to strengthen one’s argument. Furthermore, Becker (1963) noted that when a person undertakes an activity that is considered deviant, that person learns to engage in that activity in a way that will minimise the development of any trouble (p. 39). Similarly, personal accounts are structured to demonstrate credibility and minimise conflict.

In the “Confronting social discourses” section of analysis I presented several examples of how the research participants responded to specific representations of drugs and drug use. Here I proposed that the research participants implicitly responded to the diagnostic criteria defining substance dependence. In both cases the analysis is grounded in intertextual and interdiscursive practices. In this case, attention to register can facilitate the analysis. One way to identify register is to distinguish the presence of specialised terms. In this section of the analysis the following quotes are examples of specialised
medical language that were present:

- “Symptoms of withdrawal” (Joshua)
- “Habit forming drug” (Joshua)
- “Under [the] influence” (Sean)
- “Isolate yourself” (Sharon)
- “A paranoia” (Joshua)
- “Create social anxiety” (Joshua)
- “Smoke does damage to your body … Carcinogenic” (Jenna)
- “Level of addictivity” (Sean)
- “Coping mechanism” (Joshua)
- “Substance” (Jenna)

In one way the research participants demonstrate technical knowledge and establish themselves as legitimate sources. The research participants are then able to either support or refute the point under discussion. Joshua draws on medical discourses in the following example to portray marijuana positively. He describes the effects of drugs and then frames the effects according to “psychological benefit:”

Joshua: but, on top of the effects that weed’s a, calming thing, ‘cause it makes you kinda chill ‘r whatever so it, it helps that just to, be in a situations where- just relaxed, not worrying, you know, so. The psychological aspect it, ah.

Interdiscursivity can also be interpreted when a research participant refer directly and indirectly to other voices. In this section, there are few instances when research participants refer directly to conversations they had with other people, or from media, education, or even research. The interdiscursive features seem to be an interplay between specialised medical discourses and drug culture discourses. Surprising to me is that the inclusion of specialised terms does not seem to indicate that the research participants are responding to medical discourses and does not seem to give primacy to the drug discourse.

This finding is different compared to legal discourse. For example, Sharon in an earlier quote discusses her perception of the ineffectiveness of imprisonment to result in changes to drug use. The quote is provided here with additional content:
Sharon: I went to jail for six weeks. Okay so, I went through withdrawals, by the time I was done my withdrawals, I was ready to have a hoot. Like let me outta here. I wanna have a hoot. I wanna have a, drag off a joint. I don’t wanna have a cigarette. I don’t give a shit, I wanna have a hoot.

Her use of the word “okay” seems to soften the statement of “I went through withdrawals.” She emphasises “done” to indicate that the withdrawals were a transient state. She uses informal lingo of “have a hoot” three times and “drag off a joint” once. She also compares wanting to smoke marijuana to smoking cigarettes without elaboration. This implies that it is shared knowledge that smoking cigarettes is thought to be the hardest drug to quit. In this example, Sharon discounts the effectiveness of the legal system by giving primacy to the drug discourse. In this account she neither reinforces nor refutes withdrawal as an indicator of a problem.

To conclude this section, the research participants seem to be aware of the criteria that might be used to interpret their drug use as problematic, or pathological, and they respond implicitly to these criteria. They demonstrate knowledge of medical discourses and draw on these discourses to position their current drug use as being acceptable.

**Flipping the script on drugs and pushing.** To conclude this analysis, an interpretation of flipping the script will be provided. To start, the limitations of the English language lexicon to convey the meanings intended by the research participants will be described. Following this, the notion of flipping the script will be applied to understand how the research participants reframe the meanings related to “dealing” drugs.

The analysis reveals that the research participants feel constrained by the lexicon available to talk about drugs, since the words are strongly associated with concepts that do not adequately reflect their own beliefs and experiences. As a result, the research participants are quite strategic in their use of words in certain contexts in an attempt to remove the activity from associations that are stigmatising and judgemental. How the research participants talk about selling drugs is a clear example of this.

The research participants also frequently tell what I call parallel stories. When a research participant talks about an aspect of drug use that they feel is unfairly evaluated in general social settings, they draw a parallel relationship to something that is equally
problematic but more socially accepted. For example, when talking about the potential health risks associated with smoking, the person might shift to a discussion about the effects of oil (or “addiction to oil”) on global health; or when talking about the moral stigma against selling drugs, a comparison is made in relation to priests having molested children. A shared lexicon is operating here. But whereas the research participants understand the same meanings as the general public, the identical words without the potentially judgemental interpretations are used, which results in meanings that are not necessarily shared by the general public. For example, Sean instinctively uses the word “need” to discuss events when he is more likely to want to smoke a joint, but repeatedly corrects himself, recognising the interpretative meaning insinuating a compulsive, uncontrollable desire that might be considered a criteria for problematic use. Similarly, the research participants even demonstrate instances of avoiding the use of certain words. Instead of a “drug dealer,” they say “a guy.”

Becker (1963) notes that the conceptualisation of an activity as deviant is a collective social process. Therefore, a person who uses drugs will often frame their own action and talk in response to a perceived societal norm.

When we see deviance as collective action, we immediately see that people act with an eye to the responses of others involved in that action. They take into account the way their fellows will evaluate what they do, and how that evaluation will affect their prestige and rank. (p. 183)

Some of the research participants explicitly discuss difficulty expressing their experiences and opinions by drawing on the available lexicon to discuss drugs and drug use. This was demonstrated earlier in reference to the word need. There are multiple interpretations to the meanings of words, but several words in regard to drug use begin to be associated with singular interpretations that are used as jargon to position drug use as wrong, unhealthy, problematic, or amoral. The person who talks about their own drug use must navigate through a landmine of lexical selection and assume that the listener is attending to signs of disordered behaviour.

Joshua defines substance abuse as using a drug daily. When he tries to describe this, he attempts to compare it to heart medication. However, in doing so he draws a parallel to needing a drug for survival. The dilemma that is portrayed here is similar to
that seen in relation to the use of metaphors. While metaphors can be useful to portray complex ideas, they constrain by narrowing the possible ways of understanding a phenomenon (Gee, 2011b).

Joshua: I recognise it’s substance abuse, and I don’t wanna be:, abusing substances. It’s not a, [inhales] you know. And if you ask anybody who’s on heart medication, is t- if they had to take heart medication everyday, ‘r didn’t, they wouldn’t. I’m not saying I have to smoke weed everyday, bu- wh- I hope that’s not what- you got out of that. But it’s more like, you know no one wants to depend on anything. And it’s not like I depend on it, again, and [quieter] ‘ah so tough to talk\ like, it’s hard- it’s hard to say things without getting yourself into stuff like that. Like I’m not, I don’t depend on it but, uh, I’d like to say that I wou:ldn’t, shouldn’t be doing it everyday. Like, and it’s almost like I said. I’m- almost a product of the society saying I shouldn’t smoke weed everyday. You know, why? Why shouldn’t I? And the answ- there’s not really- no one can really give me a answ- a good reason not to. Other than the fact I- other than the other reasons I told you. Other than being a responsible individual, at the moment. Like if I have responsibilities to do, then you shouldn’t. But, other than that? Then, you can’t really tell me why- you can’t really tell me no?

Joshua was one of the research participants who spoke explicitly about the constraints of language on talking about his own drug use. Joshua says he finds drug jargon constraining when trying to capture the meaning of his experience, or to interpret his own experiences. On one hand he does not like incorporating these terms into his lexicon but, on the other hand, he finds it useful to be able to defend against opposing perspectives:

Joshua: [1] You get- you get pseudonyms:, you get ah, you get a name for things, like you “get high,” or:, you know, even, slang terminology stuff. I hate using it, just because, it, i- it’s associated with, slang terms associated with like illicit substances ‘n, illegal activity thing. So I hate using it. But you kinda have to, to defend it.

Joshua’s primary concern seems to be that using drug-related jargon to describe his use of marijuana supports the classification of marijuana as a drug. It relates marijuana more closely with other “hard drugs” and prevents an understanding from being developed that marijuana is more benign:

Joshua: ‘and I think\ if a psychologist analysed this [glancing at recorder], this talk.

Niki: [chuckles]
Joshua: he’d be like.
Niki: What do you think he’d say.
Joshua: Tear it apart.
Niki: Oh yeah?
Joshua: Yeah.
Niki: [laughs]
Joshua: Yeah. Tear it apart.
Niki: What would you ah:, what would you foresee.
Joshua: Well, I- just the- [1] ah th- l- the- I hate talking about it because you make the connection between how someone would sound if they’re talking about, anoth- a really hard drug.

In fact, in the following quote he says he does not like talking about marijuana in this particular context to explain his perception of the personal effects he experiences from marijuana “because it makes it seem like a drug:”

Joshua: and I hate, ah- I hate talking about it like this because it makes it seem like a drug. You know?
Joshua: To me.

Sean also reframes marijuana from being a drug to being “you know, a herb plant, that happens to get you a little high.” Jenna similarly says that “It’s grown from the Earth it’s, a plant.” Joshua explains that one of the reasons he compares marijuana to alcohol is to draw on language that conveys images more consistent with his view of marijuana: “That’s why I kinda I hate using those words. But like that’s why I try to show it- t- t- alcoh- that’s almost the same thing with alcohol.”

Another reason why it is difficult to talk about drugs is that the person who uses drugs is expected to present a consistent perspective in regard to drugs. Contradictions are frequently identified by the listener and are used to argue counter positions:

Joshua: But even in just like- but even saying it’s bad, I wouldn’t do it if I had a kid. And so why bother it be legal, why do you believe in stuff like that?: You know? Tha- so it’s hard. It’s hard not to be hypocritical. Like I have a:, [1] As I say I find it- hard ah: to be: ah consistent in arguments I guess right? Um, but yeah. I- but I apologise if I sound hypocritical. I’m not trying to but.

This reluctance to talk openly about human activity is not restricted to drugs. Jenna compares the social taboos about doing drugs to masturbation:
Jenna: You know like so I saw all that stuff when I was younger you know and, and I don’t think it was bad. Because as a child I didn’t have a judgement on it. You know I was told, after, that it’s bad. So then I went “Oh. Ok that’s bad. You’re not supposed to do that. Ok so you do it in private.” It’s like [whispering] touching yourself.

Niki: [chuckles]

Jenna: [deep voice] Don’t, do it, in front of people. [laughs]

Niki: [laughs]

Jenna: [laughing] There’s certain, social taboos. [laughs]

Another way that the research participants flip the script in relation to drugs is when they discuss the selling of drugs. While the term “drug dealer” is used, it is more frequently used to convey an undesirable aspect of selling drugs, rather than a general reference to a person who sells drugs. Haylei, for example, uses the term dealer in reference to preferring that the police target people who sell certain drugs, rather than marijuana. She says, “I mean I’d rather them go, catch coke dealers and, meth dealers.”

Paul identifies himself as part of an “organisation” that “deals with” people to “provide” them with what they “want.” He uses the term “dealer” to refer to “street level” sellers of drugs who tend to be visible and available in public settings and who are perceived to be more likely to approach vulnerable people — “a lot of them are dealing from, the street level, the street level drug dealers?” He elaborates how he and his colleagues react to this type of drug distribution:

Paul: Or else if we’re drivin’ up to one of the houses, ‘n ‘n we see a dealer standing out in a playground.

Niki: Right.

Paul: We, we have, lots of fun with them. At the point of where, they’ll be, five or six of us that go up and say, “Hi.”

Niki: [chuckles]

Paul: “Maybe you should lea:ve.” And, if not, [2] we will make them leave. At the end of the story, we, like to- ‘cause you can spot them all like a sore thumb.

Sharon identifies herself as having been a drug dealer: “I used to be a drug dealer,” and “that’s who I was.” She says she sold to people even though she knew it was contributing to problems in that person’s life.

Paul also associates being a drug dealer with a lack of “integrity” and an increased propensity for unnecessary and misdirected violence. He indicates that boundaries to what
is considered acceptable exist when he says, “Because, for example, one of the guys in- in my crew, [1] a drug dealer came, and killed his grandma. Killed his grandma.”

Alternatively, when people talk about accessing drugs in a way that is viewed as acceptable, they use more neutral terms such as “source” and “a guy.” The following quote from Sean is typical in that active verbs like “buy,” “sell,” and “deal” are conspicuously absent: “we know exactly what we’re taking, we know the source, we know the guy that we’re getting it from.”

Jenna transforms the active verbs of growing and selling marijuana to describe a person as being a “botanist.” He “makes” “bud” not as an illicit business with financial benefit, but rather as a form of “art”:

Jenna: you know, like when someone’s a- an amazing botanist, you [laughing] know, like I knew a guy in Toronto, didn’t smoke pot. Grew it. [clears throat]. And ah, was an incredible botanist. He knew what he needed to do to make really potent bud. And r-, and that’s not what he did for a living. It was part of his living. But on the other side he was an artist. You know what I mean? So he- he created art, for a lot of different things and a lot of different, functionalities of art. But he also, you know, made growing pot an art form. ‘

Sean also describes that he does not tell his wife about buying larger quantities of marijuana to sell to his friends. He disassociates from the concept of “dealing” by indicating that he is “helping” friends and not making any money from it:

Sean: you know every once in awhile I’ll, buy some extra pot and, ha- you know, and [laughs] \I make no money off it. I’m like the worst pot dea-\. [laughing voice] \You know pot guy ever. Because, I’ll like, you know just, sell it for the exact same that I, you know, exact same pri:ce, just to like, [higher pitch] \“ok,”\ y- you know, [higher pitch] \just to like help, help my buddies out\ so to speak.\ And, ah, but yeah then, you know, there’s certainly a:, an element of that in there. Ah uh, you know sorta keeping that from your wife and there w- there were, there were some episodes there, and ah:, where, where it was r-, you know and yeah, like as I was watching the show:, it was like. You know he wanted to tell his wife and, like [softer voice] “yeah I’d like [chuckling] \to tell you some of these things [Rosie].\ \[laughing voice]\ Just, be a little bit mo:re honest.” You know “I know we are open but, [chuckles] just a little bit mo:re.” So. Oh well.
Sean’s use of the term, “oh well,” seems to indicate a passive and reluctant acceptance of an external circumstance over which he has little to no control. While he would like to be “more open,” he does not see this as feasible and he accepts the nature of the situation.

Although Sharon has identified herself as a drug dealer in the past, she portrays her supplier’s involvement in a more neutral way. She would “get it” from him and he’d “cut it up.” The transaction of the exchange of drugs is minimised, and the exchange of money is framed as “bring[ing] him back his money” rather than in terms of purchasing a commodity. In contrast, she uses the term “selling” to describe her own role:

Sharon: and I’d go get it from a guy here in town. Who is very influential. And very quiet. And he’d cut up four grams for me, I’d sell those, I’d bring him back his money, and he’d give me a gram for selling it.”

Jenna reframes the concerns of one of her clients whose son was found to be selling drugs. Instead of labelling him a drug dealer she says he is an “entrepreneur.” Jenna notes that many of the qualities the son shows are desirable, but when expressed in relation to selling drugs they are seen as shameful:

Jenna: Like, like this teenage boy for instance. He’s an entrepreneur. You know his is, seeing a need within his high school and he filled it.
Niki: [laughs]
Jenna: [laughs]
Niki: Fair enough.
Jenna: [laughing voice] But that’s what we, we commend people for doing that.
Niki: True.
Jenna: You know what I mean? Like.
Niki: True.
Jenna: But then, his family and everyone around him is shaming him for it.

Haylei uses the term drug dealer fairly consistently. However, the references tend to convey a sense of irony. She uses the term drug dealer in a playful context, such as describing a time she smoked a joint with a group of other people:

Haylei: And it was weird. ‘Cause I smoked. Like I smo:ked, [1] a joint, once. When I was sixteen. [exhales] After I did the acid. With a drug dealer? And the, like, chief of police’s daughter, [1] And I was like, [quietly] ‘it was like\ something out of a frikkin’ 90210 or something,
Haylei challenges the association of drug dealing and the assumption that undesirable activities are necessarily a part of the concept. Instead, even someone who sells drugs should act according to moral standards:

Haylei: And, [4] like you know e- even if you’re a drug dealer you ha- you need a moral compa:ss. You don’t, sell kids, drugs to kids. You know, you don’t, [1] you don’t go sell drugs in a grade school. What’s wrong with you.

One of the reasons that this is important from a health professional point of view is to consider the ways in which the research participants recontextualise the associated meanings to undermine the authority of medical discourses of drugs. Jenna, providing the most poignant example, describes that her partner’s brother uses methadone to get off Oxycontin™ originally prescribed by a physician:

Jenna: So, and now he’s like has been, I think do they give them methadone to get off it?
Niki: Sometimes.
Jenna: So yeah I think he’s been been getting off it and what-not. But, starting to clean up his life, but that was just from prescriptions, from the doctor that when the doctor was writing it she goes “I’m gonna give you some Oxycontins” and he was “you know what I don’t want them.” “Oh, well you just might need them.” You know [speaking loudly] \so that’s a pusher.\nNiki: Yeah right.
Jenna: You know. Like what’s the difference between some guy who’s making a living from selling pot to someone who has a diploma on their wall, you know what is the difference? Do you- you have more credibility because you have a diploma and you went to school. Wh- which is just maddening.

In this previous example, Jenna calls the doctor a “pusher” of drugs. Again, she refers to the person selling illicit drugs as “some guy,” whereas the physician is afforded “credibility” from a “diploma on their wall.” She expresses frustration that physicians are in a position of power and yet she assumes their actions and decisions are not held to an adequate level of scrutiny in regard to the provision of drugs. In a way, this assumes that people who sell illicit drugs provide a substance that is not needed, while physicians prescribe drugs that are needed. Jenna problematises the belief that physicians are fully informed and effective in their prescription practices, despite having attained a high level of formal education.
In a similar way, pharmaceutical companies are portrayed to be focusing on profit rather than health and well-being. In the following quote Paul indicates that pharmaceutical companies earn billions of dollars annually. He suggests that pharmaceutical companies are not held accountable for their general business dealings because a “chemist” backs them:

Paul: pharmaceutical companies make, billions of dollars. And, that’s the beautiful thing about it. Pharmaceutical companies, they buy farms. They buy different, branches of stuff. That they can kinda sweep under the table. Because it’s, branch upon branch upon branch. It’s such a sub system. That, they don’t need to keep book-keeping on it. Or they- they- they get someone, they deal with a chemist inside of it, they kinda get their team to figure it out, they sell it off.

Jenna holds pharmaceutical companies partially responsible for what she perceives as physicians’ impetus to “push certain drugs.” While she is cautious enough to “not say that doctors don’t know what they are doing,” she questions whether most of them are fully informed about the medications they are prescribing. She takes a step away from holding the physicians responsible for their lack of knowledge, stating that physicians are too busy to read all the information so they rely on information provided by pharmaceutical representatives. Jenna is also under the impression that physicians are provided incentives or “bonuses” for prescribing a particular drug, which might reinforce practices of not being fully informed about the effects or alternative options:

Jenna: Look at pharmaceuticals. [1] Look at what people, like doctors are prescribing, with really like not to say that doctors don’t know what they’re doing but a lot of them have no frikkin’ idea.\ They’re getting bonuses from pharmaceutical companies to push certain drugs. [inhales] And so they do it. And they’re busy and they don’t have time to read through, all the information because people are busy. Everybody’s busy you have a booming practice. And yeah you’re like “oh well this is a new thing that just came across my desk, I just got treated to dinner, by this wonderful pharmaceutical company, the rep was cute, and”

Niki: [laughs]

Jenna: you know like “we had this great time. And he served us wine and” you know.

Jenna also problematises the assumed safety of pharmaceutical drugs. She argues that “basic street drugs” are more reliable and can be trusted because they have been used
in society for a relatively long time. Pharmaceutical drugs, on the other hand, are viewed as “playing God,” which is a colloquial term to proscribe technological and scientific adaptations of natural phenomena. Despite the fact that pharmaceutical companies are known to conduct randomised controlled trials, this does not suffice as evidence of “research” for Jenna:

Jenna: So at least we know, with basic street drugs, there’s enough, they’ve been around long enough? And there’s been enough research on them. That we know what’s going on with them. Whereas with pharmaceuticals, you’re like, you’re playing God with pharmaceuticals.

Haylei describes having taken prescribed psychotropic drugs and compares her experience with prescribed drugs to the illicit drugs that she has used. First, she opines that marijuana provides a “more natural way to relax” than pharmaceutical drugs. She then goes on to describe how she perceives pharmaceutical drugs to “numb” her to emotions, stating “I wasn’t really able to feel.” She does not immediately recognise the effect of the drug, as she initially “thought it worked.” Haylei decides to quit taking the prescription medication, and chooses not to consult with her physician about it:

Haylei: I don’t think weed, [1] changes your view on things. [1] I think it just helps you to, [3] it’s a more natural way to, relax. Than taking pills or, ‘s like pharmaceutical dru:gs. So. [3] [quietly] ‘Cause I don’t really like them.\n
Niki: Pharmaceutical drugs? Yeah?
Haylei: Ah,
Niki: You kinda tried a few here and there?
Haylei: Yeah. Well I was o:n, [2] ah I went through like a whole bunch of the like Prozac, and Effexor ‘n all those. And, sorta found one that worked. [2] And I thought it worked. And then when my dad died, I realised that, [2] I was crying sort of, ‘cause I was stressed out? And everyone else was crying? And I wasn’t really able to feel, sorta numb to the fact that my dad had died? Um, [higher pitch] ‘so I made an executive decision to wean myself off it.\n
Haylei also notes that over-the-counter drugs are easy to access, so people starting to experiment with the effects of drugs on their bodies might first try legal drugs before proceeding to try illicit ones. There are many different drugs to choose from and mix in different ways, so people learn about these drug effects by trial and error:

Haylei: I mean, you can walk into a pharmacy and you can buy that stuff. And, [3] it’s like you take one pill and you find out what it does and, I mean you do that with so many and you start mixing them and, [3] you find

In the following two quotes, Paul compares his role of providing drugs to people as similar to the role of pharmacists. Pharmacists, he posits, might not agree with the prescribing physician that the drug selected is the best option for the person. But the pharmacist’s role is to be a “vessel” to transport the drug between the physician and the patient. At the same time, the intention for both the pharmacist and Paul is to “help people deal with whatever problems” they are experiencing:

Paul: Because, people always ask, “What would you use.” And it, it’s like a pharmacist, right? It’s, if you actually care about using them because, I guarantee, three quarters of the drugs that the pharmacists is selling, they don’t want you to use. It’s the wrong stuff for you. They’re not gonna say anything. Because, they’re a vessel. They’re just there to fill up a bottle. And slap a sticker on and charge you a whole crapload of money. So, I feel that I’m doing the same thing. So, it’s, it’s, I’m trying to help people deal with whatever problems. I’m giving them a band-aid.

Paul even uses the same word, vessel, in regard to his own role of providing drugs to people. In this way, Paul portrays that he provides drugs so that people can address problems they are having. At the same time, similar to the pharmacist, it is not his role to evaluate the suitability of the drug or to advise the person against taking it:

Paul: I am just, I am more of a, vessel. To, whatever you want. If you wanna feel, really happy because your life isn’t happy, I can do that. If you wanna sleep because you have, [1] um like sleep insomnia or something. We-we’ve got that stuff. If- if you wanna do both. If you wanna feel happy, while you’re falling asleep because then you don’t have to worry about something. We’ve got that. If you wanna waste a whole weekend where it just goes by and you don’t even realise it? We can do that too. You know. It’s, we provide things that people want. And it’s, it’s like any other store. It’s just, our catalogue is, [1] not that diverse.

In the following excerpt, Joshua asserts that one reason marijuana’s illegal and not a prescription drug, despite the potential advantages compared to pharmaceutical drugs, is based on the fact that it is a “natural product” and not able to be patented. Instead, he says, pharmaceutical companies are working to isolate active components and to be able to replicate them synthetically:
Joshua: *Uhm.* [2] I know one of the biggest reasons that marijuana’s: ‘legal, is just again, uh:, it’s a natural, product that:* natural: plant. Uh, a:nd, prescription or: pharmaceutical companies don’t want that to be, a drug. I guess it’s more- it is more effective than, a lot of drugs out there. Less side effects, marketed for:, for many, conditions. A:nd they tried to replicate, like marinal:, replicate marinal, they replicated, it’s like a pill form of weed. ‘er of THC. They’re tryin’a get the people- but it’s not as effective. They tried to make a synthetic, compound.

Haylei advocates for illicit drugs to be reclassified as a “taxable product” like liquor and tobacco. She shifts from casual genre to formal politico-economic genre, intermingling the two, when she says that the government could “certify it. As like you know, good to get you high:”

Haylei: [1] What I don’t understand is, like right now, we get drugs, and it’s like where’d they come from? Like you go up the train there’s, someone’s giving it to some big wig that’s making a who:le lotta money. So why not have that person sell it to the government, who certifies it. As like you know, good to get you high or whatever.

Niki: [quietly] \Good to get you high.\n
Haylei: But then, it’s another taxable product. Like liquor. And tobacco. That’s gonna, fund health care, ‘n fund, social programs.

It can be interpreted that the research participants are largely advocating for the legalisation of drugs, or at the very least for a shift from the demonization of illicit drugs. Paul presents an exception to the idea of conceptualising illicit drugs differently and moving toward legalisation, at least while he is still in the “industry” and making a living based on the sale of illicit drugs:

Niki: What would you like people to- to understand about drugs, or to see the:m, or to see this whole kind of syste:m, in a different light?

Paul: I don’t want them to.

Niki: No.

Paul: No.

Niki: It’s not in your best interest.

Paul: At the end of the day I don’t,[laughs] But, [1] I- I think, i-in a posi:tion:, if you asked me this in about five years I would say?

Niki: Ah.

Paul: Then, at that point I would be like, have everything open. Open the flood gates on everything. Let them know, because, [1] there’s, they consider it an evil of the world.

Overall, in order to reduce some of the stigma attached to illicit drug use, it can be interpreted that the research participants alter their use of language to shift the view of
legal and ethical aspects of pharmaceutical drugs, pharmaceutical companies, pharmacist practices, and physician practices. A shift in language in regard to drugs neutralises the stigmas and assumptions associated with certain terms. Terms such as *industry*, *vessel*, and *market* are sometimes used interchangeably to describe illicit and licit drug practices. At other times illicit drugs are presented using words on the extreme end of neutral, such as *drug guy*, *a plant*, and *natural*, while licit drug practices are positioned as extremely negative by, for example, calling a physician a *pusher*, describing “synthetic compounds,” and noting that easy access to over-the-counter medications makes them more likely to be “gateway drugs.”

Flipping the script can be understood as an indirect discursive practice that provides a means to convey new meanings associated with certain words and concepts. Many terms associated with drug use convey underlying values, assumptions, and judgements. As a result, people may draw on certain words and adapt their use of language in ways that prevent the development of even worse problems, and that attempts to minimise the use of value-laden lexicon and meanings. At the same time, some of the apparent contradictions in personal disclosure may come from a person using the same word to mean more than one thing.

This type of inquiry explores how certain discourses of drugs are attributed hierarchical status. As Mansbach (2001) wrote, flipping the script is a way to *talk over* authoritative discourses and break free of definitions, explanations, and categorisations in order to reconstruct knowledge.

### 3.5 Discursive Practices within Narrative Accounts

To summarise the analysis, I propose that the research participants construct their narrative accounts in ways that function to minimise the legitimacy and authority of legal, medical, and social discourses of drug use. Legal and social discourses are frequently confronted directly in the frame of a debate. Medical discourses of drug use are problematised by drawing on recontextualisation, or script flipping, thereby challenging the conceptual distinctions between illicit and pharmaceutical drug use and distribution.
Although discourses of medicine seem to hold authority while legal discourses are opposed, the position of health professionals as legitimate sources for knowledge about drugs compared to law enforcement personnel are reversed. Physicians are frequently portrayed as not having adequate knowledge about drugs and drug use, whereas law enforcement officers are discussed as having a better understanding about drugs despite their obligation to enforce drug-related laws.

Sharon indicates in the following excerpt that doctors rely on synthetic prescription medication. She suggests that marijuana would be a better alternative for treating pain:

Sharon: You know ahm, I- if I was a doctor I’d say “You know what? Go buy a bag of pot. ‘Cause I ain’t givin’ ya pills for that. Because you’re just here, to get high, so go, go buy a bag ‘a pot.” You know. Like, well you know, if you knew you know like

Niki: Yeah.

Sharon: I mean that’s ah that would be my downfall. I’d be like, “Go buy a bag a’ pot.” Because, you know “These’ll kill you. The pot won’t.”

For comparison, Haylei describes police as having a more balanced understanding about drugs: “And, from conversations with cops too, it’s like, they would rather be, catching coke dealers, and rapists and murderers, and that kinda s-, instead of wasting their time on pot.”

Medical discourses pertaining to health and well-being seem to be drawn on to support the acceptability of personal drug use and to counter legal and social discourses of drug use. I believe this is consistent with theories proposing that health has become established as a meta-value. Although the research participants do not directly oppose medical discourses of drug use, they do seem to modulate the medical discourses of drug use by shifting emphasis to health and wellness as broader constructs.
Chapter 4

4 Discussion

I believe the major contribution of this research is that it affords voice and legitimacy to an invisible population of Canadian drug users. Although drug use is an extensively researched subject there is relatively little understanding about drug use from people who have not identified a reason or need to access addiction-related services. In this thesis, I interpreted personal accounts by attending to discursive practices, giving primacy to how language constructs ways of thinking, acting and being. The interpretations derived from analysis of discursive practices of the research participants are used to inform health professional education about drugs and drug use, which is distinct from common research and health professional practices of interpreting and reframing personal accounts based on pre-established models, theories, assumptions and perspectives. I drew on literature and methodologies from outside the field of health sciences and integrated them into the health field to facilitate critical interpretations.

One of the challenges I encountered (and I expect others will encounter) is how to reconcile the research findings with models and theories of drug use that inform health professional education. This is consistent with Becker (1963), who problematised the possibility of creating a single discourse in regard to drug use. He believed it is important to attempt to understand a phenomenon from multiple perspectives, but that it is impossible to attempt to merge the perspectives into a single, true discourse:

It is, of course, possible to see the situation from both sides. But it cannot be done simultaneously. That is, we cannot construct a description of a situation or process that in some way fuses the perceptions and interpretations made by both parties involved in the process of deviance. We cannot describe a “higher reality” that makes sense of both sets of views. We can describe the perspectives of one group and see how they fail to mesh with the perspectives of the other group: the perspectives of rule-breakers as they meet and conflict with the perspectives of those who enforce the rules, and vice versa. But we cannot understand the situation or process without giving full weight to the differences between the perspectives of the two groups involved. (p. 173)

What Becker proposes here is that to more fully understand a phenomenon it is important to step back from the instinct to merge the multiple perspectives or discourses
and find the most accurate interpretation. Instead, it is important to give equal weight to the multiple perspectives.

By drawing on a critical analysis of discourse I chose to focus primarily on personal accounts of drug use. In a way, the focus on personal accounts is consistent with therapeutic approaches of drug-related health services that rely largely on discursive forms of information gathering and intervention. Although disease models of addiction hypothesize cellular, chemical, and neurological involvement, these factors are not the focus of evaluation or intervention in health-related services. Instead, information is gathered verbally from clients to determine the extent of impact of the drug use on the person’s life and to evaluate their degree of insight. Verbal counselling techniques are applied and education provided to guide the person toward making changes in their drug use. However, one of the predominant assumptions is that people who use drugs are not able to provide reliable or accurate accounts of their own drug use or to evaluate the consequences associated with the drug use. As a result, in therapeutic interactions the client’s account is frequently reinterpreted and reframed within existing models and theories that underlie addiction counselling. The underlying question I used to frame the design of this research project was: “If we do not assume that personal accounts of drug use are inherently unreliable or inaccurate, what can we learn?”

To explore this further I will first revisit the quote provided by Project CREATE (Curriculum Renewal and Evaluation of Addictions Training and Education), a web-based initiative to provide education about addictions to medical schools in Ontario.

The devastation experienced by families because of injury and death caused by drunk drivers, the pain and suffering experienced by women and children because of domestic violence, the costs of absenteeism and workplace injuries because of alcohol and drug use, and the fear and vulnerability experienced by the whole population because of drug-related crimes are compelling reasons why physicians must begin to diagnose and treat individuals with ATOD [alcohol, tobacco and other drug] problems more vigorously. (Create Canada, 2004, para. 1)

According to the Project CREATE statement, the rationale for involving health professionals in the identification, diagnosis, and treatment of people who have “drug problems” is in response to the “devastation” to “families,” particularly women and children, as well as the “fear and vulnerability” experienced by “the whole population.”
These problems include driving when intoxicated, domestic violence, costs of absenteeism, workplace injury, and drug-related crime.

This position can be explored further by returning to the quote by Maxine Greene (1995), that opens Chapter One. Greene asserts that human science researchers endeavour to understand the social world, but our understandings are influenced, or even tainted, by what is considered to be natural or taken-for-granted aspects of daily ways of thinking, doing, and being. One of the ways that researchers and health professionals can start to question the taken-for-granted aspects of drugs and drug use is to incorporate understandings about the ways of thinking, doing, and being from the perspectives of people who use drugs everyday and have never identified a reason or need for diagnosis or treatment.

I believe that by focusing on the problems experienced by a some people who use particular drugs in particular ways, the cloud of givenness that Greene describes can be understood to be an assumption that all drug use will eventually result in problems or harms to all people. Individuals and groups in Canadian society are subsequently treated with suspicion and non-prescribed drug use is considered to be deviant. In contrast, the research participants seem to indicate a sense of choice in regard to their personal drug use. Specific drugs are used and others are avoided. The research participants select times and places where drug use would least likely impair their desired level of performance. An awareness of the appropriateness of the particular drug within the immediate social context is also important. The participants avoid using drugs in medical settings (i.e., physician appointments), legal contexts (i.e., in the presence of police officers), and in the presence of those who might think drug use is unacceptable.

Individuals furthermore demonstrate strategic disclosure of their personal drug use and their personal opinions about drugs, as well as continuous personal self-reflection of the effects of drugs on his or her performance in daily activities. Evaluation of anticipated responses from people in the social environment influence how individuals talk about drugs and drug use. The research participants reveal several ways in which disclosure of drug use can lead to negative consequences, and frequently use these consequences constitute criteria to diagnose substance abuse, substance dependence, and substance-
related disorders. Arguably, disclosure of drug use can sometimes be interpreted as more directly linked to the experience of negative consequences than the drug use itself.

I had not anticipated using recontextualisation as an analytical technique until it became evident that it could contribute to a deeper understanding of the discursive practices enacted by the research participants. In the introduction I elaborated on the notion of flipping the script as described and interpreted by Carr (2011) as a form of recontextualisation. I proposed that individuals who consider themselves to hold less legitimate or authoritative positions in society enact script flipping. The emergence of recontextualisation with its potential to contribute to the discourse analysis further complicates interpretations of disorder in health practices that assume individuals can and will provide personal accounts that represent a perceived truth. Whereas the concepts of denial, justification, rationalisation, intellectualisation, and neutralisation have been applied in the disease model of addiction to represent deficient personal insight, I found that the research participants construct their description of drug use partially in response to an awareness of the criteria used to diagnose drug problems. Personal accounts, then, are not necessarily representative of an inner truth, but are rather constructed in response to the perceived positions of the immediate and imagined audience and embedded in larger social discourses about drugs. Each research participant conveys a vigilant awareness of what he or she considers are the dominant Canadian social perceptions or misconceptions about drugs and drug use. The research participants construct their personal accounts in ways that, explicitly and implicitly, function to discount perceived dominant assumptions about drugs and drug use.

Initially I was very surprised that the personal accounts largely conformed to other social values, such as productivity, health, and parenting. I had assumed that a critical perspective toward drugs would correlate with critical perspectives toward other socially constructed values. I later came to expect it. For example, many of the research participants advocate for legalisation of drugs by touting the opportunity for taxation. On reflection, it seems to me that this proposal does not necessarily mean that the person does not hold critical opinions about the Canadian taxation system. Rather, she recognises that taxation could act as positive reinforcement for the general public and policy-makers
who have influence over drug-related laws. Similarly, several research participants discuss their drug use as contributing to their ability to act as “productive” members of society. I question whether this accurately reflects the person’s views of Canadian capitalist work ethics, or whether the value attributed to being a productive member of society is viewed as being sufficiently strong to counteract negative connotations attached to drug use. In this way, it seems to me that in order for the research participants to portray credibility in regard to their personal accounts of drug use, they may over-represent their conformity toward other perceived social values. The research participants simultaneously confront dominant constructs of drug use and demonstrate conformity to other perceived social values.

In this section of the discussion, denial, justification, rationalisation, intellectualisation, and neutralisation are revisited. While undertaking the research project I was frequently asked to describe my work. I explained that I was interviewing people who used drugs everyday and who had never identified a reason or need to attend counselling. The predominant response that I heard, whether by academic staff, health professions, addiction counsellors, or acquaintances, was: “oh, they are in denial.” This was said as a statement, not a question, with a knowing nod of the head. It was assumed that the research participants were unreliable in their own judgments about whether or not they would benefit from therapeutic intervention, despite the fact that the only piece of information that the person to whom I was speaking had was that the research participant “used drugs everyday.”

In response to numerous informal conversations I had over the duration of the research project, I came to believe that an analysis of denial would be a necessary component of this thesis. I wanted to encourage a reading of the narrative accounts that did not immediately dismiss the credibility of the research participants. At the same time, it was important that my interpretations not be rejected as naïve or uninformed if an analysis of cognitive distortions was not at the forefront. Certainly, denial, justification, rationalisation, intellectualisation, and neutralisation can be applied to interpret the data. However, my intention was to support the reader to suspend assumptions about perceived truths and to shift attention to the ways in which the research participants describe and
interpret their own experiences. The question is not whether there is evidence to support the concepts of denial, justification, rationalisation, intellectualisation, and neutralisation; rather, attention is shifted toward investigating what more can be learned by suspending the application of theories that position authoritative re-interpretations as representing the more legitimate voice.

As described earlier, denial was originally a technical term that has been integrated into common Northern American vernacular. It connotes expertise and an assumption that the person using the word is attributed privilege of interpretation over the other person. Thus, it carries with it an element of authority and legitimacy. A discourse analysis that attends to the discursive practices of a person’s use of language begins the process of questioning the assumption that clients do not disclose the nature of their drug use due to unconscious “defense mechanisms” that results in them being “unable to recognize and articulate their own truths” (Carr, 2011, p. 101). The theories of justification, rationalisation, intellectualisation, and neutralisation function in ways that are similar to denial, and can be understood to act as rhetorical devices. At this point, it is not my intention refute that there are aspects of the personal accounts of drug use that can be interpreted as denial, rationalisation, intellectualisation, justification, or neutralisation. However, I would like to present discursive practices underlying these concepts.

The defense mechanism theories linked to denial, rationalisation, intellectualisation, justification, and neutralisation assume that personal accounts are constructed to represent an inner reality or inner truth. When actual truths are potentially too painful for the person, the person may produce accounts that are not entirely accurate. The potential truth of the person’s narrative accounts is frequently evaluated against assumed truths about drug use. Therefore, as I just described, people who do not know anything about the research participants except the fact that they report using recreational drugs on daily basis and had never identified a reason or need for treatment automatically, applied the term denial. The notion that a person can do drugs and not have a reason or need for treatment generally seems to be viewed as improbable if not impossible, and therefore the person is identified to be in denial.
An alternative perspective might be to consider that the research participant is able to do drugs everyday and not have any reason or need to attend treatment. This possibility raises far more questions than answers. Can recreational drugs be used in a way that does not cause problems? Can drugs contribute to well-being and productivity? What constitutes a problem, and for whom is it a problem?

Denial, rationalisation, intellectualisation, justification, and neutralisation can be understood as discursive practices that function as responses to actual or perceived audiences. To a large degree, the person structures their description of drugs and drug use to respond to assumed dominant discourses that may be held by the listener and also in response to legal and medical discourses in general. A person who talks about his or her drug use may be replying to a spoken or unspoken social debate about drugs and drug use. For example, drawing on components of the research data, a person might hypothetically say:

I do drugs everyday but I’m not an addict. It helps me to relax and, besides, it’s no worse than the businessman who goes home and has a drink. In fact, it’s better than alcohol because look at all the social problems related to alcohol. There aren’t any conclusive research studies linking pot to a single death. Besides, I keep it away from the kids.

This example can be interpreted to have components of denial, rationalisation, intellectualisation, justification, and neutralisation. It also demonstrates that the person is highly aware of dominant arguments against drug use.

It should not be assumed that the person is unaware of any potential or existing problems just because they do not talk about it. It may be that in a particular context the person is not able to openly disclose or discuss the problems or concerns they may have. Joshua indicates this very dilemma during his interview. Several times he says that he feels “conflicted” and not able to openly discuss the various concerns he has about his own drug use with his friends who do drugs since even they may be offended by some of his opinions. He also speaks frequently about being put in a position of having to “defend” his use of drugs in response to perceived “social misconceptions.” In a way, the person who uses drugs is doubly restricted about how he is able to talk about drugs. On one hand he needs to avoid disclosure of drug use in many social contexts; and on the
other hand when he does talk about drugs he may feel pressure to prove that his drug use is acceptable, and to negate the existence of potential or actual problems. In turn, this discursive practice of negation is interpreted at a lack of insight and applied to support evidence of a disorder.

Of the many ways to interpret the discursive practices of narrative accounts, it may be limiting and potentially ineffective for health professionals to rely predominantly on assumptions of denial, rationalisation, intellectualisation, justification, and neutralisation. Health professionals are attributed significant legitimacy and authority to represent the experiences of their clients, and to make diagnoses and decisions that can have a significant impact on the person’s life. Yet, many of the analytical devices used to interpret clients’ stories start with the assumption that the client is not a reliable source to evaluate their own actions and thoughts.

4.1 Implications for Health Professional Education

Focussing on physiological and neurological variation, the disease model of addiction frames drug use as a causal factor in dysfunction and a loss of capacity to enact choice and willpower. The disease model also involves interpretations of psychological dysfunction and deficits in personal awareness and self-evaluation. In undertaking this research project it was not my attention to refute the disease model of addiction or to evaluate whether drug use is most effectively managed within biomedical institutions, though these are certainly questions that are present in the literature and warrant further consideration. Nevertheless, at this point in time in Canadian society, individual drug use is largely identified, evaluated, and addressed in health-related services and institutions.

The models and theories that inform health professional education in relation to addiction are largely based on the assumption that drug use is a deviant activity. Theories of deviance portray recreational drug use as abnormal, associated with negative consequences, and as having the potential to develop into a disorder or pathology. However, drug use that is prescribed by physicians is generally conceptualised as beneficial and responsible. I would argue that the conceptual dichotomy between medications and illicit drugs can act as a hindrance toward developing critical
understandings of drug use, and perpetuates the stigmatisation of non-prescribed drug use in contrast to the general tolerance of prescribed and over-the-counter medications (or drugs). The research participants challenge these dichotomies by emphasising the negative effects of prescribed drugs in comparison to certain illicit drugs, and by expounding the potential for desired therapeutic effects of illicit drugs. In the analysis I also interpreted that research participants adapt their use of language to flip the meanings associated with drugs in terms of being classified as prescription medication or as illicit drug. The example of the discursive practices related to describing the provision of drugs by physicians and illegal suppliers was explored.

The findings in this thesis emphasise the importance of learning to evaluate the research design, theoretical foundations, data-gathering context, interpretations, and findings to be able to critically appraise the literature that informs professional knowledge about drugs. I demonstrated how a critical analysis of discourse could be implemented as a means to analyse individual accounts of personal drug use with the intent of uncovering discourses that may typically be hidden or concealed, including personal accounts, and critical perspectives of drug use that may be concealed and frequently not openly discussed. Writing and talking about drugs in academia and other contexts where one’s job or reputation is at risk can limit disclosure of a personal opinion or a critical theory (Warhol, 2002). In order to learn more about drugs and drug use it will be important to develop contexts where people feel safe to talk more openly.

There are some practical applications for the findings of this research in health professional education. Pharmaceutical medications are frequently relied on as the primary, or sole, option for treatment, whereas non-medical interventions are not emphasised and resources are not allocated to support “alternative” non-pharmaceutical approaches. Health care policy and health professional practices may be implicated in constructing a social expectation that “drugs” are the most effective means to “treat” all physical and emotional discomfort. The findings of this thesis may problematise the social and medical discourses that construct not just drugs, but drugs as a means to achieve particular constructs of health, well-being, and desirable lifestyle.
Furthermore, interpretations of drugs from a social constructionist perspective that is more comprehensive and takes into consideration complex discourses of drug use may be used to shape health programs and services, to inform policy development and support rationale for research funding outside medical discourses.

Another consideration for health professional education is that individuals who use drugs are frequently treated with disrespect when they access health services, and health professionals feel pessimistic when working with patients who have an addiction (Bina et al., 2008). In my practice I have come to believe that health professionals’ actions toward people who do drugs are more a function of their own beliefs, opinions, and assumptions than they are a response to the individual client or patient. The implications of the findings of this project for health professional education are to encourage health professionals to listen to the personal accounts of people who do drugs with the intent of understanding and possibly providing more effective, ethical, and compassionate care to clients. Accordingly, in this discussion I will present potential implications for health professional education that take into account the discursive practices uncovered through this research analysis. The implications for health professional education in this section will focus on two main aspects. First, consideration will be given to the stigma associated with people who use drugs. Second, the potential for creating opportunities for self-disclosure in health settings will be explored.

Creating possibilities for self-disclosure.

Drug addicts are (perhaps) the last minority to be forced, legally, morally, and culturally, into the closet, without really having the option to come out.

(Warhol, 2002, p. 150)

The research participants seem to value being able to talk openly about their drug use, perhaps in response to the dominant discourses claiming that having to hide one’s drug use is an indication of a problem. It was expressed that not feeling able to talk openly about drugs contributes to or perpetuates many social harms. Three aspects of open disclosure that will be discussed in this section are individual health and well-being, the education of health professionals, and the potential for social change.
With respect to health, Jenna brings up the idea that not being able to talk openly about drug use impedes the possibility for people in the social network to intervene when there are early warning signs that drug use may becoming problematic. The inability to openly disclose drug use may also interfere with open discussion about some of the antecedents that influence a person’s choice to do a particular drug. For example, Joshua discusses some feelings of social anxiety in his narrative about personal drug use. He might be reluctant to talk to a health professional about the possible link between these two factors since it would become a part of his permanent health record. Jenna also points out the idea that a person may feel shame in regard to her drug use, and this shame can have a negative impact on her or her emotional well-being.

Several of the research participants indicate that a lack of openness in regard to drugs and drug use might have a negative impact on being able to provide accurate and valuable education to children. In turn, this can impact the child or youth’s choices around drug use and influence future well-being. Furthermore, open disclosure about drugs and drug use could better inform health professional education. There may be different ways to understand drugs and drug use that are aligned with more effective approaches to help people who need it, and possibly prevent problems from developing. Perhaps there are broader social and cultural circumstances that need to be considered. The research participants acknowledge that some people who use certain drugs in certain ways could benefit from help to make changes. However, they also express scepticism that the existing health system can adequately support these individuals. Quite to the contrary, the contemporary Canadian health system is implicated in many of the problems associated with drug use.

Interactions between health professionals and clients are social situations where there is an imbalance regarding whose voice is attributed authority and in the potential power to distribute or withhold social goods. As a result, health professionals need to be aware of and question practices that are situated on the premise that “what is not spoken has yet to be recognised by the speaker” (Carr, 2011, p. 110). In fact, I would go so far as to suggest that the opposite generally holds true, such that the speaker has an understanding that extends beyond that which the health professional is able to predict.
For example, the speaker has a metalinguistic awareness, as demonstrated by “the practiced ability to read the range of authorised, acceptable discursive possibilities within an institutionalized set of recursive linguistic practices” [sic] (Carr, 2011, p. 194). Accordingly, the information disclosed by clients is structured in regard to what is perceived to be acceptable and possible, rather than to provide an accurate representation of her opinions, thoughts, and beliefs. It is possible that health professional education that is informed by more open disclosure about drugs and drug use will also create alternative possibilities for the provision of health services.

Medical and legal discourses of drugs, drug use, and addiction hold significant authority in North America. As a result, the medical field has a social responsibility to develop a critical understanding of drug use and to problematise the underlying values and assumptions that guide the practice of health professions. Openness involves a willing receptiveness to interpretations that fall outside the dominant discourses and a willingness to seek out and attempt to understand discourses that might seem counter-intuitive, oppositional, resistant, defiant, and even conspiratorial. Openness of space to talk about drugs and drug use will be a pre-requisite to open disclosure. If hiding one’s drug use is a sign of a problem, then the responsibility for that problem may be viewed to fall more broadly into the social realm.

The term openness as used by the research participants extends beyond being able to disclose, but toward a broader openness in law, media coverage, research, and youth education. The responsibility for openness extends beyond the research participants (i.e., to tell the truth) and implicates all levels of society in the discursive practices that construct drugs and drug use. When a topic is highly contentious — governed by dominant legal and medical discourses and practices, and associated with a significant amount of stigma and marginalisation — it will be a challenge to create contexts that invite people who use drugs on a daily basis to talk openly about their experiences, particularly if they have a lot to lose by doing so.

It has been said, “social change becomes possible through re-thinking and re-describing” (Barker & Galasiński, 2001, p. 56). From this point of view, there is potential for significant social change in the area of health professional education about drugs and
drug use. Furthermore, a genuine attempt must be made to elicit and listen openly to the stories of people who use drugs because “narratives reify realities; different descriptions reify different realities” (Young, 1987, p. x).

When health professional education extends understandings of drug use beyond the disease model, it might become evident that the underlying psychological processes that guide the actions of a person who uses drugs are not so different from participation in any other activity:

We see that people who engage in acts conventionally thought deviant are not motivated by mysterious, unknowable forces. They do what they do for much the same reasons that justify more ordinary activities. We see that social rules, far from being fixed and immutable, are continually constructed anew in every situation, to suit the convenience, will, and power position of various participants. (Becker, 1963, p. 192)

Openness in health professional education means being willing to reach outside of and beyond taken-for-granted assumptions about drugs and drug use. It also means being willing to reconceptualise the relationships between drugs and health and well-being.

**Stigma and representation of the Other.**

Often, this speech about the “Other” is also a mask, an oppressive talk hiding gaps, absences, that space where our words would be if we were speaking, if there were silence, if we were there. This “we” that is “us” in the margins, that “we” who inhabit marginal space that is not a site of domination but a place of resistance. Enter that space. Often this speech about the “Other” annihilates, erases: “no need to hear your voice when I can talk about you better than you can speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become my own. Re-writing you, I write myself anew. I am still author, authority. (hooks, 1990)

It can be argued that the medicalisation of drug use has played a significant role in the establishment of health practices, research studies, and addiction theories that systematically, though assumedly unintentionally and unknowingly, silence and oppress many people who use drugs. It is somewhat understandable that health and legal discourses of drug use have focussed on disorder and pathology, since the primary purpose of these fields is corrective. At the same time, attending almost exclusively to the
problematic aspects of drug use results in or reinforces perspectives that non-prescribed
drug use is deviant and associated with negative consequences. As was discussed,
discourses that are contrary to dominant perspectives are “rewritten,” such as through
discursive therapeutic practices, or discouraged as a result of the potential for the formal
and informal negative social consequences associated with disclosure.

Medical discourses of drug use are involved in the social construction of drugs,
drug use, and addiction; and these constructs influence what is considered acceptable
activity and how people are treated in health settings. One question that arises, which has
significant implications for health professional education, is whether it is possible to
expand and enhance the scope of “authorised, acceptable discursive possibilities”
regarding drugs and drug use beyond the disease model. The next question is whether this
is desirable. Is addiction best understood as a disease that resides inside the person that
can only be addressed through individual responsibility and choice? Or can health
services and health outcomes be enhanced by inviting and recognising a broader
understanding of drugs and drug use?

The findings in this research project emphasise the impact of context on the
discursive practices of people (i.e. patients, clients) to talk about drugs. It is important to
recognise that a person will disclose personal accounts of drug use in a way that affords
her minimal risk and maximum benefit in a given situation. This is not a feature of
pathology, but rather a normal social response to which we are all implicated on a
moment-to-moment basis. Interactions are constantly and carefully negotiated by the
person who does drugs, which has implications for how the person is able to act and talk
in particular contexts with particular people.

The quote by hooks (1990) at the beginning of this section provides a way to
consider the implications of the research findings. “Speech about the Other” overlaps
with dominant discourses of drugs and drug use. The silencing hooks writes about is not
an empty space, but a space where dominant discourses reside, and where alternative
voices and discourses are absent. At the same time, hooks notes there are those who live
in the “margins” and find spaces for their voices. It is not necessarily the intention to
become dominant, but a place for resistance of taken-for-granted truths. What hooks
describes — “no need to hear your voice when I can talk about you better than you can speak about yourself…. Only tell me about your pain.” — resonates closely with the issues discussed in this thesis, where the person who does drugs is viewed as having little insight or awareness to her own thoughts and actions. In many settings the goal is to help the client to re-interpret and re-story her own life and experiences.

Research that informs evidence-based practice in the area of drug use needs to be considered with an understanding of the assumptions that guide the interpretations. One may find resonance when comparing the concepts of denial, intellectualisation, justification, neutralisation, and rationalisation with hooks’ description of “oppressive talk.” One can claim an injustice or, as hooks claimed, oppression that comes in the re-interpretation of a person’s story in such a way that it reinforces the primacy of dominant discourses and negates the intentions or meanings of the client.

Accordingly, the question of authority of dominant discourses over discourses of the Other have implications for health professional education. One implication is that the literature that informs health professional education regarding drugs and drug use should be evaluated using a critical lens. Education about critical reflexivity could be integrated into the curriculum and students taught to understand the concept of drugs from multiple positions that extend beyond the disease model.

A second implication is that students may be provided with advanced education in regard to authority in clinical interactions, as well as advanced skills for listening and understanding from the point of view of the Other — to listen for the significance of what is being said, without the preconceived drives to re-interpret and inform the Other of the more accurate interpretation of their experience.

4.2 Assessing the Quality of the Data

Discourse analysis is regarded as a rigorous, empirical practice (Nikander, 2008) because analysis and interpretation are grounded in the data, which are made accessible in transcripts. Transcripts bring immediacy and transparency to the concept, allowing researchers and readers to evaluate the findings and validity (Nikander, 2008).
Furthermore, a practice of reflexivity in the research process can enhance the reliability of the data collection and data analysis, as well as make it clear to the reader the assumptions, decisions, and processes that directed the inquiry. A responsive, reflexive, dialogic interview is characterised as follows:

- It announces its own politics and evidences a political consciousness.
- It interrogates the realities it represents.
- It invokes the teller’s story in the history that it is told.
- It makes the audience responsible for interpretation.
- It resists the temptation to become an object of consumption.
- It resists all dichotomies.
- It foregrounds difference, not conflict.
- It uses multiple voices, emphasizing language as silence, the grain of the voice, tone, inflection, pauses, silences, and repetitions.
- It presents silence as a form of resistance. (Trinh as cited in Denzin, 2003, p. 152)

Throughout the research process I attempted to remain consistent with these guidelines. Discursive practices and analyses are presented as a political project with intent toward social change focussed on health professional education, research, and health practices. Attempts to present multiple perspectives are made in ways that do not presume that there is one accurate interpretation. In addition, quotes are included throughout the literature review and analysis as an effort to retain the voices and passions of the speaker — author, research participants, and theorists alike.

A critical analysis of discourse is an inherently interpretive endeavour with no pre-existing lists of social “discourses,” “genres,” or “voices” from which to base a comparative analysis. Another challenge of discourse analysis is the identification of intertextual, or interdiscursive, features. While it is possible that a person may explicitly use phrases such as “she said,” “people say,” “it is said,” “everyone says,” “I heard,” (Bakhtin, 1981/2008), or “I read,” identification of interdiscursive features requires interpretation. Few studies offer a critical analysis of personal accounts of drug use or approach drug use as a discursive practice.
To enhance the quality of the analysis, I reviewed the literature on a regular basis and continually revisited the interpretations and findings. The thesis supervisors and several of the research participants provided feedback regarding the interpretations. At the same time, I also received informal feedback during casual social and professional conversations. From the perspective that drugs and drug use are social constructs, I took into account all comments and feedback provided in discussions about my research project, incorporating the thoughts and opinions into the interpretations.

After completing the analysis, I sent a summary to the research participants for feedback. (See Feedback Summary, Appendix 5, p. 211). Five of the six research participants received a feedback request because I did not have contact information for one participant. Jenna, Joshua, and Haylei responded briefly and accepted the general description of the data analysis. Jenna replies, “Great work Niki! You sound über professional — love it!” Joshua relayed, “Hi Niki I was really impressed with the summary you sent me. I'm sorry that I don’t have any suggestions but I feel you were honest and fair in your analysis. I'll let you know if I think of anything.” Haylei says she found the analysis to be valuable, and it helped her recognise the significance of her contribution:

Wow Niki I don't know what to say. It's really good. After reading this I feel like i was a help and not just wasting your time. I did have to read it a couple of times in parts to make sure i was understanding properly - but i have to do that with all reading. I am so proud of you! You have done an amazing job. I hope I will get to read the whole thing one day.

They seemed to find value in the recontextualisation of the data into a formal, academic context. Significantly, the tone of each message is supportive.

4.3 Limitations

This research project, situated within a particular historical context in Ontario and Manitoba, Canada, draws on English language literature. The findings are therefore not considered to represent a universal truth for all people in all contexts. The recruitment was primarily conducted using an Internet classified advertisement website, and would have been restricted to those with Internet access. Four of the participants became aware of the study through informant sampling. While informant sampling may have influenced
the range of participants who volunteered for this study, it may also have contributed positively to establishing rapport with the participants.

One of the limitations of this project is the constraint of feasibility within the expectations of a doctoral thesis. While this may be considered a limitation of the project, it also reveals potential areas for future development and research. In the interpretation, breadth of scope of analysis was prioritised over depth. I believe that it was important to structure the analysis to first address potential doubts about the credibility of the accounts. This decision allowed me to address a wide variety of issues evident in the data. The limitation is that each issue has the potential to be explored in more depth. As was mentioned at the beginning of the thesis, a discourse analysis has the potential to investigate many features of discourse, but for reasons of feasibility the researcher needs to select one focus. In this case, I selected discursive practices. Also, several linguistic features could inform depth of analysis. For example, I noticed that Sean used the term *marijuana* when discussing cannabis from a legal perspective and the term *pot* when he was talking about his own use. A linguistic analysis could be applied to investigate how these voices interact, and the functions served.

Another limitation of this study is that there is no way to verify the accuracy of the accounts of the research participants. This is a conscious decision since the purpose of the research is to analyse the ways that the research participants represent and present multiple discourses, and the discursive practices therein.

### 4.4 Suggestions for Future Research

Future considerations for research include expanding methodological approaches and strengthening the relationship between the findings and health professional education and practice. Considerations for methodological approaches include an increased range of participants and types of drugs used; application of the methodology applied in this project to engagement in other activities that are considered deviant; an expansion of existing interpretations; integration with other methodologies; inclusion of discourses represented in grey literature and social media.
I am particularly interested in expanding on this research project by recruiting participants who use Schedule I drugs (see p. 16 of this thesis) such as cocaine and heroin, and focusing on the upper-middle-class socio-economic segment of Canadian society. Because most of the research participants in this project primarily use marijuana, future research to explore discourses about drugs and drug use should include participants who use a wider variety drugs. In Canadian society, marijuana is more socially sanctioned than cocaine, heroin, and methamphetamines, for example. I also believe that drug use needs to remain even more hidden among people who are considered to be successful and respected Canadian citizens. Accordingly, the inclusion of narrative accounts from a wider range of people whose drug use has remained largely silenced may further the health professions’ understandings and conceptualisation of drug use.

The methodological approach implemented in this research project may be applied to explore other activities that are considered to be “behavioural addictions” or “impulse-control disorders, such as gambling, sex, exercise, Internet use, work, and shopping. Discursive narrative methodology can potentially deepen understandings of social constructions of deviant behaviours. This approach broadens interpretations from a focus on the experiences of an individual and attends to the social, historical and political contexts that influence how people act and how they are able to talk about their actions and experiences.

As mentioned in the previous section, there is potential for a more in-depth analysis of each of the topics discussed in the data analysis chapter. A more systematic approach to linguistic analysis could be applied to develop a more comprehensive analysis of the existing research data. In Chapter 2 the linguistic features of intertextuality and interdiscursivity, voice, speech genre and register, and decontextualisation and recontextualisation were presented to facilitate an analysis of discursive practices. While these concepts were drawn on and contributed to the overall analysis, each of these features could be analysed in more depth. Furthermore, given the influence of popular culture, media and grey literature in the social construction of drugs, and interpretation of intertextuality can provide an effective means to synthesise multi-source data.
Future research may include interviews with friends and family of the person who uses drugs to explore discourses of drugs and drug use more broadly. An ethnographic methodology may also be incorporated into the research design to learn about discourses of drugs and drug use in a broader range of contexts with a greater number of audiences or conversational partners. The research interview is a particular context that will influence the range of discursive practices. This research project can be viewed as a first step — recognising that it may be important to analyse discursive practices in multiple contexts, including settings where drugs are being used.

Another suggestion for future research is to investigate the ways in which health professional education can be informed by the incorporation of alternative perspectives and voices into evidence-based practice. This has implications for examining and applying theories and models that inform health professional education, such as the transtheoretical model of behaviour change and relapse prevention models. Research can be conducted to explore the attitudes, knowledge and skills of students and health professionals relating to effectively working with clients or patients who use drugs.

4.5 Interpreter Reflexivity

All knowledge is situated knowledge, and therefore researchers must be aware of their assumptions:

[Researchers] need to be very wary of taking things for granted, either in everyday assumptions that are made in a ready-made text or in appeals to your good common sense that your research participant in the text-in-process makes. Elaborate your suspicion that things are not the way they seem in the text, and note each and every point where you refuse to accept an assumption. An interview could be a place to encourage someone else to refuse easy assumptions and common sense. (Parker, 2005, p. 97)

By engaging in reflexive practice, the researcher is not expected to overcome her position as situated or her performance as interpretative. Rather, the researcher recognises herself to be embedded in a socially constructionist practice, and attempts to make herself and others aware of the assumptions and situated knowledges from which the research process is approached. In this section I address two aspects of reflexivity.
The first aspect of reflexivity is the determination of a focus for analysis amongst all the various possibilities. When one sits down to finally write the thesis and to hone the analysis (once the dog is walked, tea brewed, and books stacked “just so”), a decision must be made to tell the story in a particular way. Certainly, in a thesis, this is not viewed as a mere story but as a scientific process consisting of hard-core facts. Reviewing funding and ethics proposals, in fact, I am reminded that this work is grounded in [spoken in a deep voice] rigorous qualitative narrative research methodology. At the same time, I am pulled toward a phrase I read recently in the novel, “Other People’s Money,” when Justin Cartwright (2011) describes that his protagonist “loves the idea that characters in a novel or a play have a life of their own and don’t have to submit to the author’s will” (chapter 3, para. 5). I likewise recognise that the research analysis does not simply involve interpretation or identification of themes. Unlike the novelist and playwright, the author of a thesis does not always tell the underlying stories of the research participants, and does not lose control of the characters (p. 22). The role of a narrative researcher, then, requires a rigorous approach that allows her to simultaneously represent the meanings and stories told by research participants while discriminating among the elements to formulate a scientifically structured analysis according to what is deemed to be important and a valuable contribution to the body of knowledge in the field.

Each of the research participants seemed to have a distinct message underlying their personal accounts. In my interpretation, with the risk of being too schematic, I posit the following summaries. Paul conveys, “I am a moral person.” Joshua says, “I’m conflicted.” Jenna presents how to “integrate” doing drugs with having a successful life; “this is how.” Haylei seems to say, “Let’s stop making drugs seem so scary.” Sean indicates, “At the right time and place, doing drugs should be seen as fine.” Sharon seems to reach out for love and respect.

As a researcher, I feel accountable to the research participants to carry their individual messages forward. At the same time, the purpose of the research — to uncover the hidden discourses — requires attention to what is unsaid or conspicuously absent in the interview accounts. What is the meaning of the unsaid and how is the absence of a topic significant?
These personal accounts are embedded and entangled in extensive social discourses regarding drugs and drug use. As a researcher, I chose a form of analysis that works with the personal accounts in relation to social discourses and in relation to the practice of health professionals. This approach requires an iterative style of analysis that continually moves between the questions of “what can be learned from this data?” and “what are the implications for health professional education?” The analysis, therefore, takes shape by considering the meanings expressed by the research participants in relation to the contemporary knowledge and practices of health professionals.

As I studied several layers of analysis, one of my supervisors advised me to return to the original research proposal, entitled “Locating concealed discourses to advance a critical analysis of addiction.” The original purpose of the proposal was to conduct an interdiscursive analysis to identify multiple discourses and to interpret the function of the discourses in relation to one another, but the sheer volume of data quickly made this approach unrealistic. I was reminded by my supervisor to attend to the hidden and the unsaid that appeared common to all the interviews. One of the ways to uncover the hidden or unsaid is to attend to areas of apparent contradiction. Upon revisiting the data, analysis of the figuratively hidden nature of discourses shifted to the more literal: hiding the knowledge of personal drug use from others.

A glaring contradiction seemed to exist whereby, overtly, the research participants express being open about their drug use and not hiding it from others while, at the same time, needing to make sure that certain people are not aware of their drug use. Restricting knowledge about their drug use to other people is achieved in both enacted and discursive manners. In terms of enactment, the research participants described not using drugs in certain contexts, such as in public settings or making sure that their clothes did not smell like marijuana. The focus of analysis was on the discursive features that were implemented in relation to drug use and their function in social contexts.

The research participants seemed to speak freely and openly during the interviews. There are times during the interview with Paul when he hesitates regarding how much to disclose in relation to his involvement in the distribution of drugs, including the names of people directly involved in his organisation or the people to whom they sell drugs.
However, when it comes to describing personal situations and drug use, the research participants spoke for lengthy periods of time with only minimal prompting. When asked whether there was anything he thinks about saying, Sean laughed and replied, “[laughing] \You mean when I censored myself never?\\[laughing voice] \No not at all actually Niki.\\[laughs] That never came up. [laughs] So there. [laughing voice] \Yeah, it’s kinda, as from the heart as it’s gonna be.” Joshua similarly observed feeling comfortable during the interview, and remarked that doing the interview felt like having a conversation with himself.

The research participants seemed to view me, the interviewer, as an outsider. Paul informed me there were several of his associates and those from a rival organisation, in whose “territory” we were meeting, who were nearby to ensure their interests were protected. Jenna asked for reassurance prior to signing the consent form that I would not report her drug use to a child protection agency. My outsider status extended to assumptions that I am unfamiliar with drugs, drug effects, and drug distribution. Sean gave a detailed description of MDMA, Haylei gave step-by-step instructions about how to roll a joint, Sharon told me the process of making crack, and Paul explained why a person might select one drug over another. The research participants seemed to appreciate the fact that I am a researcher who would publish a document that might hold authority in certain contexts where they want to see changes instituted. My position as a health professional seemed to be viewed more tenuously. Whereas Sharon repeatedly pointed out things that “doctors” need to know, and things that I should know when working with “patients,” Joshua asked me at the end of his interview whether I thought he should seek counselling.

The second aspect of reflexivity pertains to the researcher as situated. One of the biggest surprises for me during the process of undertaking this research project was the receptiveness to the ideas presented in this thesis from other people. Although the research participants frequently mentioned the impression that drug use is viewed as “socially unacceptable,” and I had also observed many health professionals to talk and act disrespectfully in regard to people who use drugs, there was a general readiness to consider alternative perspectives. During conversations (such as with physicians or even
strangers on a plane) I would offer what I considered to be gradually more controversial aspects of the research findings to test out the ideas and public receptiveness to the ideas. Overall, I was surprised how willing people were to consider alternative perspectives of drugs and drug use, and how well these perspectives blended and complemented one another, rather than stand in opposition to one another.

While conducting the data collection, performing the data analysis, and writing the thesis, I was also employed as an addiction counsellor/occupational therapist on a medical withdrawal unit. I believe that this was fortuitous. I would not want to glamorise drug use or to underestimate or misrepresent the struggles that people do face in regard to their drug use. It also put me in a position of being very aware of my own discursive practices, and challenged me to find ways to integrate a social constructionist philosophy within a medical model of addictions services.

I believe that my engagement in the doctoral research changed my current clinical practice to some degree, and more so influenced some of the structure of the medical withdrawal services that I helped design. Beyond that, staff considered alternative, critical perspectives informed by descriptions of my research. I believe this supports the possibility that this type of research can be transformative for health professional education and practice. There are two instances that stand out for me. Essentially, the medical withdrawal unit offers clients an option to quit all drugs with medical supervision, substitute and taper from a prescribed alternative drug, and/or medicinal management of withdrawal symptoms. One client experienced a very slow taper. She explained that she was not experiencing intolerable discomfort, but anticipated potential discomfort and therefore was requesting medication preventatively. As a result, she was not permitting herself to experience discomfort, to test her ability to tolerate discomfort, or to implement non-medicinal strategies to manage her pain and emotions. The nursing staff believed it was their role and responsibility to alleviate discomfort through the means of medication. A second occurrence was when emergency room staff expressed frustration regarding patients’ “drug seeking” behaviours; in other words, patients who seek a prescription for opiate drugs to alleviate withdrawal symptoms. At the same time, the majority of other patients who attended the emergency room were prescribed
medication to manage their physical or psychological symptoms.

In both instances, it seems that drugs are the primary intervention that health professionals within a Canadian institutional context rely on, but clients who request or use non-prescribed medication are more likely to be treated in a rude and disrespectful manner. As a result of having conducted the literature review, research, and analysis, I now feel comfortable discussing with staff other considerations for viewing problems associated with drug use that involve broader social implications than the “effects of” or “addiction to” any particular drug. Relevant also are ways in which health professionals and Western medical practice and education are implicated in individual and societal expectations that “drugs” are the primary means to alleviate discomfort and create wellness.

As I mentioned at the beginning of the thesis, one of the reasons that I chose to focus on this topic was to inform health professional education about alternative discourses of drug use. This, in turn, could have implications for interactions with clients who use drugs and for influencing drug rehabilitation/treatment program structure. I hope these findings will encourage health educators and students to consider alternative interpretations of personal drug use, and expand knowledge and beliefs about what is considered to be true about drugs and drug use.

Why should health professionals interest themselves in aspects of drug use that are not problematic? The quote by Create Canada cited earlier in the discussion is a compelling urge for health professionals to protect families and communities from the severe harms from drugs. However, it is equally important to develop understandings of drugs and drug use from the possible perspectives of health and well-being. I would suggest that in relation to health professional education and practice, the disease model of drug use and addiction focuses attention on the effect of the drug and the need for the individual to make changes. Yet, as the research participants describe, many consequences associated with drug use are influenced by social contexts, including the circumstances that influence a person’s decision to do drugs, the supportiveness of people in the social environment the person confides in about personal drug use, and the punitive response toward the drug use by others. Although it has been argued that drug use is a
social, collective issue — and I believe this research project supports this stance — the disease model of addiction portrays drug use as an individual *problem* susceptible to individual remediation. By positioning individual bodies as harbouring the disease of addiction, the focus of responsibility is shifted away from other factors that influence a person’s use of drugs and the consequences of his or her drug use. Health and well-being do not reside solely in bodies; health and well-being are influenced by social, institutional, political, and historical phenomenon. The research participants portray drug use as individual choice, but they also convey that drugs and drug use are social constructs. They recognise that the “effects” of doing drugs reach far beyond any possible physiological response of the body.

I conclude this thesis with a story. I recently met a pilot in a casual setting. In the process of sharing social details, such as where we were from and where we work, my thesis topic was discussed. I told him that I interviewed people who did drugs everyday and never identified a reason or need to get counselling. I remarked that he, as a pilot, likely did not have much experience with this since pilots likely undergo periodic drug screening. He replied that he “had promised himself to stay away” from marijuana for the summer. I later admonished myself thinking, “Niki, *normal* people do not ask people *who they just met* about their drug use!”

But wasn’t this the point of the research project — for someone to be able to talk about drugs and drug use as freely as they talk about where they come from and what job they do? Of course, in telling this story I protect the person’s anonymity, since this information could have social and professional implications under other circumstances. I hope we will one day have new understandings about drug use informed by people who previously had to hide their drug use, and whose voices have been silenced. As stated earlier, silence does not indicate an *absence* of an alternative discourse, but an absence of the opportunity to *express* the alternative discourse (Severns, 2004). In this thesis, I demonstrate that health professional education can be advanced when spaces are created for alternative discourses to be heard. Knowledge begins with a willingness to listen; and understanding comes with a willingness to listen differently.
References


Appendices

Appendix 1: Ethics Approval

Office of Research Ethics
The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2468 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Western

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. S. DeLuca
Review Number: 174895
Review Date: October 15, 2010

Protocol Title: Locating concealed discourses to advance a critical analysis of addiction: Implication for health professional education.
Department and Institution: Faculty of Health Sciences, University of Western Ontario
Sponsor: None
Ethics Approval Date: November 26, 2010
Expiry Date: December 31, 2011
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above named research study on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the study or consent form may be initiated without prior written approval from the NMREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the NMREB:

- a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- b) all adverse and unexpected experiences or events that are both serious and unexpected;
- c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the NMREB.

Chair of NMREB: Dr. Riley Hinson
FDA Ref. #: IRB 00000941

Ethics Officer to Contact for Further Information

Grace Kelly (grace.kelly@uwo.ca) Janice Sutherland (jsuther@uwo.ca) Elizabeth Wambolt (ewambolt@uwo.ca)

This is an official document. Please retain the original in your files.

UWO NMREB Ethics Approval - Initial
V 2007-10-12 [phApprovalNotice/NMREB_Initial] 174895

Page 1 of 1
Use of Human Participants - Ethics Approval Notice

Principal Investigator: Sandra DeLuca
Review Number: 174895
Review Level: Delegated
Approved Local Adult Participants: 12
Approved Local Minor Participants: 0
Protocol Title: Locating concealed discourses to advance a critical analysis of addiction: Implications for health professional education.
Department & Institution: Faculty of Education.
Sponsor:
Ethics Approval Date: March 06, 2011
Expiry Date: December 31, 2011

Documents Reviewed & Approved & Documents Received for Information:

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This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

The Chair of the NMREB is Dr. Riley Hinson. The UWO NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Ethics Officer to Contact for Further Information

- Grace Kelly (grace.kelly@uwo.ca)
- Elizabeth Wambolt (ewambolt@uwo.ca)
- Janice Sutherland (jsutherland@uwo.ca)

This is an official document. Please retain the original in your files.

The University of Western Ontario
Office of Research Ethics
Room 5150, Support Services Building • London, Ontario • CANADA - N6A 3K7
PH: 519-661-3036 • F: 519-850-2466 • ethics@uwo.ca • www.uwo.ca/research/ethics
Use of Human Participants - Ethics Approval Notice

Principal Investigator: Sandra DeLuca  
Review Number: 174986  
Review Level: Delegated  
Approved Local Adult Participants: 12  
Approved Local Minor Participants: 0  
Protocol Title: Locating concealed discourses to advance a critical analysis of addiction implication for health professional education,  
Department & Institution: Education/Faculty of Education,  
Sponsor:  
Ethics Approval Date: March 20, 2012  Expiry Date: July 31, 2012

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This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above.

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The University of Western Ontario  
Office of Research Ethics  
Support Services Building Room 5150 • London, Ontario • CANADA - N6G 1G9  
PH: 519-661-3036 • F: 519-850-2466 • ethics@uwo.ca • www.uwo.ca/research/ethics
Appendix 2: Recruitment Letter

Study Volunteers Needed
- Substance Use-

Background
Many people use drugs recreationally for various reasons, such as:
- Part of daily routine
- Enjoyment
- Heightened experiences
- Lifestyle choice
- Healing or spiritual practice
- Socializing with others

The terms “drug use” or “substance use” can include:
- Prescription medication (e.g. oxycodone, benzodiazepines)
- Healing plants or medicines (e.g. san pedro, ketamine)
- Illicit drugs (e.g. heroin, marijuana, cocaine)

There is very little known about the experience of substance use from the perspectives of people who use one or more drugs regularly (i.e. daily or nearly daily), but have never had the reason or desire to attend addiction counselling or self-help groups.

Since many drugs are illegal people are sometimes not able to talk openly about their opinions and experiences.

Intention of this study
This study will provide an opportunity for individuals who use one or more substances or drugs on a regular basis (approximately daily), to confidentially discuss their own experiences and ideas about substance use. The intention of this research is to broaden the social understanding of substance use for health care providers.

What is involved?
Participation would involve an interview lasting approximately 1.5 hours, with potential for 1-2 brief follow-up interviews. Compensated for your time and effort will be provided.

Confidentiality
The information you choose to share about your experience with drugs is confidential. Your name and identity will not be released.

If you are interested in being involved in this study, please contact:
Niki Kiepek, PhD Candidate, The University of Western Ontario

Contact information:
Appendix 3: Consent Form

Locating concealed discourses to advance a critical analysis of substance use: Implications for health professional education

Introduction

This study is being conducted by Niki Kiepek, under the supervision of Dr. Sandra Deluca and Dr. Lilian Magalhães. Niki Kiepek is a Doctoral Candidate in the Health and Rehabilitation Program at The University of Western Ontario. The information being collecting will be used in her doctoral thesis. If you have any questions or concerns about the research, you are welcome to contact her or her supervisors.

Invitation to Participate in Research

You are being invited to voluntarily participate in a research study looking at substance use from the perspectives of people who have never had reason or desire to attend addiction counselling or a self-help group. The purpose of this letter is to give you the information you need to make an informed decision about whether or not you would like to participate. It is important that you are aware of what the research involves. Please take the time to read this carefully and ask questions if you would like to understand some part of it better. You should feel free to ask any questions you may have at any time. You will be given a copy of this Letter of Information and Consent Form once it has been signed.

Purpose of the Study

This research project is intended to help us better understand substance use from the perspectives of people who have never had reason or desire to attend addiction counselling or a self-help group. The findings of this project may be used to inform health professionals about substance use from several different perspectives.

Research Procedure for this Study

You are being asked to participate in an interview regarding your recreational use of substances. The first interview will last no longer than 2 hours and will take place in a private and safe location. You may be asked to be involved in one or two follow-up interviews that may last 30-60 minutes. The interviews will be audio recorded and the researcher may take notes during the interview.

Your participation in the study is completely voluntarily and you can leave it any time. If you experience any discomfort during the interviews or feel any risk, you can always stop or interrupt the interview with no negative consequences. You are welcome to refuse to answer any questions you do not want to answer. If you withdraw from the study, the data collected up until that time will used in the data analysis.
Potential Risks and Discomforts

1. There are certain exceptions to confidentiality that MUST be reported, and could pose a potential risk. These exceptions include:
   a. Under the Child and Family Services Act, a therapist must report to the children's aid society if he or she suspects a child under 16 has suffered abuse.
   b. The 'duty to warn' states that in situations where there are reasonable grounds to believe the patient intends to seriously harm another individual the health professional may disclose confidential information in order to warn a third party.
   c. The Mental Health Act permits a therapist to disclose information if he or she believes a person is suffering from a mental disorder and poses a serious threat to himself or herself or others.

2. If participating in these interviews brings difficult memories or emotions, you can ask for counselling services.

Potential Benefits

There are no known benefits to you associated with your participation in this research.

What Will Happen to the Information Collected

Information from the interview will be stored on a computer using an encrypted file and password protection. The data will be destroyed after five years.

Any information that is obtained as part of this study will remain confidential and accessible only to the researchers. If you discuss having been involved in something illegal, this is also confidential and will not be reported to the police. If any information is published a pseudonym will be used and any potentially identifying information will be removed.

You will have the opportunity to give feedback about the research findings and will have access to the results of this study. You can also request a final copy of the research report by contacting the research team.

Other Pertinent Information

The interviewer is an occupational therapist and regulated by the College of Occupational Therapists of Ontario (COTO). COTO is an organisation that regulates occupational therapists and protects the public. If you have any concerns about the professional conduct during the interview you may inform COTO. COTO requires the interviewer to document any aspect of the interview that could be viewed as therapeutic, including advice or referral for services. This documentation is kept separate from research data and would be stored in a secure location for ten years.

If you have questions about your rights as a research subject you may contact: The Office of Research Ethics The University of Western Ontario
You will be compensated for your participation in this research study, an amount that is equivalent to 2 city bus tickets in the community where the interview is held.

You do not waive any legal rights by signing the consent form.

**Consent Statement**

I have read the Letter of Information (or Information/Consent document), have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

**Signature of Research Participant**

Name: ________________________ Signature: _________________________

Date: _________________________

**Signature of Investigator**

Name: ________________________ Signature: _________________________

Date: _________________________
Appendix 4: Semi-Structured Interview Guide

Thank you for coming to the interview today. I would like to start by asking you what brings you here today? You responded to the advertisement, and agreed to meet with me today. Tell me about this.

You’ve read both the call for interviews and the consent information. What are your initial responses or points that you want to make?

Tell me about each of the substances that you use, even if you don’t consider them to be “drugs”.

If you were to explain your engagement in substance use (your experiences or perspectives) to another person, what would you say?

There is something unique that substances offer to you.

How do you think someone else might describe or talk about your engagement in this activity / use of these substances?

How do you think your experience of engaging in this activity / using these substances might differ from other people’s experiences?

How do you think your experience of engaging in this activity / using these substances might be similar to other people’s experiences?

Any other thoughts/comments?

Who would you like to read this research when it is published? Or who do you think should read it?
Appendix 5: Summary of Data Analysis for Feedback

LOCATING CONCEALED DISCOURSES TO ADVANCE
A CRITICAL ANALYSIS OF DRUGS, DRUG USE & ADDICTION
Researcher: Niki Kiepek
Graduate Program in Health and Rehabilitation Sciences
Summary of Data Analysis
For Feedback

On behalf of my colleagues and I, I again extend an appreciation of the contribution that you have made to this research project. The experiences and insights that you have shared have been very beneficial. I am in the process of finalising the data analysis and wanted to ensure that you had an opportunity to review and comment on the findings. If you have any points or issues that require clarification, please forward them to me by April 18, 2012. As before, any information that you provide will remain confidential. Please feel free to be frank and let me know if you think that there is anything that I misrepresented, overlooked or that you are not sure about. Alternatively, if there is something that you think really makes sense to you, I’d like to hear that too.

At this point, the analysis is essentially discussed in three main parts.

Part A: Hiding drug use: Concealing vs. non-disclosure

In the interviews, there appeared to be a contradiction with regards to “hiding” drug use. Although there were individual differences and exceptions, I will give a bit of a generalisation. I would say that quite frequently, people said that they were “open” about their use of drugs and did not attempt to “hide it.” At the same time, there were many instances when I was told that there are people who they are not able to talk about drugs or drug use to. These included parents, children, clients, colleagues, police officers, employers, teachers and other children’s parents.

I deduced that the word “hiding” has two distinct meanings. What appeared on the surface to be a contradiction could be understood when considered from another point of view. Hiding drug use was generally seen as undesirable. One of the reasons I think that people believe that “hiding” drug use is undesirable is that I often heard that having to hide an aspect of one’s use of drugs is an indication of a ‘drug problem.’ Also, it seems that when people feel that they have to hide their drug use they aren’t able to “be themselves.” On top of this, concealing something from others makes people feel guilty.

On the other hand, there was the idea that people really can’t disclose their drug use to just anyone, because this would, in all likelihood, create problems. Until you know someone better, it is safe not to disclose information about drug use. Essentially, not disclosing drug use prevents the development of problems at work, in relationships, legal issues, and loss of child custody. In a way, it is not the drugs that cause certain problems; the problems arise from other people’s reactions when they find out. In this way, non-disclosure is an important measure to enhance social success.
Part B: Openness

Opposite from “hiding” was the idea of “openness.” Being able to be “open” about drugs and drug use was seen as desirable. There was a desire for more open understandings in the media, in law, in health, in research, in public, and by family. At the same time, there was a reluctance for some people to talk to their children about drugs and there were suggestions of prohibiting drug use by their children. I feel that in this case, there was an opinion that drugs were generally viewed, “socially unacceptable.” So, despite the fact that some people thought that drugs were ok for themselves to do, they want to be good parents and protect their children from potential consequences of doing something that is unacceptable and illegal.

Responding to social representations / perceptions

In general, there seemed to be an impression that drugs and drug use are largely misrepresented and misperceived by the general public. Starting from education messages for children, to policy, to research studies, to media, to policy development, there were suggestions that drugs and drug use are not accurately portrayed or understood. Recognition of these dominant representations and perceptions positions people to feel the need to defend and justify their use of drugs.

Part C: Constructing success

I found it interesting that even though I didn’t ask questions specific to the diagnostic criteria of “substance dependence” or “substance abuse,” the discussions addressed and responded to a criteria.

For substance dependence the criteria include:

- Tolerance. Increased amounts of substance to achieve desired effect or diminished effect of substance.
- Withdrawal syndrome or use of another substance to relieve/avoid symptoms.
- Substance is used more than intended.
- Efforts to control substance use are unsuccessful.
- Much time is spent in activities to obtain the substance, use the substance or recover the effects.
- Decreased time is spent doing important social, occupational, or recreational activities.
- Substance use continues despite personal knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

It seems that people are at least somewhat aware of these criteria, but I’m not sure if it is from looking it up or just hearing these topics discussed casually. It seemed that people constantly evaluated their own drug use in relation to these criteria. For example, is the drug having a negative impact on your work? Are you noticing withdrawal? Is it something you have control over?
Overall, people didn’t seem to dispute these criteria as being a valid way to measure problems. The exception being the legal aspects. It was noted that the legal problems were less related to effects of drug use and more due to the illegal status of drugs.

People sometimes indicated a perceived loss of control at certain times in their life, but for the most part viewed drug use as a choice. The idea of “needing” a drug was discussed in several ways. For some people the need was a desire, such as during a certain activity, and for others it was a way to enhance a certain way of being and to dealing with circumstances.

In relation to physical and mental health, people seemed to be very aware of potential health risks and made an effort to keep themselves informed. In fact, this criteria was frequently reframed and drugs were viewed in many situations to improve health and well-being. Drugs were frequently compared to other potentially more harmful, but more socially acceptable activities such as alcohol consumption and horseback riding.

Some people described that certain drugs can interfere in certain activities or role, or they may not have any effect on the activity at all. In other situations, drugs were seem to actually enhance participation in certain activities or roles, such as being more productive at work, enjoying working out at the gym, and helping to get mundane tasks completed.

Overall, it seemed to me that people often evaluated drug use (their own or others) in relation to diagnostic criteria as a way to convey whether it was ‘problematic’ or ‘acceptable.’

Language and flipping the script

I noticed that sometimes people struggled with finding the right words to convey the intended message. There are so many words, like “drug,” “need,” and “dealer” that have negative connotations and associated meanings. In this circumstance, I found that people sometimes played with words to change the associated meaning. This can be called “recontextualisation” in academic writing, which is a lot like the idea of “flipping the script.”

These are some of the definitions of flipping the script

1. to “appropriate and modify an ‘old’ or historical concept to produce something new”
2. “to take what somebody said against you and to use it against them.”
3. “to gain control in a dialogue that is being dominated by another person so that you are now in charge.”

There were strong examples of this when the term “drug dealer” was used; it was more frequently used to convey an undesirable aspect of selling drugs, rather than a general reference to a person who sells drugs. Alternatively, when people were talking about accessing drugs in a way that was viewed as acceptable they used more neutral terms such as “source” and “a guy.” Yet, there was an instance when doctors’ practices of prescribing pharmaceutical medications were questioned and words were used like “pusher,” “dealing,” and “selling.” It was very interesting that the terms where flipped
between the person selling illicit drugs and the person prescribing medication. It seemed to be an act of resistance to question certain social distinctions and assumptions about what is considered “acceptable” and “unacceptable.”

Conclusions

The key aspects of these interpretations are to demonstrate that when individuals talk about drugs and drug use they are not just expressing opinions or thoughts. Firstly, there is a negotiation about how much can be said within each context. Secondly, talk about drug use is frequently in response to assumptions about the dominant perspectives about drugs as socially unacceptable and as drugs being associated with personal and social harms. Thirdly, talk about drugs requires a bit of strategic playing with language to be able to counter assumptions and taken-for-granted beliefs. This can also work to diminish certain authoritative discourse (such as medicine and law) and give more legitimacy of knowledge to the average person who actually has experience with the drug.

This analysis is positioned to put up to question several of the assumptions that inform health professional education. For one, this work acknowledges that people talk about drugs in a way that is expected to minimise the experience of negative consequences. In counselling sessions, for example, how a person talks about drugs needs to be understood outside theories of “denial” and “insight.” Similarly, theories of neutralisation, justification, rationalisation and intellectualisation need to be reconsidered. These terms are grounded in the assumption that drug use is deviant and that people who use drugs distort the truth to make their actions seem more acceptable. It is important for health professionals to learn to listen more openly to people regarding their experiences of drugs and drug use.
Curriculum Vitae

Name: Niki Kiepek

Post-secondary Education and Degrees:

University of Toronto
Toronto, Ontario, Canada
1996-2000 B.Sc. (Hons.)

The University of Toronto
Toronto, Ontario, Canada
2001-2003 M.Sc. (OT)

McMaster University
Hamilton, Ontario, Canada
2005-2007 diploma

The University of Western Ontario
London, Ontario, Canada
2008-2012 Ph.D. (c)

Honours and Awards:

Continuing Education Annual Prize in Social Services for the Addiction Education Program
2007

Young Scholars’ Award, Engaging Reflection in Health Professional Education and Practice Conference.
2009

Related Work Experience:

Lecturer; Clinical Sciences Division (joint appointment)
Northern Ontario School of Medicine (NOSM)
Lakehead University, Faculty of Medicine
Laurentian University, Faculty of Medicine
2011-current

Adjunct Instructor
Fanshawe College; London, ON
Sept 2011-current

Occupational Therapist, Medical Withdrawal
Sioux Lookout Meno-Ya-Win Health Centre
2011-current

Occupational Therapist, Rehabilitation Dept
Sioux Lookout Meno-Ya-Win Health Centre
2011-current
Occupational Therapist, Rehabilitation Dept  
Sioux Lookout Meno-Ya-Win Health Centre  
2010-2011

Research Assistant  
The University of Western Ontario  
2008-2009, 2009-2010

Tutorial Assistant  
The University of Western Ontario  
2008-2009

Addictions Specialist, Assertive Community Treatment Team  
Providence Care  
2007-2008

Early Intervention Clinician, Alcohol and Other Drugs Service  
Whanganui District Health Board, New Zealand  
2006-2007

Occupational Therapist  
Whanganui District Health Board, New Zealand  
2006

Occupational Therapist  
Sioux Lookout Meno-Ya-Win Health Centre  
2003-2006

Publications:  


Peer Refereed Presentations:


Kiepek, N. (2012). Advancing the role of occupational therapy to address substance use [extended discussion]. Canadian Association of Occupational Therapists. Quebec City, QB.

Kiepek, N. (2012). The role of occupational therapy at a hospital-based addictions program [poster]. Canadian Association of Occupational Therapists. Quebec City, QB.


