



Conceptualisations of substance misuse and their potential consequences

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CONCEPTUALISATIONS OF SUBSTANCE MISUSE AND THEIR POTENTIAL CONSEQUENCES

Submitted by

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In partial fulfillment of the requirements

for the degree of

Masters by Research in English

Sheffield Hallam University

November, 2019

Candidate Declaration

I hereby declare that:

1. I have not been enrolled for another award of the University, or other academic or professional organisation, whilst undertaking my research degree.
2. None of the material contained in the thesis has been used in any other submission for an academic award.
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Abstract

My undergraduate cognitive stylistic research demonstrated how conceptualisations of addiction exist on a continuum and are constantly influenced by embodied experiences. This continuum moves from choice to illness and is dependent upon social norms, which are formed by an individual's understandings of whether a person who uses drugs needs them to function. Addiction is a complex and multi-faceted area of research which encompasses several unfamiliar strands of interdisciplinary work which need further attention. This thesis investigates how professionals, who frequently come into communication with substance misusers, conceptualise addiction and the potential consequences that these conceptualisations can engender. The data will be analysed through a linguistic lens from a cognitive poetic viewpoint in order to answer the following research questions:

1. What are the emerging dominant conceptual metaphors used by professionals working in the field of addiction?
2. What do utterances reveal about how professionals conceptualise the different phases of addiction?
3. What are the potential consequences of such conceptualisations?

The application of Conceptual Metaphor Theory will enable me to analyse how metaphor is used in key passages of the discourse. By employing a cognitive stylistic approach, I will be able to combine detailed linguistic analysis with a theoretically informed consideration of how cognitive structures and processes motivate professionals' production of language and subsequently treatment and therapy for substance misuse - an essential procedure if we are to gain a true insight into how healthcare professionals think about addiction.

Dedication

Dedicated to my father, Nathaniel Johnson. The strength and courage that you have demonstrated in order to recover from your addiction has shown me that I am capable of achieving anything that I put my mind to. Thank you for all of your guidance and support and for the open and honest relationship we share. My love always.

"I count him braver who conquers his desires than him who conquers his enemies for the hardest victory is over self" - Aristotle

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Firstly, I would like to thank my family for their unconditional love; particularly my grandparents who have encouraged and supported me throughout my education, this would not have been possible without you. Secondly, a huge thank you to Dr. Jessica Mason who prompted me to pursue my interest in addiction during the final year of my undergraduate studies, suggesting that I applied Conceptual Metaphor Theory as the analytical framework. You have always been extremely receptive to my interests and I feel certain that your ongoing encouragement is what largely shaped my decision to complete a Masters of Research. Thank you to all of the participants who took the time to discuss addiction with me, your desire to help individuals who suffer from substance misuse is inspiring and I admire your perseverance and commitment. A special thank you to the counsellor and psychotherapist who willingly offered me an insight into the vulnerability he experienced as a child which he felt led to his historic substance misuse, without the voices of people like you it would be impossible to truly understand substance dependence and which conceptualisations are empowering and disempowering in addiction discourse. Thank you to my supervisory team Dr. Sam Browse and Dr. Jessica Mason for meeting with me over these past twelve months and advising me on how I can refine my work to ensure that it's to the best of my ability. I also thank Prof. David Best for the opportunities that he has given me since I reached out to him during my undergraduate dissertation. The numerous addiction projects that you have permitted me to work alongside you on have both meaningfully expanded my knowledge in the field and have improved my skills as a researcher; confirming that a career in addiction research is right for me, so once again, thank you. Finally, I thank Sheffield Hallam University and the English department for the opportunities that you have provided me with over the past four years, I am honoured to have completed both my undergraduate degree and master's degree at your establishment.

1. Introduction

Addiction is known to be one of the most prevalent stigmatised illnesses. It is clear from pre-existing research that unless we address the issues that underpin the stigmatisation of substance dependent patients, a substantial number of individuals will be denied the necessary response and intervention. While there is an abundance of work surrounding the stereotypes and stigmatisation that substance using groups face, and how this can hinder the recovery process, there is yet to be research from a linguistic lens which takes a cognitively informed approach into investigating how healthcare professionals conceptualise addiction and the potential consequences of these conceptualisations. Given that our interpretation of the world is made possible through the sensory experiences of the body, it is “not possible to describe the world without being predisposed and biased- both mentally and bodily” (Dirksen & Bauman 2008, p.114). As we mature, culturally learned values start to impact our perceptions which in turn influences our language and the way we interpret abstract notions, like that of substance misuse. Lakoff and Johnson (1980) reveal how language is a display of metaphors that can both directly or indirectly be traced back to an embodied sensation or experience. Since my research aims to reveal how healthcare professionals think about addiction, I have investigated the manner in which they speak about the different aspects of substance misuse; thus uncovering their embodied cognitive conceptualisations of addiction as a whole. All of the professionals interviewed for this thesis have unique talents and abilities in supporting those who suffer from addiction. While these can be utilised to provide the addicted person with a comprehensive package of care, what is not yet apparent, and is therefore what my research seeks to reveal, is which of these professionals’ conceptualisations are empowering or disempowering, and at what point on the affected person’s addiction journey.

After engaging in a heartfelt discussion during my undergraduate research with a person who was in the early stages of his recovery, it was mentioned that he felt the terms professionals

use who are actively supporting him in his recovery journey, more often than not, negatively impact on how he conceives of himself and his illness. This finding is what instigated my desire to demonstrate to those who frequently come into communication with vulnerable people, particularly those who suffer from addiction, the potentially negative effects that certain conceptualisations can engender. Given that people are often “unaware of the metaphorical foundations for many of their ideas” (Gibbs 2017, p.148) I hope that the application of Conceptual Metaphor Theory to datasets such as these will serve as an eye-opener not just in the worlds of metaphor studies and cognitive science, but also in the world of addiction research and practice. Furthermore, CMT has never proposed that the “metaphors we live by” (Lakoff and Johnson 1980) are unchangeable, only that much of our thinking is fundamentally metaphorical, a fact that “often has direct consequences for the nature of our beliefs and the actions we take” (Gibbs 2017, p.148). Thus, if we ensure that we deposit the time needed to find out which conceptualisations are empowering and disempowering in addiction discourses, we will be in a position to echo this to healthcare professionals which will hopefully encourage them to reconceptualise those aspects of substance misuse that are disempowering in a more empowering way.

1.1 Overview of Structure

Chapter Two provides an overview of relevant previous research, including: the embodied nature of substance misuse, how addiction is socially constructed, and the different models of addiction; all of which work to contextualise my research. Chapter Three outlines my methodological approach and offers justification for the use of CMT. Then, Chapter Four contains my analysis of each of the participants interviews which is segmented into three phases: becoming addicted, experiencing addiction, and recovery from addiction. Finally, in Chapter Five I summarise my findings and engage in a discussion relating to which conceptualisations are empowering and which are potentially disempowering.

2. Literature Review

2.1 Embodying Addiction:

Embodiment in the domain of cognitive science “refers to understanding the role of an agent’s own body in its everyday, situated cognition” (Gibbs 2005, p.1); the way we think about our experiences is subconsciously shaped by embodiment. Embodied experience provides the basis for how we interpret our own lives, the lives of others, and the world around us. Whilst embodiment “may not provide the single foundation for all thought and language” (Gibbs 2005, p.3), it is a fundamental part of cognitive and perceptual processes “by which we make sense of our experiences in the world” (Gibbs 2005, p.3). This being said, a discussion of embodiment is essential in a research project that investigates conceptualisations of substance use and their consequences because drug users are repeatedly culturally represented as individuals who do not care about their bodies (Bailey 1993, p.61), and are subsequently perceived as uncaring of themselves and others around them, generating a recurrent embodiment of shame (Manning 2013 p.235). I will begin the chapter with a general overview of how the addict’s body is represented in different popular cultural forms that are central to the social construction of both addiction and the addict’s body. I will then move onto a discussion about how embodiment, lived by the patient, is perceived in a clinical context and the importance of ‘perceiving sympathetically’ in order to suitably treat the patient (perceiving the addict’s lived experience). Finally, I will discuss the exchange of embodiment in an interview setting where the researcher has past lived experiences of being a substance user.

Representations of drug use and addiction in popular media work to construct the substance user as an outsider to conventional society by honing in on specific metaphors and images which “tend to stress the abject body, bodily decay, and embodied ‘otherness’” (Waskul and Vannini 2016). Schutz and Natanson (1962) argue that it is predominantly through embodied

experience and visual interpretation of the symbolic meanings associated with bodies that we come to have an awareness of the 'other'. Huggins (2012) examines the cultural significance of substance misuse and the representation of addiction and associated issues through discourses and images of the addict's body in popular media. He works from a tradition that understands the notion and meaning of addiction as socially constructed and argues that the addict's body is utilised as a metaphor and symbol of social and moral decay which is often visually represented. Visual representations of substance misuse commonly take the form of 'mugshots' over a period of time which depict the subject's "complete mental and physical breakdown" (Hickman 2002, p.129) or by images of marks left on the substance user's body from the injection of drugs; thus highlighting the metaphorical links between substance misuse and physical bodily damage (Huggins 2012, p.172). Such representations have played a central part in the growth of medical, political and moral discourses of substance use and have contributed not only to the representation of addiction at the level of the individual but also as a collective body. For example, the notion of the 'junkie', "the user of needles, of spoons, of pipes, of smack or crack" (Huggins 2012, p.176) is instantaneously conceptualised as deviant, whereby it is conceived of, understood, and interpreted as a set of actions that take place through and within the lived body of the individual and is "constructed in concert with that body" (Moore and Kosut 2010, p.384) making it a deeply embodied experience. In fact, Campbell and Ettore (2011) highlight that the present transfer of the relocation of addiction from the body to the brain has produced a dynamic termed "embodied deviance" (p.2). Embodied deviance is defined as "the historically and culturally specific belief that deviant social behaviour (however that is defined) manifests in the materiality of the body, as a cause or an effect, or perhaps as merely a suggestive trace" (Terry and Urla 1995, p.2). While the visible signs of substance misuse are represented as social and cultural wrongdoings, Campbell and Ettore (2011) argue that we must urge healthcare professionals to understand that the true nature of addiction is "usually located in bodily pathology, deficit, or

vulnerability” (p.2). Thus, this very process of trying to *see* addiction and make this “inherently invisible condition visible- from en/visioning addiction” (Hickman 2002, p.120) is what is in fact contributing to the ‘othering’ of substance users as these visualisations reflect both “the perceived social otherness and marginality of the addict” (Huggins 2012, p.167). By focusing on the material body of the addict, the body in turn acts as a kind of symbolic map “not just for the social significance of drug use and addiction but for broader notions of deviance and social bodily disorder” (Moore and Kosut, p.384). Indeed, one maps onto the other and back again as the significance of the symbolic form is deepened by the socially marginal location of the substance user (Fraser, 1996; Meyers, 2004; Ettore 2015). Addicts are consequently understood as aberrant individuals’ whose “very embodied ‘essence’ is to be marked as deviant, abject, and ‘other’, and they are therefore positioned as deserving the very social exclusions that exacerbate their otherness” (Campbell and Ettore 2011, p.2).

Wisnewski (2015) explores the relationship between our bodily existence and our perceptual reality in a clinical context. His aim is to develop an understanding as to what extent a physician should be trained to “perceive the altered form of embodiment lived by a patient” (2015, p.310) and to what extent an “emphasis on rules in medical ethics (both the literature and the training currently undertaken by physicians)” (2015, p.310) is hindering the development of perceptual ability. He supports the claim that physicians have a responsibility to foster sympathetic perception in order to develop their perceptions of the patient in such a way that they can suitably treat them. Furthermore, he draws attention to the idea that in instances of illness, disability, and disorders the body is at the forefront of observation; the body is the reason for one’s existence and thus “something that *cannot* be a mere object” (Wisnewski 2015, p.311). However, during the stages of diagnosis we find that the body is, with no exception, objectified and depersonalised, even if only temporarily. With this in

mind, we must be aware that ethical guidelines cannot substitute understanding and that what can be assessed is not necessarily synonymous to what matters. By viewing symptoms of the patient as distinct segments of data that need to be assessed, the physician pays too little attention to the endangered agency of the patient and in turn is not perceiving sympathetically. However, it is important to note that it is unlikely that *all* doctors will view the symptoms of the patient as ‘distinct segments’ so one must be careful not to over-generalise ‘The Physician’. Nevertheless, this is a prominent issue that patients suffering from addiction face, as attention is, more often than not, given to those aspects of their substance dependency that are visible. This being said, physicians might be less inclined to perceive sympathetically towards substance users because they are trained to focus on the material body of the addict, such as the marks left on their body from the injection of drugs (Huggins 2012). Thus, the very essence of focusing on where the addict has ‘*chosen*’ to harm his or her self is less likely to engender sympathy than focusing on the person’s addiction as a whole. Whilst sympathy can be conveyed in language it is more often than not expressed in non-verbal ways.

Wisniewski (2015, p.312) claims that “to be sympathetic *just is* to perceive sympathetically- to see the distress and anxiety in those one encounters and to respond appropriately”. In other words, we demonstrate our sympathy rather than merely state it, our emotional attitudes towards others are expressed “beneath the level of reflective self-consciousness” (Wisniewski 2015, p.312). Often in medical realms complex issues like that of substance dependency are not seen for what they are but instead viewed as cases to which one’s logically assumed rules apply. In terms of professional intervention which rules are deemed appropriate to employ will depend heavily on which model of addiction the professional has been ‘taught’ to adhere to. These rules can, in turn, obscure reflection and impede what the professional views as morally problematic, leading to “an immoral ignorance of the fine structure of difficult moral situations” (Wisniewski 2015, p.317). At the heart of Wisniewski’s (2015) argument is the idea that there is a myriad of ways that one can follow a rule: “one can do so out of sense of

obligation, or out of fear, one can do so with an understanding of the importance of the rule or without it- with sympathy or without a drop of it” (p.318). Whilst there is no ‘set in stone’ instruction for being sympathetic, rule-based medical ethics can create barriers between healthcare professionals and those who are seeking help for complex illnesses; they can generate a focus on the rules rather than a focus on the people. Thus, in rule-based ethics “good consequences do not justify wrong or bad acts” (Adamson 2008, p.17) whereas people-based ethics is more complex in that it does not focus so much on the action but instead on producing ‘good’ consequences. Nevertheless, people-based ethics does pose some dangers with regard to implicitness and the fact that it relies solely on intuition meaning there is no trail of diagnostic evidence for review.

A personal connection with a research area can spawn an intense emotional and personal reflection especially in literature addressing substance use as this issue is known to be acutely embodied. Harris (2015) highlights that there has been inadequate reflexive literature in regard to the personal experience of injecting substance use, particularly in relation to the vulnerabilities that “disclosure of this not only illicit but socially ‘abject’ practice connotes” (Harris 2009). In research where embodiment is a focal point, attention is, more often than not, given to the embodiment of the participant rather than the researcher (e.g. Glenberg & Kaschak, 2002; Zwaan & Yaxley, 2003; Gustafsson & Hammarström, 2012; Piran, 2017); Harris (2015) seeks to change this and reflects on the interchange of embodiment in an interview setting and the way in which his body became a focal point of inspection during the research process. The article draws on three qualitative studies: an exploration of people living with hepatitis C, the life-history of people who inject illicit drugs, and an ongoing project following people through their hepatitis C treatment. Throughout the paper Harris (2015) considers how the interviews caused him to reconceptualise his own heroin-using past and experiences of suffering with hepatitis C. Prior to starting the study he mentions that he

conceptualised his impatience and dislike of social situations as ‘character flaws’, but that as the interviews progressed he came to understand that this was a direct consequence of living with hepatitis C. This demonstrates that he, as the researcher, reconceptualised his sense of self as someone who was ill rather than simply ‘bad-natured’ (Harris 2015). After listening to others’ experiences of hepatitis C treatment he decided to follow in their footsteps and his decision to commence treatment thus involved a temporal realignment; “a reconceptualization of treatment from six long months of fearful side effects, to providing the possibility of feeling better for the long term” (Harris 2015, p.1692). Despite the positive outcomes of these conversations, Harris (2015) emphasises that talking with others who injected drugs was not risk free with regard to his own recovery, but also how his heroin memories had become “tempered with the murky reality of that time” (p.1692). As the interviews progressed he notes that he became skilled in observing his own thoughts of using without putting them into action; they became a “background/ foreground play of embodied memory” (Harris 2015, p.1692). Nevertheless, even in the absence of drugs during the interviews their presence was recorded as being felt in one sense or another, whether this be a memory or a desire a powerful energy was generated. Harris’s position as an ex-substance-user also created a specific kind of interview dynamic with one participant stating: “These ‘textbook junkies’ I call them, they just know what they read in a book. Have they ever felt a rattle? (Abby)” (Harris 2015, p.1694). This foregrounds the idea that heroin withdrawal is a physical, deeply embodied experience and one which cannot be learnt or understood from reading a book. This helps to explain why physicians sometimes experience difficulties in perceiving the altered form of embodiment lived by the patient (Wisnewski 2015), particularly in the case of addiction as they have rarely experienced this form of embodiment. Furthermore, this lack of perception can, in turn, create barriers between healthcare professionals and those who are seeking help for a substance dependency. For example, the service user might disagree with their service provider about what treatment / interventions they should be engaging in on the

basis that their service provider has no prior lived experience of addiction or addiction treatment. Abby's remark provides a vivid example of embodiment as being "that of the body as a lived experiencing agent, located in a substantive web of connections" (Harris 2015, p.1697). Thus, we can conclude that a person's narrative of what it means to be 'ill' or 'healthy' is influenced by a variety of embodied socio-cultural meanings and motivations.

2.2 The Socially constructed Illness Narrative

The previous section explored how social identity is formed by the perceptions of others and how substance dependence is subject to extreme stigmatisation expressed through the media's fascination with the most horrifying photogenic aspects of drug use (Hickman 2002 and Huggins 2012). Consequently, most substance users will present themselves differently in different social situations for socially functional reasons. For example, to fellow users they may present themselves as "taking drugs on purpose because they enjoy them, while to healthcare professionals they may present themselves as more addicted" (Pickard and Ahmed 2018, p.226). There are complicated cultural and social processes that people have to go through that make it difficult for people to receive the correct help without expressing themselves as 'suffering' (Fassin 2002). Thus, substance users, because of their socially marginalised position, are often placed in a situation whereby in order to receive appropriate help they are obliged to display their suffering; this in turn may lead to them having to "conform to an ideology of addiction if they reveal their problem" (Pickard and Ahmed 2018, p.226). This being said, an understanding of how addiction is socially constructed matters immensely for relevant theory, policy and practice. I will therefore open this section with a discussion of Segal's (2007) suggestion for how we can establish an agreement about what constitutes illness deserving care which works to alleviate substances users from their socially marginalised position and 'addict' identity. I will then move to an exploration of how a 'non-addict' identity narrative is constructed and the social nature of these narratives.

Substance users are known to be one of the most demonised groups in society, and as Paylor et al (2012) emphasise, the popular conception of the substance user among health and social care professionals is often that they are "morally bankrupt, unable and unwilling to help themselves, unlikely to change and only have themselves to blame" (p.50). Furthermore, effective substance use treatment is not a 'one-size-fits-all' solution, meaning the service

provider may have very different views from their service user about what treatment and intervention will work best, which can lead to “resistance among service providers to involve service users” (Paylor et al 2012, p.94) in deciding which treatment / intervention they should engage in. This may be more generally experienced in services for substance users than in other services offering health and social care because of the nature of the problems and the stereotypical opinions of the service user group. Fundamentally, treatment and diagnosis for substance dependence stems from professionals’ embedded, metaphorical conceptions about what addiction really ‘is’; these conceptions can in turn limit or expand the range of solutions for tackling such a complex and multifaceted illness. For example, Segal (2005, p.139) suggests that in a doctor-patient setting the patient is expected to comply with their doctor’s orders; if this is the case, the patient’s illness experience is likely to be influenced by their doctor’s entrenched beliefs about which model of addiction is the most accurate. Segal claims that recent shifts in medical literature to reform the ‘compliance’ question to one of ‘concordance’, which requires practitioners to engage with literature on patients’ perspectives on prescribing and medicine taking, “does not so much improve adherence rates to doctor-recommended treatments as they confound issues of who is qualified to give advice and what the warrants for taking it” (Segal 2008, p.134).

Segal (2007) argues that more importantly, instead of remodelling the compliance question to one of concordance, there needs to be a drive for physicians to engage in a rhetorical analysis of their patients’ problems. She claims that by focusing on *types of arguments* it will divert the attention away from *types of patients* and “provide a more neutral means of judging claims to illness” (Segal 2007, p.227). Her wish is to put forward a framework which endeavours to assess the complaints of patients and one which alleviates individuals “of the burden of the types to which they may be seen to belong” (Segal 2007, p.229). This would be particularly advantageous for those who are seeking treatment for a substance dependency as

discourses of addiction are currently presented as a form of epideictic rhetoric. Epideictic rhetoric involves speech that either celebrates or criticises individuals- where the discourse places either praise or blame on someone or something (Enos 2013, p.231). Segal claims that “values have always been implicated in epideictic rhetoric: we praise people for embodying qualities we admire and blame them for embodying qualities we deplore” (2008, p.61). This is of particular significance to my research as discourses relating to those who suffer from a substance dependency, more often than not, place blame on the dependent individual. Furthermore, an understanding of epideictic rhetoric is necessary in an investigation into the effect that discourse has on medical diagnoses because it most successfully deploys the values needed for certain attitudes, which in turn “produce actions that may range from medical diagnosis to healthcare policy production” (Kalitzkus and Twohig 2009, p.129). By concentrating on patients’ arguments rather than the type of patient Segal believes that experts will be able to establish an agreement about “what constitutes a good case for illness deserving care” (2007, p.229). However, it is important to note that theory does not always translate well into practice. For example, some patients, such as those who suffer with mental health, are sometimes less able to form arguments because of the nature of their illness. Segal’s emphasis is not on the idea that the patient is one who is ‘difficult’, but instead one who is suffering. In relation to substance use this framework could, to some extent, help prompt service providers to reconceptualise the substance user; for instance, they might be inclined to view the person with a substance use problem as an individual who is suffering with an illness rather than as a criminal: “Criminal justice is founded on a stereotyped conception of the offender (drug user) as a pariah- a wilful wrongdoer who is morally bad and deserving of the community’s condemnation” (Isralowitz 2002, p.37). Whilst Segal (2007) is by no stretch of the imagination claiming that a rhetorical account of illness should replace a biomedical one, she is suggesting that as part of an interdisciplinary collaboration “rhetoric

has something to offer the study of illness as argumentation” (Segal 2007, p.240) in that it provides a partial solution to the problem.

Segal’s (2007) work demonstrates the importance of physicians engaging in a rhetorical account of their patient’s illness narratives in order to adequately assess their complaints.

McIntosh and McKeganey (2000) build on this notion arguing that both personal and professional narratives play an important role in the identity transformations of those who are in recovery from a substance dependency. There exists a major identity loss and ‘redemption’ narrative in addiction literature describing how individuals move from an ‘addiction identity’ to a ‘recovery identity’ (Dingle et al 2015, p.1). Constructing a non-addict recovery identity is something which is not reached by the individual when in isolation but is instead achieved in conjunction with others. Buckingham and Best (2016, p.1) highlight that both recovery and identity change are *social movements* and that people “gain resilience from joining others with similar goals through a process of subjective identification” (p.1). Furthermore, sociological accounts of the transition from substance dependency to recovery has proven that constructing a non-addict identity is of utmost importance (Best et al 2016; Bathish et al 2017; Crutchfield & Güss 2018).

McIntosh and McKeganey (2000) highlight that there are three main areas in which individuals’ narratives of their recovery journey construct a ‘non-addict’ identity. These areas make reference to: their drug using lifestyle, reconstruction of their sense of self, and provision of convincing explanations for their recovery. The aim of McIntosh and McKeganey’s (2000) study was to gather in-depth information from recovering addicts about their experiences in order to assess what ways the recounting of personal narratives might be a valuable part of the recovery process. It is important to note that the term *recovering addict* was used throughout the paper because it depicts recovery as a “process rather than a fixed

state” (McIntosh and McKeganey 2000, p.1503). The article argues that individual’s own narratives of their recovery experience are similar to the accounts offered by those who are experts in the field of substance misuse. What is of particular interest is the fact that McIntosh and McKeganey (2000) found these correspondences to be a product of the “socially constructed nature of the narratives” (McIntosh and McKeganey 2000, p.1501), rather than a result of the intrinsic nature of the recovery process. The accounts given by the individuals who are in recovery at first glance appear to be composed entirely by themselves, for instance: *“My decision is to get my life back, that’s it in a nutshell really, to live the way you live if you like. To be able to get up in the morning and feel like you don’t have to take anything. (Bill),* (McIntosh and McKeganey 2000, p.1505). McIntosh and McKeganey (2000, p.1508) draw attention to the fact that these narratives have not necessarily come about without premeditation but instead may often have been developed in communication with others, particularly with those who are professionals in the field of substance dependency. One example of this is evident in Kerry’s narrative (McIntosh and McKeganey 2000, p.1508) where a conversation with her drug counsellor caused her to reconceptualise her reasons for wanting to ‘get clean’- *“...when I spoke to Lorraine (her drug counsellor) she said to me that I had to find things to keep me occupied to give myself natural highs, people can't make me stay clean. It's only me that can be clean and make myself clean”(Kerry).* This finding emphasises how individual’s narratives of recovery are influenced by the professionals with whom they converse, thus helping to explain why there is a “striking parallel between addict’s own accounts of their recovery and the characterisations of the recovery process found within much of the addictions literature” (McIntosh and McKeganey 2000, p.1508). Therefore, both personal and professional narratives highlight the importance of identity transformation: *“identity transformation is so fundamental to the prevention of relapse”* (Walters 2014, p.95). While some might argue that the similarities found between the narratives of those in recovery and practitioners is a result of the intrinsic nature of recovery, McIntosh and

McKeganey (2000, p.1508) claim that it is the product of “the socially constructed nature of the narrative process”. This study is of particular importance to my research because it highlights that we must gain a better understanding of how different professionals in the field of substance dependence address issues of identity in their work, particularly if McIntosh and McKeganey (2000) are correct in thinking that an essential part of the recovery process is for the individual to construct a ‘non-addict’ identity through a narrative of recovery.

2.3 Models of Addiction

From examining how illness narratives are socially constructed it is clear that healthcare professionals, particularly in the realm of addiction, have an immense impact on the identity transformations of those they come into communication with. Given this impact, I will now move to a discussion centred around the different ways that substance misuse has been socially constructed, focusing on three primary models of addiction which healthcare professionals tend to adhere to:

1. The Disorder of Choice Model (Mercadante 1996; Skog 2000; Heyman 2009);
2. The Brain Disease Model (Miller and Chappel 1991; Leshner, 1999, Lubman et al., 2004);
3. The Behavioural Model (Darke 2012; Szalavitz 2016; Lewis 2018).

For much of the twentieth century theories of addictive behaviour and motivation have been polarised between two models, the disorder of choice and the disease model. The first views addiction as “a moral failure for which addicts are rightly held responsible and judged accordingly” (Pickard et al 2015, p.5). The second views addiction as a “specific brain disease caused by neurobiological adaptations occurring in response to chronic drug or alcohol use, and over which addicts have no choice or control” (Pickard et al 2015, p.5). I will open the next section with a discussion of these two diametric opposite models before moving to a discussion of a relatively new theory which views addiction as a learned behaviour. This model when properly understood purportedly resolves many of addiction’s contradictions making it “easier to see why it is neither a moral failing nor a brain disease in the traditional sense” (Szalavitz 2016, p43).

1. Choice Model:

“Behaviour that was once called sin is often today called addiction” (Mercadante 1996, p.5). This perception of addiction can be considered particularly disempowering and ineffective since it produces an understanding of substance misuse as being a hedonistic pleasure-seeking activity, rather than an illness. However, recently there has been a shift toward describing many human issues, like that of addiction, as medical. Thus, the expanding range and usage of the term addiction offers an interesting account into changing cultural metaphors. It is part of a “discursive shift that affects not only language but also perception, experience, and behaviour” (Mercadante 1996, p.5). Mercadante (1996) focuses on the addiction-recovery philosophy claiming that “the concept of sin often serves implicitly as a lightning rod, set up in the dichotomy ‘not sin but sickness’” (Mercadante 1996, p.6). She proposes that there are similarities between the two concepts, sin and addiction, arguing that the “addiction concept has in many ways taken over from the sin doctrine” (Mercadante 1996, p.40). Here we can see a reconceptualisation of sin whereby there is a complex relationship between the addiction-recovery metaphor and the sin doctrine: “It springs out of, replicates, replaces, and challenges it, all at the same time” (Mercadante 1996, p.26). However, it is important to note that addiction recovery today is generally based on the principle that addiction is a disease and not a sin, it is regarded as a medical problem rather than a moral one. Browne-Miller (2009) offers a new way of thinking about sin, highlighting that the largest misconception around the Christian doctrine of sin is that it is about morality when it is in fact about relationality: “sin refers to one’s orientation toward or away from God, self, and others” (Browne-Miller 2009, p.98). Turning away from sin means turning away from destruction in an attempt to accomplish *self-actualisation* and *fulfilment* within the context of the wider community. In many ways this new conceptualisation of sin makes it sound significantly like addiction whereby there is a sense of withdrawal from society, withdrawal from people and places one would normally associate with, and where individuals are often thought of as

becoming part of “deviant subcultures” (Paylor et al 2012, p.37). Nevertheless, this innovative theological understanding does not change the popular association of the word ‘sin’. Browne-Miller argues that when people dismiss the idea of sin, especially in relation to addiction, they are most often “linking the theological concept with guilt, blame, and free choice” (2009, p.98). In other words, when sin is understood as a moralistic issue the human will is assumed to be operative, with an ability to choose good over evil. However, ever since St. Augustine this view has been excluded by Christian theology and stamped ‘Pelagian’ (rejecting the need for God’s grace and praising humans for exercising their free will). Under this conception of sin, both substance users and alcoholics have chosen their plight and are viewed as being solely responsible for their condition.

In the same manner as the doctrine of sin, the choice model is perceived as reducing addiction to “mere weakness of will with respect to one substance or activity” (Dunnington 2011, p.35). Heyman (2009) in his book *Addiction: A Disorder of Choice* argues that the factors that influence everyday decision making are also the factors that influence drug taking in substance users. He recognises that people do not ‘choose’ to be addicts as such, but postulates that normal choice dynamics can lead to addiction. He claims that choice processes, which at first seem rational, can in fact generate poor long-term outcomes (in this case addiction), and that an understanding of these processes is vital in order to offer an effective approach for the prevention and treatment of addiction. Heyman rejects the common consensus that treatment is the reason for substance users ceasing their addiction, arguing that the majority of all addicts eventually stop using illegal substances irrespective of whether they have followed a treatment programme or not: “the relevant research shows most of those who meet the American Psychiatric Association’s criteria for addiction quit illegal drugs by about age 30 and that they usually quit without professional help” (Heyman 2013, p.7). For Heyman, whether an individual keeps using drugs or quits “depends to a great extent on their

alternatives” (2009, p.84). He believes that the notion of choice always involves selecting the better option within that particular moment of time. One could interpret this in terms of Plato’s distinction between ‘harmful pleasures’ and ‘beneficial pains’ which works as an analogy to better describe this concept of choice. ‘Harmful pleasures’ and ‘beneficial pains’ highlight the potential conflict between immediate and delayed gratification; interestingly, Kringelbach and Berridge (2010) note that what sets us apart from animals is our ability to “override our instinct for immediate rewards in favour of some greater food” (p.329).

However, in some circumstances drugs are often thought of as having advantages over other outcomes in that they provide instant gratification and their negative effects are postponed causing them to undermine the worth of the other choices. Neuroimaging data supports the idea that the human capacity for appreciating delayed or abstract rewards is processed “separately from the phylogenetically older immediate gratification system” (Kringelbach and Berridge 2010, p.329). Heyman (2009) differentiates between local perspective (the immediate better option), and global perspective (the long-term rational option). He argues that individuals choose how to *frame a sequence of choices*, with the global perspective requiring “a continuing sequence of choices” (p.132) which is thought to be a key deterrent to substance use as it requires both “reflection and forethought” (Heyman 2009, p.158).

However, Heyman (2009; 2013) emphasises that when the *frame of reference* is limited to the current values of the immediately available options, the drug is understood as the best choice. According to this justification, ongoing substance use reflects the workings of a local perspective, whereas abstinence reflects the workings of a global perspective. For Heyman, whether or not drug use persists depends on “factors that influence decision making, particularly values that emphasize global as opposed to a local frame of reference” (2013, p.9).

2. Disease Model:

The disease model characterises addiction as a “primary, chronic brain disease” (Hajela et al 2015) where, instead of the individual being solely responsible for their substance dependence, it assumes those who become addicted to a substance are *victims* and have “lost control due to some type of biological condition or brain disorder” (Bruno and Csiernik 2018, p.33). This perspective implies that the substance user can be treated and that rehabilitation is both possible and necessary. However, the disease notion is argued not to be established in scientific fact, and is for Bruno and Csiernik (2018, p.34) “more of a metaphor for a loss of control than it is a biological condition”. This brings to the fore that addiction is often positioned in the context of wider environmental and cultural frames where it is socially defined: “substance dependence as a disease has been socially constructed, not empirically validated” (Bruno and Csiernik 2018, p.34). To the contrary, Leshner makes two primary assertions. First, that drug addiction is a “biologically based chronic relapsing disease that results from the prolonged effects of drugs on the brain” (1999, p.83). Second, that the use of particular chemicals to the extent that one becomes addicted alters the brain and that this is evident when one “uses advanced neuroimaging capabilities and looks at brain scans of addicts versus the brain images of drug-free individuals” (1999, p.83). From the viewpoint of Leshner prolonged drug use creates “changes in the brain at the molecular, cellular and structural levels...and these changes persist long after an individual has stopped taking drugs” (Miller 2010, p.214). It is worth noting that drugs, when ingested by anyone, addicted or not, affect the “cerebral cortex, midbrain and cerebellum” (Miller 2010, p.214); however, the exchanges between drugs and the brains of those who are not addicted differ from the exchanges that take place in the brains of those who are addicted. Leshner (1999) asserts that at the point that the exchanges have been made in those who are addicted the substance dependent individual can no longer control their behaviour without the help of treatment strategies such as “behavioural therapy (counselling, cognitive therapy or psychotherapy),

medications such as methadone, or a combination of these” (1999, p.83). Scientists have revealed that the addicted brain is in fact meaningfully different from the non-addicted brain, as manifested by “changes in brain metabolic activity, receptor availability, gene expression and responsiveness to environmental cues” (Miller 2010, p.214). Leshner (1997) supports this claim stating that: “an addict’s brain is different from a non-addict’s brain, and the addicted individual must be dealt with as if he or she is in a different brain state” (p.46).

In the same vein, Lubman et al. (2004) understand addiction as a brain disease whereby: “addicts lose control over their drug use, and engage in repetitive self-destructive patterns of drug-seeking and drug-taking that takes place at the expense of other important activities” (Lubman et al. 2004, p.1491). However, in contrast to Leshner (1999), they do not imply that addicted individuals are “automatons under the direct control of substances or related stimuli acting on the brain” (West 2013, p.86), but instead that characteristics of decision-making are impaired in either a direct manner, via a dysfunctional inhibitory system which is critically involved in self-regulation; or indirectly, through a dysfunctional reward system that is over-responsive to substance use and related stimuli. Whilst this explains the uncontrolled nature of drug cravings and the desire to use drugs, it does not shed light on *why* individuals are unable to control this desire even in the face of “potentially disastrous consequences” (Lubman et al. 2004, p.1499). Thus, this evident loss of control over drug associated behaviours indicates that addicts are “unable to appropriately regulate the *reward* system” (Lubman et al. 2004, p.1499). In other words, the brain fails to control its reward system which leads to uncontrolled consumption that in turn “leads to physiological and psychological harm” (Netherland 2012, p.205). Thus, after durations of repeated substance use, the reward system is unable to respond to activities that would typically yield large amounts of dopamine (e.g. food, exercise, humour). According to Farmer (2009, p.142) “the result is an addicted brain in which the reward circuitry malfunctions or becomes dysregulated, and even larger amounts of

the drug are required for a person to feel a reward". Through this lens substance dependent individuals are viewed as being unable to self-regulate or make sense of their behaviour due to their cognitive processes and reasoning being compromised.

Whilst the concept of addiction as a brain disease has been embraced by significant specialist organisations such as the American Society of Addiction Medicine (ASAM, 2011), professionals in the realms of psychology, philosophy and psychiatry disagree, arguing that the brain disease model masks the role of "choice, agency, and social environment in producing the destructive behavioural patterns we associate with addiction" (Kirmayer et al 2015, p.375). The rise of the brain disease model together with the increasing prominence of neuroscience has initiated a new engagement of critical addiction scholars. Kushner (2010, p.16) argues that addiction is an outcome of humans' "drive to alter consciousness and what we label 'addiction' might be understood as a possible consequence of the human desire to alter consciousness". To elaborate on this, he believes that addiction is not for the minority, referred to as 'addicts', but is better understood as a syndrome that can affect each of us. For Kushner the classification of certain substances as legal or illegal tells us more about "social norms and power relationships than about the psychopharmacological properties of the substances themselves" (2010, p.8). For example, social studies of addiction have concluded that prohibition at the international level is founded on an "arrogant and patronizing culture of discrimination by dominant societies" (Payan et al 2013, p.266) and that this is because of the imposition of the values of the strong over the weak. Thus, substances that are not deemed acceptable to the 'strong' are prohibited (e.g. opiates and crack cocaine), while substances that do "fall within the parameters of the dominant cultural model are used and abused with lower or no penalties at all (e.g. alcohol and tobacco)" (Payan et al 2013, p.266). Therefore, they have insisted that addiction should be positioned in the context of wider environmental and cultural frames (Levine 1978; Kushner 2006, 2010).

Analogous to Kushner, Vrecko (2010) argues that much cultural analysis assumes that “biomedical formulations of addiction simply provide a façade for forms of social control” (p.36). He adds to cultural theorisations about the regulation of aberrant forms of thought and behaviour through an analysis of approaches to managing ‘*behavioural addictions*’. He argues that conceptualising behavioural compulsions as ‘*diseases*’ and their synonymous therapeutic interventions as ‘*treatments*’ is ineffective and that instead it would be more advantageous to describe those treatment interventions as processes which are in place to “produce better citizens, rather than to cure biological diseases” (Vrecko 2010, p.36). He raises concerns about the consequences that discursive framings of addiction can have and emphasises that, although defining addiction can be useful for research purposes, it can have detrimental effects insofar as these definitions change the way in which “behavioural problems are conceptualised in popular culture and the media, and play a role in increasing interest in biological approaches to managing behavioural compulsions” (Vrecko 2010, p.40). He argues that we should instead be civilizing problematic desires and cravings claiming that in terms of conceptualisations ‘*civilizing technologies*’ (adopting satisfactory social behaviours instead of problematic behaviours which are a direct result of substance desires and cravings) generates far fewer institutional connotations than the term ‘treatment’. However, from a linguistic perspective one could argue that the term ‘civilizing’ is embedded in ideological connotations since it implies that the substance user is neither educated, cultured, or polite and therefore needs to be ‘civilised’ by an external agent. Similarly, the term ‘addict’ which derives from Latin and is used in Roman law to refer to a person who is “enslaved through a judicial procedure” (Heather and Segal 2016, p.7) can have a negative impact on our interpretation of substance dependent individuals. This direct association of enslavement reinforces that it is of utmost importance that we continue introducing new kinds of descriptive vocabularies which will generate new concepts and in turn new ways of thinking about addiction. In other words,

“when new descriptions become available, when they come into circulation, or even when they become the sorts of things that it is all right to say, to think, then there are new things to choose to do” (Hacking cited in Salecl 2000, p.89)

Active critiques of the brain disease model of addiction have been supported by researchers from a vast range of disciplines and by specialists in various health occupations. They argue that by thinking about addiction as a *disease* we are masking how substance users continue to exercise choice, even under highly constrained conditions (Raikhel and Garriott 2013, p.15). Schaler (2000) believes that the brain disease model is a self-fulfilling prophecy whereby the substance dependent individual is prompted to believe that they have an inability to moderate their consumption of drugs and alcohol resulting in them being more likely not to moderate. He highlights that the beliefs of addiction treatment services are of paramount significance and that “knowing more about the beliefs that treatment providers hold dear can thus help us to comprehend what is done in the name of treatment for addiction” (p.38). This is a key component of what my research seeks to explore as by examining how professionals from mental health and addiction services are conceptualising substance use, I will be able to investigate the effects that these conceptualisations can produce. It is important to note that regardless of whether the treatment provider’s beliefs about the most accurate model of addiction are true or false, those beliefs are what “largely shape their actions” (Schaler 2000, p.38). Fundamentally, what occurs in the name of treatment is based on certain beliefs that professionals in the field of substance use assert to be the truth about addiction.

3. Learning Model:

Unlike both choice and disease models of addiction, the learnt behavioural model offers a relatively new outlook on the notion of addiction. Szalavitz (2016) offers a contemporary way of understanding the nature of addiction, highlighting that the issue with our current

conceptualisation lies in the fact that we are ignoring the role of learning and instead trying to medicalise it or treat it as some sort of moral failing. She emphasises that society does not cope well with conditions that cross boundaries and that too often conversations in the field of substance use are centred on “semantic battles that push stigma around” (Szalavitz 2016, p.37). For example, in the realm of addiction the noun ‘disease’ is an “ideological frontline” (Szalavitz 2016, p.37) which carries both moral and historical baggage. Unlike Heyman, Szalavitz does not view addiction as a choice but instead as something which is acutely affected by embodiment alongside cultural factors: “the way individuals perceive their own experience” (Szalavitz 2016, p.38). She highlights that addiction is not something which happens overnight but is instead a condition which unfolds, claiming that if you manage not to develop an addictive coping style during your adolescence the risk of you developing one later is “dramatically reduced” (Szalavitz 2016, p.38). From this perspective addiction is a “maladaptive coping mechanism” (MacMillan and Sisselman-Borgia 2018, p.95) which in spite of ongoing negative consequences is persistent because “*overlearning* or reduced plasticity makes the behaviour extremely resistant to change” (Szalavitz 2016, p.39). In contrast to ordinary forms of learning, addiction alters brain reward mechanisms and motivation causing adjustments in the way the brain decides what it values. However, the learned behavioural model of addiction differs from the traditional disease model in that addicted individuals are not perceived as having no free will. For example, addicted people do not tend to take illegal substances in front of the police, instead they plan specifically to ensure their supply and avoid being caught (Szalavitz 2016, p.275). Furthermore, they often end their drug-taking career when their situation changes for the better such as the birth of a child or falling in love. Nevertheless, substance dependents undoubtedly behave compulsively and irrationally. Thus, understanding addiction as a learnt behaviour accounts for this paradox “far better than either the disease model of complete slavery to drugs or a moral model of completely free choice” (Szalavitz 2016, p.276).

Lewis (2018) like Szalavitz argues that brain change in addiction is a result of learning rather than disease. However, he draws attention to the fact that the brain disease model is the chief model of addiction in the western world, dominating both professional and public discourse. Whilst he does not regard all elements of the brain disease model as enforcing negative outcomes, noting that because of its focus on biological factors rather than moral arguments, it has “helped reduce the stigma faced by those with addictions and their families” (Lewis 2018, p.1551), encouraging access to treatment and care in replacement of exclusion and punishment. He emphasises that addiction is learnt rather than a disease because it is not pathologic but is instead a deeply ingrained habit. For Lewis (2018) addiction, although unfavourable, is a “natural context-sensitive response to challenging environmental contingencies” (Lewis 2018, p.1551) rather than a chronic relapsing brain disease. His examination of addiction within a learning framework is informed by contemporary and classic cognitive perspectives which integrate the brain changes seen in addiction without reference to disease or pathology; his wish being to make sense of addiction by combining neurobiological and environmental accounts. Lewis (2018) urges that a stable model of addiction must recognise that the organism and its environment are connected at every level, interacting continuously “as an open system” (Lewis 2018, p.1557). During adolescence the scope of potentially meaningful environmental features can be immense, especially if the child is being raised in a household with unpredictable, disengaged, or violent caregivers. These individuals tend to find increased meaning in drugs that “reduce stress or promote feelings of security and well-being” (Lewis 2018, p.1557) particularly because these effects can be achieved without intervention from other people. Lewis (2018) suggests that the addiction spiral is initiated by early psychosocial difficulty whereby trauma leaves lasting effects on nervous system functions. He concludes that addictive activities are determined neither solely by brain changes nor solely by social conditions, but instead it follows that the

narrowing seen in addiction takes place “within the behavioural repertoire, the social surround, and the brain- all at the same time” (Lewis 2018, p.1558). For Lewis, addiction is a learnt behaviour because addictive activities feedback to the social environment which generates a further narrowing of what is often “already limited opportunities for well-being” (Lewis 2018, p.1558). Addiction from this perspective is a behavioural problem which requires both motivation and willpower to change.

From Lewis’s viewpoint addiction is a skill which is learnt in order to self-medicate underlying trauma. He takes the viewpoint that just as we learn to walk and talk the principle at work in the realm of addiction is *neuroplasticity*, which refers to the ability of the human brain “to change as a result of one’s experiences” (Fitzpatrick & McCarthy 2016, p.238). Learning model thinkers accept that there are structural changes to the brain when addiction develops but that this is neuroplasticity at work. By contrast, disease model thinkers also believe that there are structural changes to the brain but that it is instead a disease process. Thus, learning model scholars argue that the structural brain change which takes place as a result of addiction is not a sign of disease but instead a learned behavioural problem which results from some form of trauma.

Darke (2012) stresses the importance of the self-medication hypothesis (SMH) highlighting the role of distressing affect as the “primary motivator for the compulsive use that leads to substance dependence” (Darke 2012, p.659). The SMH is made up of two formal constituents: the *psychopathology postulate* which argues that substance dependency stems from the relief of distressing psychological symptoms and is therefore known as the “causation postulate” (Preedy 2016, p.264) and the *drug-specificity postulate* which supposes that the drug of choice will reflect its ability to improve specific distressing symptoms, for example opiates are thought to “attenuate feelings of rage or violence” (Elzer and Gerlach 2014 p.293). Darke

(2012) examines the SMH in relation to the development and chronicity of heroin dependence, arguing that there are a vast number of reasons for the family disruption and abuse which contributes to a “shattered childhood” (Darke 2012, p.660) and consequently heroin dependence. In fact, Pugatch et al (2001) reported that one in four adolescent heroin users had psychiatric histories. Darke (2012, p.662) emphasises that not all individuals who are heroin users will have suffered from childhood abuse and that their dependence may instead be a result of subgroup culture; however, he argues that these appear to be a minority and that “trauma and psychopathology appear a major path to heroin dependence” (Darke 2012, p.662). This raises questions around how addiction can be understood as an attempt to alleviate suffering when there is so much of it involved in substance dependency. Khantzian (2013) claims that this relates to the “compulsive nature of addiction” (p.668) whereby the *repetitious* aspects of substance misuse can be understood as displaced attempts to cope with powerful feelings that render the person helpless. Here we can see how the SMH ties in with the notion of addiction as a learned behaviour as repetition does eventually equate to a “deeply ingrained habit” (Lewis 2018, p.1551) and, in such instances, “the operative changes from one of relieving suffering to controlling it” (Khantzian 2013, p.668). To conclude, childhood trauma plays a crucial role in the SMH which, from a clinical perspective, understands heroin use as being concomitant with high levels of psychopathology and the onset of traumatic experiences. It is established in an empathetic and humanistic custom which works to help society better understand addiction and support, rather than reject, individuals suffering from a substance dependency. It is worth noting that Darke (2012) is not proposing that each and every heroin user is self-medicating but instead that the SMH is a prominent, and indeed dominant avenue to heroin dependence.

2.4 Summary

This chapter has presented the relevant literature that contextualises my research. Studies relating to embodiment emphasise how cultural representations of substance misuse influence physicians' ability to perceive sympathetically, as more often than not their focus is on those aspects of addiction that are visible. Moreover, the literature highlights that because substance misuse is a deeply embodied experience, physicians sometimes have difficulty in perceiving the altered form of embodiment lived by the patient. This section of the thesis helps inform my study since each of the participant's responses will have arisen from their embodied, everyday lived experiences that shape their conceptualisations of addiction. Furthermore, studies into how illness narratives are socially constructed help give insight into the importance of physicians engaging in a rhetorical analysis of their patient's problems in order to adequately assess claims to illness. In addition, this section emphasises how individual's own narratives of their recovery are influenced by the accounts offered by healthcare professionals. Finally, the literature has proven that there is an abundance of research centred on the different models of addiction. Thus, it is undoubtedly important that practitioners are aware of how these models can influence their conceptualisations of substance misuse and, in turn, how this can impact patients' conceptualisations of themselves and their illness. On this basis, a focus on practitioners' conceptual metaphors is warranted; I will therefore conduct a rigorous cognitive poetic analysis of these conceptualisations and how they are implemented in real instances of practitioners talking about different aspects of addiction.

3. Methodology

Since the purpose of my research is to investigate how professionals in the field of addiction uniquely conceptualise substance misuse and how their utterances act as linguistic evidence for their embodied understandings, the data was analysed through a linguistic lens from a cognitive stylistic viewpoint. To achieve its objectives, the following research questions direct my study:

1. What are the emerging dominant conceptual metaphors used by professionals working in the field of addiction?
2. What do utterances reveal about how professionals conceptualise the different phases of addiction?
3. What are the potential consequences of such conceptualisations?

In order to answer my research questions, I gathered data by recording and then transcribing interviews with professionals who specialise in substance dependence. Since I sought to gain valuable insights into professionals' embodied experiences, perceptions, and attitudes I decided to use a combination of semi-structured interviews and cognitive poetic analysis. The use of semi-structured interviews permitted me to "explore human 'behaviour' through interaction" (Gosai 2011, p.49), whilst engaging in a cognitive poetic analysis meant I was able to examine the cognitive underpinnings of participants' utterances. In terms of recruitment, I interviewed a professional from three different areas of addiction specialism because of their varied embodied experiences and differing expertise in the field of substance misuse; this in turn assisted me in gathering the necessary data to make a valid exploration into how professionals conceptualise the different phases of addiction.

The professionals I was fortunate enough to interview consisted of: a former senior counsellor at the Priory (the leading independent provider of behavioural care in the UK), who now

works as an independent addiction counsellor and psychotherapist and who has historical embodied experiences of being a substance user ('CP'); a research nurse who specialises in drug assisted sexual assault ('RN'); and a senior consultant in addiction psychiatry who is also an influential academic and has authored over one hundred papers in international journals ('PC'). Whilst I was able to interview both 'CP' and 'RN' in person, I interviewed 'PC' via a telephone conversation. Prior to participating in the study informants were given an information sheet which explained that they were being asked to take part in a study about conceptualisations of addiction; involving asking about their beliefs regarding substance misuse and what treatment / interventions work best. Each of the interviews were structured around four primary questions:

1. What causes someone to become addicted?
2. Do you have to be a certain *type* of person to become addicted?
3. Who is responsible for someone becoming addicted? And whose responsibility is an individual's recovery?
4. What treatment and therapy do you find works best?

I chose to ask participants these specific questions because they effectively prompted conceptualisations relating to all of the different phases of addiction:

1. Becoming addicted
2. Experiencing addiction
3. Recovery from addiction

They therefore enabled me to gain an insight into how professionals conceptualise addiction as a whole; from the type of person likely to become addicted right through to recovering from addiction and whether or not this phase is possible. Throughout the data analysis section of this thesis I will explore how participants' conceptualisations contribute to their overall

understanding of the process of addiction. In terms of ethics, I have followed all of the appropriate protocols and have gone through a rigorous process of making sure that my research was undertaken in an ethical way.

3.1 Chosen Data Analysis Method

In this thesis I use Lakoff and Johnson's (1980) theory of Conceptual Metaphor to analyse the data. CMT will help me to understand participant's mental representations of the complex concept of addiction which are "inherently structured by a set of metaphorical correspondences" (Stott et al. 2010, p.11) that give rise to their cognitive processing of these concepts. The cognitive study of metaphors is based on the analysis of ordinary day to day language and has been found to demonstrate that metaphor is omnipresent both in everyday language but also in our thought and action. From a cognitive linguistic perspective, the way we articulate our thoughts in our daily language reflects our shared experience of the world. For example, our conceptual structure in relation to our reality is founded predominantly on metaphor through the use of metaphorical expressions which can be understood as CONCEPTUAL DOMAIN (A) IS CONCEPTUAL DOMAIN (B). An example of a metaphorical expression in the context of substance misuse is ADDICTION IS A CONTAINER. Here the noun 'CONTAINER' is functioning analogically as a conceptual domain (B) that is, the source domain, which we use to try to comprehend the abstract target domain (A) 'ADDICTION'. This process is referred to as the principle of *unidirectionality*; that is, "the metaphorical process typically goes from the more concrete to the more abstract but not the other way around" (Kovecses 2010, p.7). We can therefore propose the following model of the functioning of the unidirectionality principle:

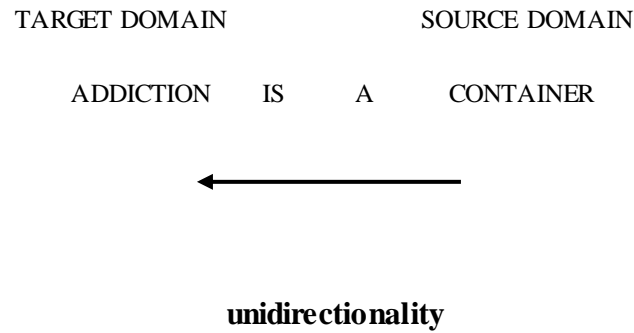


Figure 1. Model of the unidirectionality principle, adapted from Jasinska (2010, p.8).

Moreover, Lakoff and Johnson's (1980) theory of conceptual frames, the "larger coherent packages of knowledge" (Radden and Dirven 2007, p.17) and *mappings*, conceptual shifts involving the projection of "one set of conceptual entities onto another set of conceptual entities" (Radden and Driven 2007, p.17) will assist me in explaining how I understand participant's language use as evidence for particular conceptualisations and thoughts. Lakoff and Johnson (1980) view metaphor as a cognitive device which gives "more than the precise propositional approach in understanding what the 'literal reality' is" (Renkema 2004, p.243) in that it offers a way of studying our obscure imaginative mechanisms. CMT, assumes that people create embodied metaphorical representations from their "phenomenological experiences of the body and their sensori-motor interactions with the physical world" (Gibbs & Steen 1999, p.152). In other words, individual's metaphorical understanding of a particular abstract notion is fused together with image schemas that "partly arise from recurring bodily experiences" (Gibbs & Steen 1999, p.152). This being said, participants might have diverse mental representations of the abstract concept of addiction that are structured by metaphorical mappings "constrained by the image schematic structure of the source domain" (Gibbs & Steen 1999, p.152). To summarise, embodiment encompasses both sensorimotor and the socio-cultural sides; our conceptual structure originates from embodiment, known as embodied cognition, in the sense that the "nature of our embodiment determines and delimits

the range and nature of concepts that can be represented” (Evans and Green 2006, p.176). The notion of image schema is embedded in the development of embodied cognition because embodied experiences give rise to image schemas within the conceptual system, making them “pre-conceptual in origin” (Evans and Green 2006, p.180). For example, image schemas like the CONTAINER schema are “directly grounded in embodied experience: they relate to and derive from sensory experience” (Evans and Green 2006, p.180). Mandler (2004) proposes that they are formed from these sensory experiences in the early phases of human development that precede the formation of concepts. However, “once the recurrent patterns of sensory information have been extracted and sorted as an image schema, sensory experience gives rise to a conceptual representation” (Evans and Green 2006, p.180), otherwise known as the development of conceptual metaphors.

3.2 Using CMT in analysis of Health Discourse

Conceptual Metaphor Theory is an ideal analytical framework to analyse addiction professionals' conceptualisations of substance misuse because it has been productively used in several health studies which argue that metaphors aid communication by conveying illness in a more recognisable manner (Semino and Demijen 2017; Tongeren 1997; Knapton 2013). Moreover, there is an abundance of work on how therapies, which are frequently implemented during recovery for substance misuse, work toward positive reinforcement and sustaining recovery through the application of metaphor (Otto 2000; Tay 2016; Sarpavaara 2010).

Semino and Demijen (2017) examine how the use of metaphors involve the perception of similarities or correspondences between unlike entities and processes, allowing us to think and communicate about one proposition in terms of another. The use of metaphors "expands our ability to feel, reason and communicate in ways that are characteristically human" (Semino and Demijen, 2017, p.1). There have been several recent studies that have documented the persistent widespread use of war-related metaphors used to describe cancer in the media. Camus (2009, p.470) reported that "CANCER IS WAR" is the most prevalent conceptual metaphor in a corpus of articles about cancer, appearing in twenty out of the thirty-seven texts; a finding that is continually supported by earlier research (Clarke and Robinson, 1999; Seale, 2001; Tongeren, 1997). Semino and Demijen (2017, p.388) propose that we must recognise the "potential negative consequences of these metaphors" but also note that the use of metaphors "allows the cancer experience to be integrated into people's lives, giving it meaning and highlighting the experience's potential to stimulate intellectual and emotional growth" (p.389). Thus, the use of metaphor helps patients in managing their emotions and identities throughout cancer treatment. This being said, paying close attention to patients' metaphor use may assist nurses and other health professionals in achieving "clearer

and more meaningful exchanges when planning care interventions” (Appleton and Flynn 2014, p.382). This is something which is particularly important when considering the notion of addiction, as preferred choice of language is individualistic and often those with substance use problems are sensitised to certain labels. Although language that describes disorders is now the professional norm in most of behavioural health, in the addiction field “it is still common to hear labels being applied to people” (Miller et al 2011, p.13). In fact, Kelly & Westerhoff (2010) found that health professionals were far more likely to blame and suggest punishment when a person was described as a ‘substance abuser’ rather than ‘having a substance use disorder’. This finding implies that how we refer to individuals with substance use disorders may “inadvertently elicit and perpetuate stigmatizing attitudes” (Kelly and Westerhoff 2010, p.206). Therefore, we should be encouraging those communicating with individuals affected by their addiction to think carefully about the terminology they use as, “the less stigma that affected individuals perceive, the more likely they will be to seek help as seek it earlier” (Kelly and Westerhoff 2010, p.206).

The ‘CANCER IS WAR’ construction (Camus 2009; Clarke and Robinson, 1999; Seale, 2001; Tongeren, 1997) is something which Sontag’s (1978) work explicitly attacks. She argues against the use of metaphor in cancer discourse insisting that metaphors such as ‘CANCER IS WAR’ “mythicize disease by connecting the physical to the moral and by figuring illness as a mysterious and malevolent “predator” (Sontag 1978, p.11). Furthermore, the re-issue and updated version of her earlier work (Sontag 2013) claims that cancer metaphors are “in themselves implicitly genocidal” (p.81), particularly in relation to their political usage which she argues are doubly harmful because they do not treat cancer as a disease but instead as a demonic enemy “making [it] not just a lethal disease but a *shameful* one” (2013, p.57). She goes on to say that images such as these are frequently imposed upon people who are suffering from an illness. Interestingly, we can see an overlap here with how substance

dependence is socially conceptualised; control being a notion which is frequently explored in the literature on addiction, not to mention factors such as shame and embarrassment. Sontag argues that metaphors are devices which distort what it really means to have cancer and that we should instead use literal language to discuss the disease. However, this is problematic given what Lakoff & Johnson (1980) say about metaphor as CMT offers a foundation for a new, cognitively orientated theory of meaning. Metaphor is thus viewed as being “among our principal vehicles for understanding our physical, social and inner world” (Lakoff & Johnson 1980, p.159) by mapping conceptual structures from the familiar ‘source domain’ (the domain from which we draw metaphoric expressions), onto the more abstract ‘target domain’. From this perspective, metaphor is a powerful linguistic tool which makes the experience “coherent” (Musolff 2012, p.302). In this sense metaphors can be viewed as “self-fulfilling prophecies” (Lakoff & Johnson 1980, p.156).

For Sontag (1978/2013) metaphors neither represent the experience of being ill, nor express scientific knowledge already available or likely to be available. Her work is centred on preconceptions about what illness and science are and offers an analysis of the language surrounding illness. My research takes a different stance on language surrounding illness as I argue that we cannot isolate illnesses from their symbolic meanings and that metaphors must be studied in their specific contexts (like that of addiction), in order to gain a better understanding of their implications. The issue is not metaphors but instead individuals’ application and social uses of metaphors that in turn portray problematic conceptualisations. Therefore, my research attempts to discover the relationship between how professionals conceptualise addiction and how addiction is socially constructed.

It is worth noting that in terms of epistemological implications, Sontag’s (1978/2013) work can be considered somewhat self-contradictory as she states: “Of course one cannot think

without metaphors. But that does not mean there aren't metaphors we might abstain from or try to retire. As of course, all thinking is interpretation. But that does not mean it isn't sometimes correct to be 'against' interpretation" (2013, p.5). Here we see Sontag acknowledge that it is impossible to separate metaphor from cognition and subsequently discourse; however, at the same time she is proposing that we abstain from using certain metaphors entirely. In her own words, the goal is: "not to confer meaning...but to deprive something of meaning" (2013, p.14). What is interesting is that in *Illness as Metaphor* she appears to treat metaphors as "a kind of germ that thinking must resist and language needs to sterilize" (Abelove 2012, p.217). Furthermore, in *AIDS and Its Metaphors* Sontag explicitly urges us to *abstain* from the "seductiveness" (2013, p.5) of metaphor. These references not only display a metaphorical way of thinking but also endorse the "prejudice, oppression, and violence that gay people with AIDS daily encounter" (Abelove 2012, p.217). Just as supporters of abstinence-only programs believe that abstinence is the best way of implicating "the right to the highest attainable standard of health...and ultimately the right to life" (Beyrer and Pizer 2007, p.373) (safe sex means no sex), for Sontag the "only secure practice of metaphor must avoid the practice- or rather must assume it can" (Abelove 2012, p.217).

In contrast to Sontag, Tongeren (1997) argues that metaphors must be understood as essential cognitive and communicative devices that should be utilised throughout the field of medical science. She argues that scientific facts do not derive from passive observations of reality but instead that "imaginative thinking and the use of metaphors are required to make the unknown accessible to us" (Tongeren 1997, p.194). By analysing various texts from medical handbooks she uncovers what type of conceptual metaphors are used to refer to particular medical phenomena; this enables her to investigate how closely metaphors in these texts can be related to their synonymous theories and which features of medical reality are emphasised and which are obscured by the metaphors used. Her exploration reveals that both doctors' and patients'

conversation techniques are subjective prompting specific socially constructed meanings. These meanings are characterised as conceptualisations “tailored to the specific of linguistic convention” (Langacker 1987, p.99). The conceptual structure that provides the content of linguistic expressions can range from “fairly simple concepts or a perceptual experience to quite complex knowledge clusters” (Depraetere and Salkie, p.107). Furthermore, metaphors portray *frame conceptualisations* and thus different *frames* result in different meanings (Tongerren 1997, p.133). In other words, the meaning of the expression is understood against the background of a coherent (culture-specific) conceptual frame. For example, ADDICTION is likely to evoke the DISEASE frame for medical professionals, relative to which they would also understand terms such as: *substance dependence*, *drug use* and *drug addict*. Frames can thus be defined as “tightly linked chunks of conceptual knowledge which get evoked together” (Dancygier and Sweetser 2014, p.18). This is of particular significance to my research because it emphasises that how professionals understand concepts and contrive meaning will depend upon various factors including which model of addiction they perceive, consciously or subconsciously, to be the most accurate. Individuals interpret the events and actions that make up their lives based on “past experiences and current meanings derived from social interaction” (Grant 2008, p.3). How individuals who are in recovery understand concepts during interaction will have a direct effect on how they interpret meaning within their recovery experience. Thus, if someone believes that language is being used suggestively, rather than to objectively discuss their illness, they may also interpret what is said about their condition as applying to them as an individual. For example, doctors might refer to substance users’ urine samples as being ‘dirty’ as opposed to ‘clean’ if they are currently using drugs. These terms have been influenced by the idea that addicts can control their own behaviour and make the conscious decision to “live in poverty and squalor with their drugs” (Tannenbaum 2008, p.5).

Like Tongeren (1997), Knapton (2013) uses CMT to explore subjective conceptualisations of health discourses, in this case anorexia. Knapton (2013) uncovers how members of a pro-anorexia website conceptualise anorexia in a way that contributes to the continuation of the disorder. She highlights that during the mid-2000's female pro-anorexia site users were attacked, regarded as "dangerous, irresponsible villains who brainwashed their passive victims" (Knapton 2013, p.463). This is particularly significant in relation to the notion of blame and the consequences that particular conceptualisations can engender as it suggests that those who suffer from anorexia are to blame for their illness; thus it will be interesting to see whether similar conceptualisations arise in relation to substance misuse. Anorexia, like substance dependence, carries a myriad of social issues that need addressing. Knapton (2013) attempts to address these concerns through a cognitive based discourse analysis which employs Lakoff and Johnson's (1980) theory of Conceptual Metaphor to offer an analysis of the language found on pro-anorexia websites. Her findings suggest that pro-anorexia members' conceptualisations of female beauty are not an obscure system of beliefs but in fact extensions of Western societies' conceptualisations of what it means for a female to be aesthetically pleasing. Furthermore, these conceptualisations are not dissimilar from the enunciated Western belief that "thinness is desirable" (Knapton 2013, p.467); this undoubtedly brings into question the legitimacy of communal uproar against pro-anorexia websites. A corpus analysis showed that members structured their eating disorder practices through two dominant conceptual metaphors: ANOREXIA IS A SKILL and ANOREXIA IS A RELIGION, with suggestive "linguistic realisations of these metaphors revealing that these structures are inescapable and ingrained within member's conceptual systems rather than short-lived creative devices" (Knapton 2013, p.467). It is clear from the findings that the belief that anorexia is a learned skill which gives a 'well-earned' status of superiority is "more than reminiscent of society's values that encourage women to learn beauty tips, desire a lower body weight and judge their self-worth on their physical attributes" (Knapton 2013, p.474).

Similarly, the notion that anorexia is a religion has associations with the idea that detoxification can cleanse impurities from sinful food and that women should adhere strictly to their beauty regime. Knapton (2013) highlights that we must stop demonising those who are suffering from illnesses like anorexia and substance dependency as this will only “push them towards more extreme and dangerous practices” (Knapton 2013, p.474). Instead we should be investing time into helping these individuals recognise that recovery does not mean that they will continue to live their lives feeling empty and meaningless (Allen 2004, p.9).

3.3 Addiction Therapy and Metaphor

Addiction is a multifaceted area of research and therefore individuals have diverse ideas about what is rewarding or attractive when it comes to recovery resources and therapy. Recovery is a challenging and lengthy process which compels the individual to re-organise and re-prioritise many aspects of their lives. Kelly (2017) believes that there needs to be a shift in addiction treatment approaches away from negative reinforcement: “alleviation of withdrawal symptoms” (Kandel 2002, p.338) and toward positive reinforcement: pleasure seeking and making recovery attractive. What individuals with a substance use problem find attractive will depend on a myriad of factors and thus discovering models and pathways of ‘personalised recovery’ will help to “identify which factors might have the most value and for whom and at which point in the recovery journey” (Kelly 2017, p.764). On this basis, I will discuss how therapies, which are frequently implemented during recovery for substance dependence, work towards positive reinforcement and sustaining recovery through the application of metaphor. The fact that CMT is already an established approach within talk therapies for addiction offers an additional justification for this project’s focus on professionals’ conceptual metaphors because it aligns with the considerations and techniques that are already in use.

Cognitive-behavioural therapy (CBT) is concerned with helping clients to cope with “irrational or disturbing emotions, and to cultivate rational, healthy, and proportionate ones in their stead” (Robertson 2010, p.3). People with substance problems often conceptualise themselves as failures with an inability to change. The use of metaphor alleviates this by placing emphasis on “separating the problem from the person rather than demanding that the person own the problem” (Corey 2009, p.236). Otto (2000) demonstrates how the use of metaphors in CBT provides the client with a method of enhancing information processing. For example, if the substance user is suffering from depression one effective method of using metaphor is externalising the depression as a detached ‘being’. One instance of this is the

gargoyle story which suggests that the gargoyle is responsible for whispering negative thoughts in the client's ear; thus helping patients to recognise depressogenic cognitions by providing "an emotional symbol to identify a self-critical style" (Otto 2000, p.169). Moreover, Hayes (1995) uses metaphor to display a client's position when they first enter treatment emphasising how "old habits, even ones that lead to difficulties, are often hard to drop" (Otto 2000, p.170). The metaphor is centred on an individual who has fallen in a hole and is desperately trying to get out using a shovel; however, even when the shovel is replaced with a ladder the very essence of releasing the shovel can be challenging.

Another common therapy in addiction treatment is Transference Focused Psychotherapy (TFP) which aims to bring the client's unconscious past experiences to the surface so that they can be actively worked through to uncover how those experiences are unconsciously affecting their present situation (Yeomans and Kernberg 2002). Tay (2016) demonstrates the relationship between metaphoric conceptualisations and transference by tracing how the conceptualisation PRESENT IS PAST is constructed by the client during conversations with the therapist. The transference-as-metaphor model attempts to *map* feelings at the transference level from the concrete, familiar, PAST source domain to the abstract, somewhat unfamiliar, PRESENT target domain in order to explore how the client's past experiences are shaping their present situation and thoughts. It enables individuals to work through, and to some degree, "heal the wound caused by trauma...allowing them to become present and free of the past" (Evans and Sullivan 1995, p.225).

Motivational interviewing (MI) is another frequently used therapy in addiction treatment, it places emphasis on the idea that change happens through self-actualisation in a democratic partnership between client and counsellor. Using metaphor during MI encourages the client to reconceptualise negative thoughts and emotions through a process of metaphorical mappings

which offer a new and empowering way of conceptualising the *reality*. The use of metaphor creates a shared understanding of the existing problem between the counsellor and client, assisting the counsellor in creating a positive conceptualisation of the client's future in response to negative evaluations of their past in order to help the client envisage their current situation in a new light (Sarpavaara 2011). Thus, it is fair to conclude that metaphor is a multifaceted tool that can be utilised for a variety of purposes and at different stages of interaction with those who are suffering from addiction.

3.4 Concluding Methodological Remarks

Being qualitative in nature, this project does not seek to offer an extensive characterisation of metaphor in the realm of addiction as this would require a combination of both qualitative and quantitative analysis. Instead I am seeking to explore professionals' conceptualisations of addiction and the consequences that they can potentially produce. To further elaborate on my reasoning for utilising a qualitative analysis I will draw on Tay's (2013) distinction between a *genre study* and a *genre-based study*. Genre studies are concerned with "exhaustive descriptions of specific phenomena within the genre" (p.8) while genre-based studies "use data from some selected genre to illustrate wider issues which are not necessarily tied to it" (p.8). Genre studies of metaphor, such as Charteris-Black (2000; 2004) and Koller (2004) endeavour to understand how the purpose of the genre and the central topic determines the "type, frequency, and functions of metaphors therein, across an ideally representative sample of text and/ or talk" (Tay 2013, p.8). For example, Charteris-Black (2004) combines critical discourse analytic procedures and concerns with those of corpus and metaphor research in order to discuss "the persuasive and ideological role of metaphors found in some of the typical genres" (Semino and Demjén 2016, p.196). Whereas this thesis, as a genre-based study, takes features of CMT in order to investigate how particular instances of metaphor use support or challenge current theoretical understanding. There is therefore no suggestion that the analysed extracts are representative conceptualisations of every addiction professional, as this would be problematic in any case given that each and every one of us have different embodied experiences and thus diverse beliefs about what addiction *really* is.

4. Data Analysis

The data analysis revealed that participants' conceptualisations were structured around different iterations of the JOURNEY metaphor. Thus, if LIFE IS A JOURNEY and subsequently ADDICTION IS A JOURNEY located within one's life journey, then it is possible that we can position ourselves at different points on that journey; for example, at the start, middle, and end. On this basis, I have decided to structure my analysis in terms of: becoming addicted, experiencing addiction, and recovery from addiction in order to provide a coherent exploration into how professionals conceptualise substance dependence from its starting point, through to its ending point. Whilst the use of the LIFE IS A JOURNEY metaphor is not peculiar because it is endemic in the language system. What is relevant here is the use of the ADDICTION IS A JOURNEY metaphor which acts as a sub-route through the conceptual mapping; thus meaning that addiction is metonymical within the life cognitive model. Furthermore, it is imperative that we gain an insight into how healthcare professionals conceptualise the entire process of addiction, rather than solely one specific aspect, so that the patient can be appropriately supported throughout their addiction journey. The ADDICTION IS A JOURNEY metaphor promotes the idea that addiction must 'go' somewhere, it must have a "final destination" (Eaglestone & Beecher Field 2015, p.100), but does it? The metaphors professionals in the field of addiction choose to employ in order to interpret substance misuse contribute in shaping how we as society understand addiction, those who suffer the pain it causes, and its treatment and interventions. In other words, how the events 'look' will depend on the conceptual metaphors used.

4.1 Phase 1: Becoming Addicted

This section will highlight the different conceptualisations that professionals have relative to becoming addicted. For the research nurse (RN) people become addicted because of two factors: the OBSTACLES that they are faced with during their LIFE JOURNEY that prevent them from moving forward, or, the PATH that they have been ‘led’ down either as a direct result of the obstacles or because of an external agent who has guided them there. In the former case the OBSTACLE gets reconceptualised as the ADDICTION CONTAINER, whereas in the latter the PATH is understood as having the ADDICTION CONTAINER on it, emphasising how these two conceptualisations are interwoven but focus on slightly different aspects of the journey metaphor. In contrast, the counsellor and psychotherapist (CP) conceptualises the probability of someone becoming addicted in terms of negative embodied experiences that are metaphorically represented through the spatiotemporal action of pouring PAINT into an empty PAINTPOT (the body of the individual), generating a switch in how the body is conceptualised from a CONTAINER OF THE SELF to an ADDICTION CONTAINER. Moreover, the analysis of the psychiatric consultant’s (PC) utterances reveal that he is conceptualising becoming addicted as being dependent on a combination of factors. For him addiction is understood as a PATH that only those born with the ‘RISK’ have accessibility to. Interestingly, in the case of ‘PC’ the CONTAINER schema only arises when someone is already located on the ADDICTION PATH. Unlike in the instances of ‘RN’ and ‘CP’ containment is not caused by addiction but is instead a consequence of practitioners unintentionally placing substance users into the ‘boxes’ to which they are thought to belong. I will now examine how these metaphors are used in more detail.

4.1.1 Participant 'RN'- Research Nurse:

“...there’s probably **more than one cause** [of addiction] ...I think people find it as **an escape from their problems**...they may not have support elsewhere... **I think it’s about support and lack of support and the struggles that people are faced with**” (RN)

Here we can see how ‘RN’ conceptualises becoming addicted in terms of obstacles and an absence of something, namely support. The use of the linguistic metaphor “*the struggles that people are faced with*” can be conceptualised as OBSTACLES that someone is confronted with during their life journey, thus activating the conceptualisation that LIFE IS A JOURNEY. The conceptual metaphor LIFE IS A JOURNEY is so deeply ingrained in our conceptual system that it has in fact become an “integral part of our everyday thought and language” (Eaglestone 2002, p.92). Its unique, powerful, and central position in helping us to understand ourselves and the world around us in ways that no other modes of thought can has enabled us to view things that happen in our life as things that happen to us on a journey; for example, in terms of: OBSTACLES, BARRIERS, PATHWAYS AND CROSSROADS. The metaphors we choose to utilise in order to interpret addiction in fact shapes *how* we interpret addiction. The conceptual metaphor LIFE IS A JOURNEY in this instance manifests itself mainly through the conceptual element of the OBSTACLE, where the ADDICTION JOURNEY is opened because of the obstacles that are preventing one from moving forward. Thus, the more obstacles that someone is faced with: “*there’s probably more than one cause*”, the more chance there is that this will lead someone to enter the ADDICTION JOURNEY. Interestingly, ‘RN’s’ use of the utterance “*it’s about support and lack of support...*” is significant spatially as it suggests that it is ok to be faced with an obstacle provided that you have the *support* to get around it. However, if support is what is lacking, movement forward is stopped (TIME IS SPACE), and you are forced to either enter the OBSTACLE (that has the potential to be the cause of addiction); or take an alternative PATH (which may have the ADDICTION CONTAINER on it). Thus, this alternative

PATH is one which misleads the person into thinking that they will escape the OBSTACLES that they were otherwise faced with on their life journey: “*an escape from their problems*”. From an agentive perspective the idea of support is particularly interesting in this instance as the agent is unknown. However, if we are to draw on our embodied knowledge of what support means in the context of preventing substance dependence we can infer that she is conceptualising *support* as family members, friends, colleagues, or anyone who is in that person’s social support network who will help the individual in overcoming the obstacles that they are faced with during their LIFE JOURNEY, whether this be physically, emotionally, or financially. Therefore, the idea that “drinkers tend to have drinking and heavy-drinking social networks and drug users tend to be part of drug-using social networks” (Miller and Carroll 2006, p.169) is relevant given ‘RN’s’ conceptualisation that the likelihood of becoming addicted relies heavily on the support which they receive. Furthermore, the notion of support is particularly interesting as SUPPORT can be conceptualised as something which is structural. From this perspective, support is something which physically enables the traveller in overcoming the obstacles that they’re faced with, resulting in them being in a position spatially to be able to move forward on their LIFE JOURNEY without entering the ADDICTION JOURNEY.

“...we’re all responsible for our own actions...people who are coming out of prison...if they have...a programme in prison then come out they can find it **difficult to sustain that because of the challenges that they’re faced with**...but...we as individuals are responsible **but I think that there’s lots of factors that lead people to become substance misusers in the first place**” (RN)

We have already explored how ‘RN’s’ overarching conceptualisation that LIFE IS A JOURNEY and subsequently ADDICTION IS A JOURNEY establishes itself mainly through the conceptual

element of the OBSTACLE, where problems in their life journey are understood as obstacles (PROBLEMS ARE OBSTACLES) that may prevent one from moving forward. The utterance: “...because of the challenges that they’re *faced with*...” provides an egalitarian outlook on addiction, specifically that “addiction can happen to anyone from any walk of life” (Masters 2004, p.84). Again, this utterance is interesting spatially as it suggests that it is ok to be faced with problems (OBSTACLES), provided that you are able to get around them. However, if one is unable to get around the obstacle(s) that they’re faced with movement forward is stopped, causing a switch in terms of the metaphor used whereby the OBSTACLE is reconceptualised as a CONTAINER (AN OBSTACLE IS A CONTAINER). It is understood as the reason that the individual is in a position spatially whereby they are unable to move forward on their life journey and thus is the cause of them becoming addicted. Therefore, ADDICTION IS AN OBSTACLE on the LIFE JOURNEY that if you are unable to get around becomes an ADDICTION CONTAINER which you have to go through an additional journey to get out of. Since everyone is faced with obstacles throughout their life that could potentially cause them to become addicted, the question we need to ask is: “*What forms the likelihood of an individual being able to get around an obstacle?*”. The answer to this question is not straightforward. Take ‘RN’s’ utterance: “*challenges that they’re faced with... in life after prison*”. It suggests that this depends greatly on the severity of the problem (OBSTACLE). Adjusting to life after prison can be an extremely challenging obstacle for people to overcome; therefore, it is no surprise that ‘RN’ maps this onto the *type* of obstacle that could cause someone to enter the ADDICTION CONTAINER; perhaps for the first time or as a returned state of being. Kinner and Rich (2018, p.88) highlight that although pre-incarceration substance use can be a strong predictor of post-release substance use this is not always the case, and that for many people post-release substance use is a “coping mechanism used in the face of substantial challenges many people experience after release from prison” (Kinner and Rich 2018, p.89). Since our lives are filled with obstacles of all sizes, some minute, others traumatic, it is important to

note that “the magnitude of any obstacle is based on the perception of the person who experiences it. What may be a big problem to one person is only a bump in the road to another” (James 2005, p.109). This helps to explain why people can face the same life challenges but only some develop substance use problems. Furthermore, the utterance: **“there’s lots of factors that lead people to become substance misusers”** is particularly significant when considering ‘who’ is responsible for someone entering the state of addiction, as opposed to ‘what’ is responsible. The term *lead* carries connotations of a superior individual leading someone to something and is associated with those who reside somewhere near the top of the organisation in positions of power and prestige. This traditional perception of the term *lead* seems to have “great staying power, perhaps because it satisfies certain needs people have to let someone else be in charge” (Davis 2003, p.11). When applied in the context of substance dependence, it suggests that people do not *choose* to become addicted but instead that someone, or something, *guides* them in the direction of addiction; this interpretation can be understood as credible given ‘RN’s’ overarching conceptualisation that LIFE IS A JOURNEY. Nevertheless, there is still an element of choice involved because when you are faced with a decision, you can either choose to follow someone’s lead, or conversely do what you feel is the right thing for you. Whilst the former option is “initially easier to do” (Gogatz and Mondejar 2005, p.119) in the end it can be harder to live with, as is the case with addiction.

“...society generally has a (.) erm (.) should help people...because **I’m a mum and I’ve got a child...him erm (.) being a potential substance misuser in the future is one of my...greatest fears...**” (RN)

This utterance is illustrative of ‘RN’s’ recognition that ADDICTION is an available PATH which her son could potentially go down during his LIFE JOURNEY. We have already examined in the

prior analyses how if one is unable to get around the obstacle(s) that they're faced with on their life journey, movement forward is stopped causing a reconceptualisation of the OBSTACLE as that of an ADDICTION CONTAINER. Therefore, the above utterance is a hypothetical statement whereby addiction is a *potentiality* along the path and therefore both the PATH and the ADDICTION CONTAINER are image schematically activated and combined into one idealised cognitive model (Lakoff 1978) of what addiction is, or could be. The idea that addiction is something which is a potentiality contrasts with the idea that it is something which is inevitable. If addiction is an inevitability it would mean that for some people, there was only ever going to be one PATH and it was always going to have the ADDICTION CONTAINER on it. While the latter conceptually removes the idea of choice entirely because it is regarded as a certainty, 'RN's' perception of her son being "*a potential substance misuser*" is conceptually significant because it can be interpreted in a myriad of ways. It could be understood as illustrating that 'RN' believes that addiction will be a very prominent path in her son's life journey, or that there will always be other options that her son could choose rather than addiction (it is a potentiality rather than inevitability). Conversely, the utterance could be perceived as supporting the idea that addiction can happen to anyone, given that even her son whom she has nurtured and would seek to protect from addiction at all costs ("*... is one of my... greatest fears...*"), has the propensity to become an addict. The fact that her son being a potential substance misuser is one of her "*greatest fears*" is indicative of the shared cultural understanding of addiction as being something which harms, or even destroys, the addicted individual and their loved ones. This is further supported when she states: "*...my aunty...two of her sons were erm (.) alcohol and substance users and erm that broke down their whole family*". Therefore, it is not surprising that the addicted individual is often conceptualised as someone who has been *wasted* or *destroyed* as "refuse matter" rendered as such by a causal agent (that is, addiction) that charts a path of destruction or

devastation across the body of the addict, as well as within the personal and professional arenas of the addict's life" (Diehl 2016, p.17).

"...anyone can be addicted to things (.) it's like sexual violence...anyone can be subjected to that and people might have this stereotypes of...certain kinds of people that...have problems with substances but erm no I think that you know any age (.) erm background" (RN)

Here 'RN' maps *sexual violence* onto the source domain **"anyone can be addicted to things"** to form the underlying conceptualisation that ADDICTS ARE VICTIMS. This conceptual mapping infers that the probability of someone becoming substance dependent is unknown, and given the overarching conceptualisation that LIFE IS A JOURNEY she is understanding ADDICTION as either an OBSTACLE or PATH that is available to everyone during their life journey. Thus, just as sexual violence is something which happens to someone and is out of their control:

("anyone can be subjected to that"), becoming an addict is, in the same vein, a bad thing which happens to someone and is out of their control: **"any age (.) erm background"**. Here we can see a superordinate conceptual model at play whereby an agent is doing something to someone else. In the case of sexual violence, the agent is the perpetrator committing the act whilst the person whom the act is being committed upon is the victim. However, significantly in this instance, the agent responsible for causing someone to enter the state of addiction is unidentified. Why is it then that we naturally refer to those who have experienced something traumatic as 'victims', even when it is not necessarily a result of someone else's heinous behaviour? Lakoff claims that this is a direct result of *cognitive unconsciousness*, that is, at the level of the "structures in our brains that we cannot consciously access, but know by their consequences: the way we reason and what counts as common sense" (Lakoff 2004, p.15).

However, Mardorossian (2014) highlights the potential consequences that framing people as

victims can have in relation to sexual violence claiming that: “the use of the word automatically suggests an acceptance of defeat and an internalization of failure that are highly gendered and are taken for granted when the term victim is used” (2014, p.26). Interestingly, when we apply this conceptualisation in the context of addiction the term ‘victim’ has the potential to carry less negative connotations: “people become addicted for various reasons, none of which are their free choice. Addicts are victims of genes/ and or circumstances beyond their free choice” (Dix 2013, p.50). We can therefore infer that the agent responsible for one entering the state of addiction will vary from person to person and, from a professional perspective, will depend on which model of addiction they believe to be the most accurate. For example, if they believe in the brain disease model then they will be far more likely to conceptualise the agent as being the disease itself: “so many addicts feel like victims and, in reality, they are victims of the disease of addiction” (Griffin-Shelly 1997, p.63). Whereas someone who believes in the disorder of choice model is far more likely to conceptualise the agent as being that of the addicted individual: “addicts are individually responsible for their addiction even when they have endured severe childhood abuse or other events that could cause severe dislocation...for others have undergone the same suffering without falling into addiction” (Alexander 2010, p.296).

4.1.2 Participant ‘CP’- Counsellor and Psychotherapist:

“...if you can imagine lots of different pots of different coloured paints and **if you imagine an empty pot of paint for an individual person so some of these different pots of different coloured paints might be stuff like childhood trauma (.) abandonment issues (.) it might be mum and dad separating or splitting up...so an individual might think to themselves that brown colour over there which for example might be childhood sexual abuse that happened to me and I really feel the impact of that so I’m going to put a lot of that colour in...if you went through all the different coloured pots of paint and put in**

accordingly...then a person would end up with lots of different colours and **if you mix it all together there would be a uniqueness to the reason as to why they (.) have come to be the addict**” (CP)

Here we can see how ‘CP’ describes individual people as being unique pots of paint which are made up from a combination of different colours, each colour representing a different embodied experience. The paint pot metaphor is not a conventional one- it is very different from the life is a journey metaphor. It is important to note the clash between addiction as a container that you have to escape and a person’s body as a container for their addiction (and other things). Thus, the paint metaphor is an appropriate illustration of how motivated associations between source and target domains can be explained differently. Cognitive linguists would assert that the metaphoric scenario of a person being a unique pot of paint is motivated by the CONTAINER image schema, because both a pot of paint and the human body can be image schematically structured in CONTAINER terms. This provides a “motivated basis for mapping the INTERIOR, EXTERIOR, and BOUNDARY of the former onto the latter” (Tay 2013, p.61). Lakoff and Johnson believe that the structural segments of INTERIOR, EXTERIOR, and BOUNDARY organise how we perceive and comprehend our individualistic embodied experiences of being “in and out of certain phenomenological states” (Tay 2013, p.52). In this instance ‘CP’ expresses what causes someone to become addicted in terms of a CONTAINER and the act of pouring different coloured paints into that container; paint being representative of the individual’s unique phenomenological experiences, such as “*childhood sexual abuse*”. We are already aware from the analysis of participant ‘RN’s’ phase one responses that addiction is a deeply embodied and isolating state to enter, which comes about largely because of the difficult situations that a person is faced with. Thus, unsurprisingly, it is depicted by both professionals in terms of the CONTAINER metaphor, containers being renowned for conveying “emotional intensity or depth” (Masters 2013).

The linguistic realisations of addiction as ADDICTION IS A CONTAINER also point towards the possible existence of other conceptual metaphors, such as THE ADDICTED BODY IS A PRISON; this is coherent in this instance given that the CONTAINER is symbolic of the body of the addicted individual: *“if you imagine an empty pot of paint for an individual person...if you went through all the different coloured pots of paint and put in accordingly what should go in...there would be a uniqueness to the reason as to why they (.) have come to be the addict”*. This is interesting both conceptually and spatially when compared to the research nurse’s conceptualisation because in her responses the ADDICTION CONTAINER is understood as something which the individual enters (e.g. the body enters the ADDICTION CONTAINER and is consequently isolated within it). Conversely, in ‘CP’s’ response the ADDICTION CONTAINER is the body of the individual that is metaphorically represented by an empty pot of paint, which is transformed into an ADDICTION CONTAINER by the act of something else, namely the pouring of paint into it: (e.g. *“childhood sexual abuse that happened to me and I really feel the impact of that so I’m going to put a lot of that colour”*). Furthermore, the CONTAINER in this example can be understood as symbolic of the addicted person’s body since childhood trauma, abandonment, and childhood sexual abuse are all things which happen to someone. Thus, it may be that the conceptual metaphor, ADDICTION IS A CONTAINER, is in fact a “higher level conceptual key that is composed of several related, subordinate conceptual metaphors” (Charteris-Black 2004, p.16). Conceptualised as a CONTAINER, addiction can be understood as being directly linked to feelings of isolation and detachment.

What is particularly interesting is that ‘CP’ repeatedly makes reference to examples which have underlying connotations of isolation and detachment when listing reasons that might lead someone to become addicted: *“stuff like childhood trauma (.) abandonment issues (.) it might be mum and dad separating or splitting up”*. Notice that what is shared in all of these

examples is that the PAINT/FLUID, (e.g. childhood trauma, abandonment, parental separation) metaphorically represents the thing which has caused the person to experience feelings of isolation and distress which has in turn led the person to become addicted. The PAINT POT/CONTAINER, (the addicted person's body), whereby the individual is trapped metaphorically represents their addiction; thus creating a conceptual mapping whereby the FLUID is mapped onto the CONTAINER. I believe that it is conceptual mappings such as these that play a constitutive role in the construction of the basic structure of our understanding of addiction and its counterparts, that "virtually every alcoholic and substance abuser leads an isolated life" (Robak 1991, p.53). Without the mapping it is difficult to understand how addiction could have come to acquire the structure it seems to possess, that is: a situation (e.g. childhood trauma) produces a force inside a person which causes the person to act in a certain way that should ordinarily be suppressed (substance misuse) (Kövecses 2003, p.115).

"...anybody if they have been in certain conditions [can become addicted]...it's **either what's happened to them or maybe what hasn't happened to them...if they didn't feel nurtured or supported and loved which is really important for a child...anybody who's been in certain environments and has had certain challenges and certain traumas...I feel that everybody has the propensity to become an addict** (2) sometimes it's to more typical addictions whether it's alcoholism or drug addiction (.) for others **it might be...less obvious addictions...they might clean too much or they might gamble too much (.) or they might over eat...**" (CP)

Becoming addicted is, for 'CP', dependent on: "***either what's happened to them or maybe what hasn't happened to them***". This statement implies that whether the human body reconstructs itself from merely a CONTAINER OF THE SELF into an ADDICTION CONTAINER is determined by either something that *has* happened to the individual, e.g. childhood trauma, or,

conversely, something that has not: “*if they didn’t feel nurtured or supported and loved which is really important for a child*”. Whilst the former example image schematically generates a negative spatiotemporal image of PAINT (childhood trauma) entering the CONTAINER (the soon to be addicted body) the latter suggests that a lack of this spatiotemporal action, when referring to a fundamental part of a child’s upbringing (e.g. how a child is nurtured and loved), can, similarly, be equally responsible for the reconstruction of an individual’s body from a CONTAINER OF THE SELF to an ADDICTION CONTAINER. This way of conceptualising addiction is synonymous to that of Fraser et al’s (2014) understanding of addiction as “an agent internal to the addict’s body”. Thus, conceptualising the individual as the source of all action and meaning is particularly problematic in relation to discourses of addiction as it places blame for loss of control solely on the addicted individual.

Furthermore, ‘CP’s’ utterance “*anybody who’s (2) been in certain environments (2) and has had certain challenges and certain traumas*” is interesting conceptually when considering the notion of choice. The use of the verb phrase ‘*has had*’ suggest that the challenges the person who has come to be addicted experienced were, for them, unavoidable and in fact out of their control. This is coherent given ‘CP’s’ prior image schematic construction of the act of PAINT (negative experiences), being poured into the now addicted individual (an external agent doing something to someone else). ‘CP’s’ conceptualisation of the challenges that cause someone to become addicted differ from that of ‘RN’s’. Whilst the research nurse conceptualises them as OBSTACLES that you are *faced with*, suggesting that they are something that, given the right support, you can ‘get around’ or overcome, the counsellor and psychotherapist (‘CP’) conceptualises challenges as things that are inescapable since they enter the body (CONTAINER) of the person experiencing them. Therefore, in contrast to ‘RN’s’ conceptualisation, the person does not *enter* the ADDICTION CONTAINER but instead *becomes* the ADDICTION CONTAINER. It is important to note that for ‘CP’ addiction is not limited to a

particular *type* of person but is instead multifaceted: *“it might...be less obvious addictions...they might clean too much or they might gamble too much (.) or they might over eat”*. This suggests that a person’s body is transformed from a CONTAINER OF THE SELF to an ADDICTION CONTAINER, irrespective of whether their addiction is visible on their body or not; thus creating the conceptualisation that ADDICTION IS INVISIBLE. This emphasises that is important to tread carefully when representing addiction in popular media as by focusing on specific metaphors and images which “tend to stress the abject body, bodily decay, and embodied ‘otherness’” (Waskul and Vannini 2016) of substance users we are attempting to make something which is very much invisible visible.

When asked: “...do you feel that suffering from post-traumatic stress contributed to your substance use addiction?” ‘CP’ responded: “...for me personally if we go back to the pots of paint (.) I would probably put a splash in for that but certainly not the big dollop...**my two biggest pots of paint are (.) abandonment by my father when I was three and watching him beat my mum up...I still feel that emotionally now as I say it (.) so...I know that it’s still there...and...also growing up with an anxious mother...**”

Within the context of substance dependency, it is suggested that: “while the ostensible *symptoms* of addiction overwhelmingly consist in social or cultural transgression, its underlying *nature* is generally located in one or another sort of bodily pathology, deficit or vulnerability” (Hughes et al 2006, p.130). Therefore, it is important that we provide a conceptual space for those who have embodied experiences of problematic drug use if we are to gain a true insight into the reasons as to why someone might become addicted. For ‘CP’, childhood trauma has played a pivotal role in his historic substance dependency:

“abandonment by my father when I was three and watching him beat my mum up” and *“growing up with an anxious mother”*. The idea that these factors are his *“biggest pots of*

paint” suggest that they are the concepts largely responsible for the switch in his bodily container metaphors from a CONTAINER OF THE SELF to an ADDICTION CONTAINER. This notion is coherent given that the HUMANBODY is frequently understood as a CONTAINER and subsequently PEOPLE are conceptualised as CONTAINERS. Thus, it is only natural that we also conceptualise the sufferer’s body, in this case the body of the addict, as a CONTAINER and “one within the boundaries of which pain occurs or resides” (Lascaratou 2007, p.150). The conceptual metaphor ‘THE HUMANBODY IS A CONTAINER’ is, in many diverse languages in the world, the conceptualisation of emotions whereby the BODY is understood as the CONTAINER in which the emotions occur, hence the “widely observed metaphor EMOTION IS A SUBSTANCE IN A CONTAINER” (Lascaratou 2007, p.150). This universal metaphor can, in the context of substance misuse, help to explain why someone might end up in the state of addiction. If emotion is the substance, (PAINT), representative of negative embodied experiences like those mentioned above, it seems cognitively logical that someone would be inclined to take another substance (drugs), in an attempt to dilute the substance (negative emotions) already present in their BODILY CONTAINER. The idea that negative life experiences (PAINT) are in fact emotions (substances held in the container of the human body), is further support when ‘CP’ states: ***“I still feel that emotionally now as I say it (.) so...I know that it’s still there”***. This statement suggests that negative lived experiences continue to be preserved in the BODILY CONTAINER for years after the event has taken place. Therefore, it is how the individual copes with these experiences which will determine whether they become addicted. It is important to note that an individual would not attempt to alter their emotions within their BODILY CONTAINER unless they had become “uncomfortable in some way, or they could see...a more pleasant-looking place” (Buckley and Buckley 2012, p.32). Drugs often deceive vulnerable people into thinking that they are in a more ‘pleasant place’, that is until their BODILY CONTAINER is transformed into that of an ADDICTION CONTAINER. An individual’s behaviour will be influenced by both positive and negative life experiences that will determine their present

state, hopefully moving “towards the positive and away from the negative throughout life” (Buckley and Buckley 2012, p.32).

4.1.3 Participant ‘PC’- Senior Consultant in Addiction Psychiatry:

“...there’s not just one reason [that someone could become addicted] **it’s a combination of biological (.) psychological (.) and social factors**...there could be biological reasons it could be part genetic there could be some **risk that the person is born with (.)** it could be something to do with **the person’s brain in terms of chemicals (.) so the way parts of the brain are connected**...and these also include **the person’s personality (.) coping resources...social factors such as peer influence...often there is an interaction or interplay of these factors that ultimately determine whether a person gets addicted or not**” (PC)

The above extract demonstrates how ‘PC’ explains his conceptual understanding of the cause of addiction as something which involves biological, psychological, and social models and how genetic, psychological and social risk factors are largely responsible for someone developing an addictive disorder. This perspective on the likelihood of someone becoming addicted is interesting conceptually in relation to the notion of blame. The idea that addiction could be a “***risk that the person is born with***” on the one hand suggests that the individual is not responsible for ending up in the state of addiction because they are born with it, whilst on the other hand the term ‘*risk*’ indicates that although addiction is a potentiality it is not a certainty and therefore “you’re responsible for it, and with effort, you can influence it” (Shaw et al. 2011). Thus, ADDICTION can be understood as a PATH that only those who are born with the RISK have accessibility to. However, there is no access to the PATH unless certain ‘things’ become available on their LIFE JOURNEY. For ‘PC’ ADDICTION IS BIOPSYCHOSOCIAL as he views biological aspects (***the person’s brain in terms of chemicals (.) so the way parts of the***

brain are connected) as impacting psychological aspects (*the person's personality(.) coping resources*), as further impacting social aspects of the individual (*peer influence*), in an “ongoing, interactive manner” (Miller 2014, p.9) (Figure 2.1). This way of understanding what causes someone to become addicted is advantageous in that it accounts for the complicated “contributing factors of addiction” (Miller 2014, p.10) and therefore encourages individual assessment in order to pinpoint the underlying cause of a person's addiction. For example, some addicts “may have a significant biological component without much in the other two areas (Figure 2.2), while others might have a small biological component (Figure 2.3)” (Miller 2014, p.10). Whilst an individual may become dependent on drugs because of a single factor, it is more likely to be “several interacting factors” (Nutt et al. 2006, p.150): “*often there is an interaction or interplay of these factors*”. Although this model encourages an understanding of the cause of one's addiction that is tailored to the individual, it is somewhat complex: “talk to anyone who is truly knowledgeable in the field of addiction and you will get a complex answer because addiction is a complex disorder” (Taleff 2006, p.99). Therefore it could create barriers between healthcare professionals and clients when used to explain the cause of their addiction.

Biopsychosocial Model, adapted from Miller (2014, p.9-10):

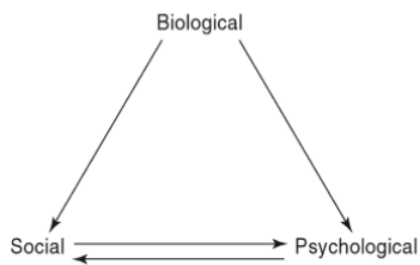


Figure 2.1 Biopsychosocial Model

Example 1

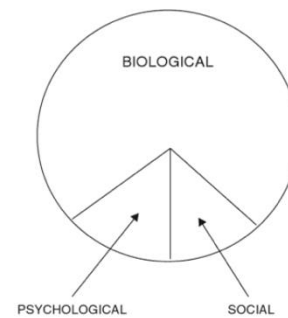


Figure 2.2 Contributing Factors of Addiction:

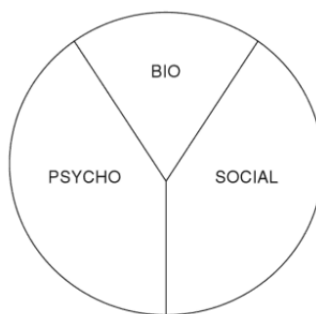


Figure 2.3 Contributing Factors of Addiction: Example 2

“...I don’t think that there is a specific type or profile of a person who is an addict (.) anyone who has these risks...can get addicted...I don’t think we can construct a stereotype...each person has their own individual characteristics or difficulties...as practitioners for us it’s important to...acknowledge that and **not put these addicts in boxes**...time needs to be spent with addicts to find out how he or she is different and then target your interventions and approaches appropriately...**not all drinkers you know might be wife beaters and not all addicts might be depressed or have a history of childhood sexual abuse**” (PC)

Given that ‘PC’ conceptualises ADDICTION as a DISEASE: “addiction is a chronic brain disease” (appendix C), it is not surprising that he understands addiction as an issue that can affect anyone who is exposed to the risks discussed in the prior analysis: “addiction is the

world's most democratic disease; it can affect anyone" (Seymour 2001, p.11). According to Conceptual Metaphor Theory, metaphors occur from our everyday embodied experiences of the world around us, including one's cultural values and norms. Thus, the idea that the likelihood of someone becoming addicted is reliant upon the DISEASE concept is informed by 'PC's' understanding of the BIOPSYCHOSOCIAL MODEL. This model works to shift the focus away from the drug itself and towards understanding drug use as a "disease whose course depends on the interactions of the addictive drug or compulsive behaviour" (Martin et al. 2007, p.22). It offers a different perspective from the traditional medical model in that it does not regard drug use as merely "a bad habit, until organ damage occurs" (Martin et al. 2007, p.22).

The DISEASE notion dominates in addiction healthcare and diagnosis as it is considered to stand on objective ground; something which 'PC', as a senior consultant in addiction psychiatry, will be immersed in from his training and role within the medical community. Furthermore, his embodied knowledge of addiction will have developed from his extensive experience of assessing patient's physical, emotional, and mental health needs. 'PC's' utterance "*I don't think we can construct a stereotype...each person has their own individual characteristics or difficulties*" is significant as it illustrates that he is conceptualising ADDICTS as INDIVIDUAL PEOPLE rather than as a COLLECTIVE GROUP and how, similarly to 'RN' and 'CP', the cause of their addiction is unique. This way of understanding substance misuse is particularly useful in relieving the pressure of addiction as it engenders the idea that it is something that is individualistic, rather than collectivistic. Thus, it raises the idea that a person's entire persona cannot be identified by substance misuse. The latter part of 'PC's' utterance "*not put these addicts in boxes*" is important conceptually both from an agentive perspective and schematic viewpoint. The notion that the "CONTAINER schema often involves a PATH schema since human beings seem to constantly move from one bounded

space into another” (Fabricius 2018, p.46) is relevant given that in the analysis for ‘PC’s’ prior utterance we observed how the RISK (addiction) is a potential PATH on a select number of individual’s LIFE JOURNEY’S. Therefore, for ‘PC’ the CONTAINER schema arises once one is on the ADDICTION PATH and has consequently become the ‘*addict*’. Here ‘PC’ is recognising that practitioners can unintentionally be responsible for containing substance users by putting them into the ‘*boxes*’ to which they are thought to belong. The notion of CONTAINMENT is thus conceptualised in terms of the physical experiences of motion along a PATH into a BOUNDED SPACE (box). The image schemas PATH and CONTAINER are combined hierarchically to make up the dual structure of the complex “Event-Structure metaphor” (Fabricius 2018, p.44) which enables us to understand the event (the likelihood of someone becoming addicted) in terms of LOCATIONS (PATHS) and OBJECTS (CONTAINERS). The conceptual analogies, “*not all drinkers you know might be wife beaters*” and “*not all addicts might be depressed or have a history of childhood sexual abuse*” further work to assist one in ‘unwrapping’ or ‘decoding’ the idea that it is not plausible to construct a stereotype of the *type* of person who is likely to become addicted. From this perspective, analogies are “CONTAINERS for the purpose of transporting ideas” (Aubusson et al. 2006, p.41). Moreover, the analogies illustrate that just how the cause of addiction varies, so too does the type of person likely to become addicted. Thus, applying a ‘*one method cures all*’ approach to treating the addicted person will not be effective and therefore we must urge addiction professionals to acknowledge that there are various paths to recovery. Each person’s experience of addiction is unique and that is why it is imperative to “*find out how he or she is different and then target your interventions and approaches appropriately*”.

4.2 Phase 2: Experiencing Addiction

This section of the analysis will draw attention to the different conceptualisations that professionals have in relation to experiencing addiction. For 'RN' the ADDICTION CONTAINER has a JOURNEY of its own with distinct problems to those faced on one's LIFE JOURNEY. However, these problems are conceptualised differently than those mentioned in phase one of the analysis as they are no longer understood as OBSTACLES that can potentially be overcome, but instead as things that the individual has to learn to 'deal' with implying a kind of battle or struggle; thus forming the conceptual blend, THE ADDICTION CONTAINER JOURNEY IS A BATTLE. In contrast, 'CP' conceptualises experiencing addiction as the transformation of one's BODILY CONTAINER OF THE SELF to an ADDICTION CONTAINER. For 'CP' the ADDICTION CONTAINER is understood as a PERSON with a MIND of its own which temporarily deceives the contained individual into thinking that they are located in a better place than prior to their addiction. Finally, for 'PC' once the affected person is on the ADDICTION PATH, ADDICTION is understood as an OBJECT that the addicted person carries around with them on the PATH and to which stigma attaches itself. I will now examine these conceptualisations of experiencing addiction in more detail.

4.2.1 Participant ‘RN’- Research Nurse:

“[Addiction means] that someone needs something and they feel like they can’t manage without...**it’s not something that they can just snap out of...it’s an illness**” (RN)

In phase one of the analysis we saw how ‘RN’ conceptualised LIFE as a JOURNEY and the challenges that one is faced with as OBSTACLES. However, if the individual is unable to overcome these obstacles then they are thought as having the potential to end up in the state of addiction, which ‘RN’ conceptualises as a CONTAINER: “***it’s not something that they can just snap out of***”. Following CMT, the underlying conceptual metaphor of this utterance is that ADDICTION IS A CONTAINER which establishes itself via the linguistic expression “*snap out of*”. Moreover, the use of the utterance “***it’s an illness***” further supports the conceptualisation that ADDICTION IS A CONTAINER since it is generally agreed that “the worse the illness (and/ or its phases), then the more the probability exists that the ill person will feel or become isolated” (Royer 1998, p.65). Since isolation is understood as something which blocks us from “the outside world” (Tay 2013, p.52) it can therefore, be conceptualised as “ISOLATION IS CONTAINMENT” (Refaie 2019, p.50). Cognitivists would claim that given the context in which this utterance appears it can be considered to be motivated by the CONTAINER image schema where “the structural elements of interior, exterior and boundary organise the construal of our subjective experiences of being in and out of certain phenomenological states” (Tay 2013, p.52). The target equivalent of “*out of*” in ‘RN’s’ prior utterance is irrelevant in this example since its function is to initiate the conceptualisation that ADDICTION IS A CONTAINER. We do not therefore have to understand “out of” itself in terms of something else, as is the case for LIFE IS A JOURNEY. Thus illustrating “the distinction existing between metaphor on a linguistic and a conceptual level” (MacArthur et al 2012, p.57). While the former metaphor used in phase one is implemented to highlight the likelihood of becoming addicted, the latter in phase two is used to emphasise what the state of addiction is; since they

are focused on different aspects of addiction there is no complete overlap between them. Nevertheless, it is possible to focus jointly on the “JOURNEY” (how one comes to be addicted) and the “CONTAINER” (what the state of addiction is). What characterises this overlap is a “shared entailment between the two metaphors” (Hong 2006, p.25). For example, in the journey metaphor, the more substantial an obstacle is (the larger and more problematic it is), the more likely one is to end up in the state of addiction. Similarly, in the container metaphor the more bounding surface there is (the surface used to hold content), the more difficult it is to get “out of”. Therefore, the more substantial an obstacle is that the traveller faces during their journey (via the journey surface), the more likely the traveller is to enter the obstacle (container), and consequently the more difficult it will be for the traveller to get out of the container (via the container surface). The overlap of entailments between these two metaphors is the “progressive creation of a surface which provides a ground of coherence between them” (Hong 2006, p.25). Thus, these two metaphors can be understood as working together to give a coherent and comprehensive understanding of the concept of addiction as a whole.

When asked: “How do you think members of the public understand addiction?” ‘RN’ responded: “...I work with patients that have long term chronic conditions and that impacts on their abilities to feel well emotionally...the consultants that I work with sometimes...you’re reminding them that **they can’t just...be positive and erm get on with it...it is very difficult to think differently because of their world that they’re in and the things that they’re dealing with...you’re reminding them that it’s very difficult for them to do that because they are in a different mind-set_and they’re depressed**”

Depression and drug addiction are often constructed as similar conditions (Clark 2008); therefore, unsurprisingly, ‘RN’ draws on her embodied experiences of working with people who struggle with depression to give a more accurate account of how she conceptualises the

public's understanding of addiction. Interestingly, Clark (2008, p.100) highlights that those who suffer from depression often describe their experiences in comparable terms to those who suffer from substance dependency, using similar metaphors and narrative trajectories.

Metaphors of "entrapment, descent, and darkness predominate in accounts of both depression and drug addiction. These metaphors aptly convey the despair, isolation and helplessness that both depressives and addicts report as their governing affective states" (Clark 2008, p.100).

'RN's' utterance: "***they can't just...be positive and erm get on with it***" can be conceptualised as TIME IS SPACE since it appears to naturally link to the process of spatialisation and temporalisation through embodied experience. The fact that 'RN' highlights that these individuals are unable to just "*get on with it*" illustrates that they are unable to move forward on their life journey and therefore can be considered to be underpinned by CONTAINMENT schemas. This helps to explain why addiction is repeatedly referred to as a 'trap' which people spend years trying to free themselves from: "millions of our neighbours are either addicted to chemicals today or may have spent years trying to free themselves from this vicious trap" (Cohen 1995, p.13).

'RN's' following statement: "***it is very difficult to think differently because of their world that they're in and the things that they're dealing with***" is particularly interesting in relation to the LIFE IS A JOURNEY metaphor because it implies that the ADDICTION CONTAINER has a journey of its own with distinct problems. This becomes apparent in the latter part of the utterance where she highlights that these individuals have to *deal* with separate 'things' (problems) whilst in the addiction container. How these problems in the ADDICTION CONTAINER JOURNEY are conceptualised differs from how they are conceptualised on the LIFE JOURNEY. They are no longer understood as OBSTACLES because this would imply that they can be overcome by making the decision to "move forwards with hope, faith, and determination" (Hunter 2010, p.1), whereas problems in the ADDICTION CONTAINER JOURNEY

are conceptualised as bad things which happen to someone that cannot necessarily be overcome but instead the individual has to learn to cope with. Thus the relatively subjective nature of effectiveness makes a conceptual analysis of *dealing* with something complex and seemingly contradictory. Whilst to deal with something may indicate an ability to manage, it may also mean 'getting by'. Therefore, in relation to the ADDICTION JOURNEY, it may be conceptualised as merely surviving "which implies a kind of battle or struggle" (Collis 2013, p.102) within the container itself; or, in contrast, it may be conceptualised as "the capacity to hold one's own and to remain independent of outside forces" (Collis 2013, p.102). Which of these conceptualisations are more accurate in the context of this utterance becomes clearer toward the end of 'RN's' response when she states: "*it's very difficult for them to do that because they are in a different mind-set and they're depressed*". This indicates that the former conceptualisation (which implies a kind of battle or struggle), is most fitting given that it is "*very difficult*" for them to think differently because they are "*in a different mind-set*". The latter part of this utterance implies that there is more than one mind-set, namely the 'ordinary' everyday LIFE mind-set vs the ADDICTION / DEPRESSION mind-set.

Related to conceptual metaphor theory is conceptual blending, the process by which two concepts are blended into a novel idea through a "complex event in which particular elements and their relations pertaining to the initial two concepts are combined selectively into a new whole, which is understood to be structurally richer" (Eppe et al. 2018, p.107). With this in mind, it can be said that the conceptual blend ADDICTION (LIFE) JOURNEY IS A BATTLE is formed in three stages. In the first stage there is the conventional metaphor that LIFE IS A JOURNEY and thus obstacles form part of this. In the second stage, the conceptual elements from the domain of LIFE are blended with the concepts from the domain of BATTLE, since ADDICTION is initially conceptualised as a potential *challenge* (OBSTACLE) on one's life journey (LIFE JOURNEY IS A BATTLE). In the third stage, the LIFE JOURNEY IS A BATTLE

metaphor is blended with the subsequent domain ADDICTION. These two domains establish input spaces for the blended space that one's ADDICTION (LIFE) JOURNEY IS A BATTLE since OBSTACLES are frequently conceptualised as things that have to be FOUGHT: "the greater the obstacles you face...the greater and fiercer the battle will be" (Salu 2013, p.1). This blend is a "conventional metaphor for understanding the concept of life, present in everyday language" (Kuczok 2014, p.142) and therefore the generic space can be the "cultural script of A CONFLICT, with TWO OPPOSING SIDES and AN ARGUMENT BETWEEN THEM, as it points to those aspects in both the domains of war and of life that are highlighted by the metaphor" (Kuczok 2014, p.142). This means that notions connected with addiction are incorporated into the already existing metaphor which results in the conceptual model that THE ADDICTION (LIFE) JOURNEY IS A BATTLE.

The relationship between the LIFE IS A JOURNEY conceptualisation and the ADDICTION IS A JOURNEY conceptualisation becomes ever more apparent in 'RN's' utterance: "When I worked at the health centre there was...a lady who had substance misuse problems...**she's struggling to keep her family...and is struggling to keep her children because they've been taken away from her before...sometimes she would sit in the car and just not feel able to come into the building** and have her dressings changed"

Allan (2014) maintains that it is often not the person's substance use per se that causes problems for their relationships with family members but is instead the "various consequences of that use such as erratic conduct, criminal behaviour, impaired social functioning and endless crises" (p.217). 'RN's' utterance "**she's struggling to keep her family**" reinforces the idea that the ADDICTION JOURNEY is a CONTAINER which acts as a BARRIER from the outside world (LIFE JOURNEY). The fact that she is 'struggling' to keep her family implies that those who were previously on the now addicted person's LIFE JOURNEY will continue to move

forward on their own life journeys' distinct from the addicted individual's ADDICTION JOURNEY. Interestingly, the substance user is often conceptualised as the individual responsible for making the decision to isolate themselves from their loved ones: "addicts become walled up with their drug(s) of choice and isolate themselves from intimacy with family" (Bushfield and DeFord 2009, p.57). However, this short but significant extract suggests otherwise. To struggle for something, in this case to keep her children, infers that it is something that the individual desperately wants and is willing to fight for. Moreover, the fact that they have been "*taken away from her*" further suggests that an external agent is responsible for her isolation from her family, but '*who*' this external agent is remains unknown from a purely linguistic level analysis. If we are to draw on our shared cultural knowledge of addiction as something which "preys on creating and then maintaining a sense of loneliness for the victim" (Allen 2014, p.21) we can logically deduce that it is the ADDICTION CONTAINER that is responsible. The loneliness and despair that the person in the ADDICTION CONTAINER experiences is often so immensely intense that "some are not sure how to manage life and continue to survive" (Allen 2014, p.21). This helps to explain why the 'lady' who 'RN' is referring to in this passage would sometimes "*sit in the car and just not feel able to come into the building*". Thus, we must urge those who understand the addicted individual as someone who "isolates himself or herself" (Knauer 2002, p.15) to reconceptualise and realign this notion of isolation away from the addicted person and toward the addiction container. This extract has exemplified that the addicted individual is by no means the '*isolator*' but is instead the person who is *isolated*, often to a depth that not even they can explain. In other words, as the ADDICTION JOURNEY progresses one's sense of connection with loved one's decreases and loneliness gets "more and more intense" (Allen 2014, p.21).

4.2.2 Participant ‘CP’- Counsellor and Psychotherapist:

“...I feel that [all drugs are used for escapism] whether it’s an opiate a depressant kind of drug which...blocks out...but actually the zippier kind of drugs like MDMA or cocaine or whether it’s gambling the ones that get more...adrenaline pumping (.) they still block out...**whether you go to an exciting place (.) an up and exciting place (.) or a low and detached place it still takes you away from what you might need to escape from (.)** just in a different way”
(CP)

While it is important to note that some drugs are more harmful and “containing than others” (Weegmann and Cohen 2008, p.9), what all drugs are inclined to do is eventually reduce, or even destroy, the adapting self (CONTAINER OF THE SELF) of the addict in its ability to contain and process painful states of mind, such as childhood trauma discussed in phase one of the analysis. Thus, the addict’s BODILY CONTAINER OF THE SELF loses its containing ability and in the process diminishes the addict’s own abilities for containment, leaving the individual in an even worse state than prior to their substance dependency, (in the ADDICTION CONTAINER). In chronic addiction it is probable that the addicted person has suffered an inability to contain his or her needs from a young age, as is the case for ‘CP’. Consequently, there is a desire generated within the individual’s BODILY CONTAINER OF THE SELF to ‘*get rid*’ of what “cannot be tolerated by the containing part of the self in the individual who has become immersed in, and habituated to a cycle of gratified pleasure and painful psychic content” (Weegmann and Cohen 2008, p.10). The ADDICTION CONTAINER then, irrespective of whether it takes them to “***an up and exciting place***” or a “***low and detached place***”, has the power to temporarily deceive the contained person into believing that they are located in a better place than they otherwise would have been had they remained located in their BODILY CONTAINER OF THE SELF. Thus, the ADDICTION CONTAINER can be conceptualised as PERSON with a MIND of its own. This notion is particularly interesting in relation to CMT because there is a switch in the

order of the metaphor and instead of the frequently used metaphor: THE MIND IS A CONTAINER (Bereiter 2005), the CONTAINER gets repositioned as the target domain (THE ADDICTION CONTAINER IS A MIND), and the MIND becomes the source from which we draw the metaphoric expression to try to understand the target domain (THE ADDICTION CONTAINER). This *switch* takes place because whilst a CONTAINER is something considerably more concrete than the MIND, when we are referring to the ADDICTION CONTAINER it becomes far more abstract than the MIND. The idea that THE ADDICTION CONTAINER IS A MIND is coherent given that the mind has an ability to make us believe that we are either in a *good*, (UP), or *bad*, (DOWN), place regardless of where we are located physically in reality. For example, if someone is suffering from depression they are likely to refer to themselves as being in a ‘bad place’ even when physically located somewhere very pleasant. Therefore, just as the mind has an ability to take us to a particular place, so too does the addiction container; thus forming the conceptual metaphor THE ADDICTION CONTAINER IS A MIND. Furthermore, what is interesting is that in the former example the ADDICTION CONTAINER is conceptualised in positive terms, ‘*up*’ signifying something *good* and *happy* (GOOD IS UP / HAPPY IS UP). The use of the orientational metaphor GOOD IS UP is complex conceptually in this specific instance because, according to Lakoff and Johnson, it is “based on physiological well-being, signalled by an upward posture” (Semino and Demijén 2016, p.125). However, this does not cohere entirely in the context of addiction as essentially the ADDICTION CONTAINER signifies physiological distress rather than wellbeing; this is because irrespective of whether the chosen drug takes the individual to an ‘up’ and ‘exciting’ place (GOOD IS UP) or a ‘low’ and ‘detached’ place (BAD IS DOWN), once the drug begins to wear off they will return to the *reality* of the ADDICTION CONTAINER and will be located spatially deeper still within it. Therefore, addiction can temporarily be conceptualised as offering an escape from negative containment, e.g. the lifelong effects of childhood trauma: “*it still takes you away from what you might need to escape from*”, that is until it becomes a

container that is far worse than the original BODILY CONTAINER, namely the ADDICTION CONTAINER.

4.2.3 Participant ‘PC’- Senior Consultant in Addiction Psychiatry:

Unlike ‘RN’ and ‘CP’, ‘PC’ does not illustrate how he personally conceptualises experiencing addiction but instead offers an account of how he thinks others in the medical realm perceive those with substance use problems: “...**there is a degree of stigma attached** (.) but that again varies from country to country or even within the same country...**whether you walk into the priory or whether you walk into your GP in the middle of say Birmingham...**it is a stigmatising condition and again that varies by the substance taken by the person...**a drinker does not carry the same amount of stigma as an injecting heroin user...**it also depends on the exposure that the professional has had...**a junior doctor who has never seen an injecting heroin addict might think you know that he’s bad or terrible or dangerous...**” (PC)

The former part of the above utterance: “*there is a degree of stigma attached*” is significant conceptually because it turns ADDICTION into an OBJECT and subsequently something which the addicted individual carries around with them on their ADDICTION PATH. Interestingly, most people learn as toddlers that they can “exercise total control over objects because objects do not resist influence” (Landau 2016, p.147). This helps to explain why ‘PC’ conceptualises ADDICTION as an OBJECT that public stigma *attaches* itself to because people who suffer from addiction are often punished and viewed as having a “compulsive behaviour over which the addicted person has no control” (Schram 2000, p.68); the idea that they have no control implies that they need to be controlled by an external agent. The notion of stigma attachment, relative to addiction, also involves *self-stigmatisation* whereby the “mythological stereotypes that feature in public stigmatisation of addiction” (Avery and Avery 2019, p.13) influence how the addicted individual conceptualises themselves and their illness through a process

referred to as *stigma consciousness* (Avery and Avery 2019, p.13). Publicly generated mythology around addiction which engenders extensive stigmatisation toward addicted individuals is in fact “perniciously at odds with the reality for those it purports to describe” (Avery and Avery 2019, p.14). This suggests that the public’s misunderstanding of addiction is centred on the idea that they have come to be in the state of addiction because of some sort of hedonistic pleasure-seeking that is out of control. Furthermore, ‘PC’ states that stigmatisation will depend on location and whether: “***you walk into the priory or whether you walk into your GP in the middle of say Birmingham***”. This claim implies that stigma in a medical setting is sometimes determined by geographic location. It is important to note that stigma in a clinical setting, where there is often a power imbalance, can be particularly detrimental as it can cause the addicted person to feel that they are not in a position to question their exposure to an imposed stereotype. It is circumstances such as these that, even when the affected person has been able to resist the publicly enforced stereotype, lead to one adopting behaviours that could obstruct their recovery in an attempt to protect themselves from those maintaining the mythological stereotype of an addict.

The conceptual mapping: “***a drinker does not carry the same amount of stigma as an injecting heroin user***” illustrates the mapping of elements from one conceptual domain with elements of another conceptual domain. Here we can see how ‘PC’ has mapped the ‘*DRINKER*’ onto the ‘*INJECTING HEROIN USER*’ through a process of comparison to offer a clearer account of the group of individuals who are stigmatised the most in relation to addiction (injecting heroin users). This begs the question: “*Why is the injecting heroin user more stigmatised than users of other substances and why is there a specific focus on how the drug is administered (intravenously)?*”. Heroin is thought to attract the most stigma, more so than a myriad of other substances, because of its association with “the most negative stereotypical image, often represented by the term ‘junkie’” (Valentine 2017, p.76). Interestingly, there is a hierarchy

even among illicit substances themselves, heroin being at the “bottom of the hierarchy of shame” (Valentine 2017, p.76) because of its user’s supposed lifestyle as being that of “dirty, filthy and seedy” (Valentine 2017, p.76), hence the frequent conceptualisation HEROIN IS DIRTY. This is significant conceptually in comparison to a user of cocaine; unlike heroin users, these users are conventionally thought to be ‘well-off’ individuals and therefore their drug of choice is conceptualised as ‘*clean*’ (COCAINE IS CLEAN), even when in reality it can be just as dangerous as heroin. This helps to explain why he perceives how a junior doctor might conceptualise an injecting heroin addict as: “*bad or terrible or dangerous*”. Moreover, there is further stigma attached to intravenous heroin use in comparison to smoking it: “smoking it somehow seems less desperate than injecting it into any vein that you can find...” (Mother E, cited in Valentine 2017, p.76). Again, this is significant conceptually especially in relation to the addict’s body as it suggests that because intravenous heroin use is more easily visualised, by the marks left on the body from the injection of drugs, it works more successfully to highlight the metaphorical links between physical bodily damage (Huggins 2012, p.172). Furthermore, even though restrictions on smoking are increasing rapidly, “cigarettes are still highly socially acceptable” (Green and Kagel 1996, p.216); this raises questions around whether the widespread acceptability of smoking has played a role in intravenous heroin use being more heavily stigmatised by both medical professionals and the general public.

4.3 Phase 3: Recovery from Addiction

This section will illustrate the different conceptualisations that professionals have relevant to recovery from addiction. For ‘RN’ whether a person is able to get out of the addiction container and embark on their recovery journey depends on the support which they receive. She believes that an individual who was once conceptualised as a victim of the addiction container can be reconceptualised as a survivor and return to their life journey provided that they reach the *final destination* (sustained abstinence) on their recovery journey. In contrast, ‘CP’ conceptualises recovery in terms of a safe container which both the client, and person who is helping them to get out of their bodily addiction container, can become immersed in. For ‘CP’, RECOVERY IS AN INTERNAL JOURNEY and one must first bring a ‘desire’ to the safe container to do whatever it takes if they are to embark on their transformative inner journey to recovery (RECOVERY IS TRANSFORMATIVE). Whether a person is able to get out of the state of addiction, and remain out of it, is, for ‘CP’, largely dependent on their ability to learn emotional resilience and intelligence in order to resist the force of the mind of their addiction bodily container. Finally, ‘PC’s’ utterances demonstrate how obstacles (interventions) work to restrict movement forward on the addiction path giving those who choose to enter them the opportunity to join a more optimistic recovery path. However, for ‘PC’ the recovery path is one which is lifelong whereby the previously addicted person is never fully recovered. I will now examine how these conceptual metaphors are used more closely.

4.3.1 Participant 'RN'- Research Nurse:

“...I guess **it’s possible that people can get themselves out of** [the state of addiction] **but I can’t imagine how they would achieve that...**I haven’t really got any examples of people...that actually have **been able to get themselves out of it** (2) like sports personalities...can use exercise...to refocus and bring their mood up...**but I think it’s something that they need support with to be able to move on from**” (RN)

The path to recovery is often conceptualised as an individual one, but one that is “rarely done alone or in isolation for the rest of someone’s life” (Roth and Best 2013, p.96). Therefore, it is not surprising that ‘RN’ “*can’t imagine*” how someone would be able to “*get themselves out of*” the ADDICTION CONTAINER without some form of *support*: “*I think it’s something that they need support with to be able to move on from*”. Sherman (2012) goes as far as saying that “if ever there were a contest where support is crucial, this is the winning entry...recovery is not easy. You need help. Help is support. Support is help” (p.27). Conceptually, the notion of *support* in relation to getting out of the ADDICTION CONTAINER and entering recovery is particularly interesting. To say that support is what is needed in order to progress past the state of addiction (“*move on from*”), implies that the individual did not exercise the right degree of control in the first place, hence ending up in the ADDICTION CONTAINER; by saying that it is the thing that is needed, it suggests that it was the thing which was lacking. This raises the question: “*What is support and what role does it play in ‘getting out of’ the addiction container?*” Since the temporal aspect of CONTAINMENT includes the notions of “entering and exiting” (Confalonieri et al 2018, p.104) (just as there is a means of entering the container there must also, simultaneously, be a means of exiting), we can logically deduce that this process is directly linked to the container itself. Thus, it is appropriate to apply the theory of image schemas to this particular extract because it suggests that our “conceptual world is grounded in the perceivable spatio-temporal relationships between objects”

(Confalonieri et al 2018, p.104). Given that the image schema CONTAINMENT easily merges with the image schemas to ENTER and to EXIT leading in this example to the more complex image-schematic concept EXITING THE CONTAINER, we can infer that *support* must relate to an external agent, from outside of the addicted person's substance using network, physically helping the individual EXIT THE ADDICTION CONTAINER and join the RECOVERY JOURNEY through some form of scaffolding internal to the container. We have already explored how the ADDICTION CONTAINER is one which is immensely isolating and therefore it is logical to deduce that *support* refers to the ways in which the addicted person is made to feel free from isolation (free from the ADDICTION CONTAINER). Even those who realise that they have a serious problem often do not believe that they need help to get better; one of the most common reasons for a failed attempt at sobriety is that people try to '*get out of*' addiction alone when, in reality, "getting out of the deadly grip of addiction" (Seaman 2009, p.107) (ADDICTION IS A BEING), often takes the help of numerous people. Therefore, support in this sense refers to those who assist the addicted person in getting out the ADDICTION CONTAINER so that they are in a position spatially to be able to "*move on from*" their addiction and enter recovery in the hope of continuing their LIFE JOURNEY.

In response to the question: "Are there any metaphors...that you find particularly useful?"

'RN' stated: **"In rape they talk about people who are survivors...people say once you're an addict you're always an addict...people talk about addictive personalities...they might give up drinking and then...start gambling instead...with surviving sexual violence it's about...learning that there are new versions of themselves...they're never going to be that person that they were..."**

The idea that "*once you're an addict you're always an addict*" is not necessarily a belief held by 'RN', or all those who have suffered from addiction. However, she acknowledges that it is

a belief held by a considerable number of professionals in the field, particularly those who favour the disease model of addiction. For example, physician director and prior problematic alcohol user Haroutunian claims: “Once addicted, always addicted. We are never ‘recovered’ but always ‘in recovery’. We are never cured; we are always a work in progress” (2013, p.59). From this perspective, the conceptual blend ‘the ADDICTION CONTAINER JOURNEY is eternal’ is activated; however, it suggests that there is another CONTAINER (the RECOVERY CONTAINER) within the ADDICTION CONTAINER which is opened only when the individual embarks on their never-ending journey to recovery. Disease model advocates affirm that “if you are an addict your disease will follow a progressive course (that is, get worse over time)” (Denning et al 2003) and that the disease is incurable: ““Once an addict, always an addict”” (Denning et al 2003). This way of conceptualising addiction can have significant consequences for how the individual located within the ADDICTION CONTAINER conceptualise themselves, their addiction, and in particular their capabilities of attaining recovery. Interestingly, Slate et al (2017) highlight how the term ‘*recovery*’ has no end and is a lifestyle “built around the negative *addict self-image* and focused on fighting the disease of addiction”. They claim that viewing recovery as something which is lifelong can be extremely problematic for the person who is abstinent as it can instigate “fear of relapse and sustain a self-image of fragility that keeps you in self-doubt and fosters permanent victimhood” (Slate et al 2017). Thus, it is no surprise that ‘RN’ maps her embodied knowledge of working with people who are in recovery from sexual violence onto how people might best recover from addiction: “***in rape they talk about people who are survivors***” and “***with surviving sexual violence it’s about...learning that there are new versions of themselves***”. Here we can see a complex conceptual mapping taking place whereby ‘RN’s’ utterance demonstrates a coherent mapping built up not only with “the connections between abstract and concrete concepts” (Setti and Borghi 2018, p.232), but between two abstract concepts (SEXUAL VIOLENCE and ADDICTION). The noun ‘*survivors*’ implies that recovery has a final destination, rather than something which is never-

ending: “being a survivor implies persistence and recovery, despite the abuse that has occurred” (Wiehe 1998, p.2). In other words, the individual who was once a VICTIM of the ADDICTION CONTAINER can eventually return to their LIFE JOURNEY as a SURVIVOR provided that they reach the *final destination* (prolonged abstinence) on their RECOVERY JOURNEY. The idea that there are ‘*new versions of themselves*’ suggests that if they return to their LIFE JOURNEY as a SURVIVOR then they will have a different self-identity than when they were: a.) in the ADDICTION CONTAINER, b.) on their RECOVERY JOURNEY, and c.) prior to ending up in the ADDICTION CONTAINER: “***they’re never going to be that person that they were***”. For example, when located in a.) their self-identity is likely to be that of a *hopeless addict*, whereas when located on b.) they might view themselves as a *hopeful and recovering addict*. This idea of self-discovery aligns with a narrative strategy described by Catherine Emmott as the “split selves” phenomenon, whereby a character or real-life individual is “divided and/ or duplicated in any way” (Emmott, 2002). It is important to note that whilst some people may eventually stop viewing themselves as addicts altogether, many with “true addiction, no matter how long they’ve been clean, forever see themselves as addicts” (Boyd and Metcalf 2012). It is therefore impossible for these individuals to progress any further than the RECOVERY JOURNEY. From this perspective addiction is something which is conceptualised as lifelong whereby the individual continues their journey in a permanent state of victimhood (ADDICTS ARE VICTIMS). Whether or not an individual develops “out of addiction” (McGee 2018) and leaves their susceptibility to addiction in the past is thought to be heavily reliant on whether the person is vulnerable: “In vulnerable people addictive substances and behaviours permanently turn on genes associated with craving and loss of control. This is why for some, once you have addiction, you have addiction forever” (McGee 2018). This idea sheds light on ‘RN’s’ claim as to why people “***talk about addictive personalities...they might give up drinking and then you know start gambling instead***”. Unfortunately, it is these individuals who are forced to continue their journey inside the ADDICTION CONTAINER as they are unable

to join the RECOVERY JOURNEY and consequently are not in a position spatially to return to their LIFE JOURNEY.

The importance of constructing a new and positive non-addict identity when getting out of the ADDICTION CONTAINER becomes ever more apparent when she states: **“It’s one step at a time...giving themselves time to move forward...it’s accepting that you’ve got to let go of the past and move forward...theories of grief and loss tied in a lot when they talk about moving on from sexual violence** so I don’t know if that’s something that’s informed talk about **healing from addiction”** (RN)

Since a fundamental part of the recovery process from substance misuse is an individual’s “ability to construct a non-addict identity for him- or herself” (Loseke 2012, p.163), it is imperative that we gain a better understanding of how this is achieved. ‘RN’s’ utterance: ***“it’s accepting that you’ve got to let go of the past and move forward”*** (THE PAST IS AN OBJECT), reinforces the importance of the affected individual leaving their addict self-identity of being that of a VICTIM (ADDICTS ARE VICTIMS) in the past. On the surface this could appear somewhat harsh and unsympathetic given that the individual has suffered so immensely at the hands of addiction. However, some addiction professionals have expressed strong concerns regarding the possible negative effects on clients of adopting such a label. They argue that it “encourages clients to think of themselves (and encourages others to think of them) as being only their disorder or their disease and thus increases their exposure to the negative effects of stigma still associated with these labels” (Evans and Sullivan 1995, p.102). Nevertheless, conceptualising the person who is substance dependent as a VICTIM, whilst they are located within the ADDICTION CONTAINER, can be considered to work toward a more compassionate and supportive conceptualisation of addicts, as it shifts the blame away from the addicted person and toward an external factor. However, by transferring this VICTIM self-identity onto

their RECOVERY JOURNEY and progressively onto the individual's LIFE JOURNEY, the connotations of the term *victim* change; it no longer promotes a more positive conceptualisation of the individual as someone who is suffering, rather than a wrongdoer, but instead promotes a "negative self-identity, one that overemphasises limitations and ignores strengths" (Evans and Sullivan 1995, p.102). Thus, it can be extremely difficult for the individual to let go of their VICTIM identity as addicts "drink, gamble, and drug away the most precious things life has to offer while in their disease and then need to come to terms with all the destruction" (Rogers 2011, p.2). Therefore, "much of recovery is about dealing with loss" (Rogers 2011, p.2) and this helps to explain why it is so important to take "*one step at a time*" and give themselves "*time to move forward*". Furthermore, 'RN's' statement that "*theories of grief and loss tied in a lot when they talk about moving on from sexual violence*" is important given that victims of sexual abuse are known to "grieve for their lost innocence" (Rogers 2011, p.16). This highlights that grief isn't exclusively about the death of a loved one, but instead great sorrow over loss, and how much sorrow we feel will depend on how important something or someone is to us. The notion of grief is particularly relevant in the context of substance misuse since one of its "favourite ways to show itself is through addictions" (Rogers 2011, p.16). Addiction initially allows us to escape all of our problems, or so we think, that is until it becomes the problem and reason for both grief and loss: "substance abuse causes grief, loss, or both...many addicts witness the end of important relationships in their lives as a result of their behaviour or loved one's response to their behaviour" (Fisher and Roget 2009, p.431). Thus, unsurprisingly, 'RN' maps grief and loss from her embodied knowledge of sexual violence as concepts that might inform talk about "*healing from addiction*". It is essential that we acknowledge that in some circumstances letting go of one's addict self-identity can trigger feelings of grief and loss as often those who are in recovery from addiction have to cease relationships with people, places, and behaviour that have played a part in their substance misuse; this can lead to further feelings of isolation

even when they are no longer situated within the ADDICTION CONTAINER. This being said, it is crucial that there are substantive supportive systems in place to help support, encourage, and guide individuals entering recovery.

In response to my concluding remark: "...when someone is in that state of mind as well it's hard for them to know where to look for help", 'RN' stated: "...**they just can't see a different self** so when they are offered help they may not...see that as something that is achievable...**they can't envisage another way of being**"

'RN's' response in the above extract indicates that whether or not a person will progress out of the ADDICTION CONTAINER, onto the RECOVERY JOURNEY and ultimately return to their LIFE JOURNEY, will depend heavily on their self-esteem and ability to imagine a different way of being. The idea that they "***just can't see a different self***" suggests that they are blinded by the walls of the ADDICTION CONTAINER, which is logical given the nature of a container as something which confines visibility to only what is within it. Thus, because of blocked visibility it can make believing that recovery is something which is achievable extremely difficult. If we draw on the conceptual metaphor SEEING IS BELIEVING: ("*seeing is understanding/ believing/ thinking*" (Danesi 2012, p.80)), it becomes apparent that an addict's inability to *see* in turn affects their self-esteem and self-efficacy and subsequently their ability to believe that there are alternative versions of themselves and that change is both possible and achievable. This helps to explain why addicts are often misunderstood as people who are weak and unwilling to change, rather than individuals who are suffering and confused. Therefore, if low self-esteem is the reason for someone turning to self-destructive behaviours like addiction, then "building up an addict's feelings of self-worth is a good way to cement the path to recovery" (Heather and Segal 2017, p.319). How we act toward those who are suffering from addiction plays an all-important role in the process of helping them to see that

change is possible, as a large proportion of addicts believe that it is “impossible to break the cycle and live a happy life without their substance” (Heather and Segal 2017, p.319).

Therefore, it is a vital task for all those who work with addicted clients to help them envisage how real and rewarding recovery is; it must be promoted as something which is a “visible, achievable goal for all” (Roth and Best 2013, p.96).

4.3.2 Participant ‘CP’- Counsellor and Psychotherapist:

“It is always the individual [who is responsible for their recovery]...it’s really helpful...if they can find the right support...most often **it’s about the relationship with the person who is helping them (.) if they can be in a deeply safe and trusting relationship then that’s going to be the biggest support...that’s going to create the safe container to do the work that they need to do”** (CP)

For ‘CP’ whether someone succeeds in *‘getting out of’* their BODILY ADDICTION CONTAINER depends on the individual and the choices that they make: ***“it is always the individual”***.

This being said, it does not mean that the addicted person will not need help and *support* in achieving this. Support for ‘CP’ is conceptualised as the SAFE CONTAINER that is constructed in unification with the client and the person who is helping them to succeed in their recovery:

“it’s about the relationship with the person who is helping them...that’s going to be the biggest support...that’s going to create the safe container...” The question we need to ask

then, is: *“How is the SAFE CONTAINER in which the work is done to help someone reach recovery conceptualised?”* There is no straightforward answer to this question, however, if we think about CONTAINER SPACE and apply it to the SAFE CONTAINER constructed in recovery from addiction we come to understand it as something which “limits and restricts forces within the container” (Howe 2006, p.238). Therefore, the SAFE CONTAINER is limited to the client and person(s) supporting their recovery. This limitation of forces means that the

contained persons, in particular the client, have a relative fixity of location external from the ADDICTION CONTAINER. This relative fixing of location within the container means that “the contained object becomes either accessible or inaccessible to the view of some observer” (Howe 2006, p.238), the *observer* in this instance being the ADDICTION CONTAINER. Thus, the client, when immersed in the SAFE CONTAINER, becomes inaccessible to the MIND of the BODILY ADDICTION CONTAINER. The SAFE CONTAINER confines and protects the client, restricting motion in order to temporarily provide a safe space. Furthermore, the sides of the container work to ‘hide’ those who are located within it from the ADDICTION CONTAINER in order to- “block visual perception” (Howe 2006, p.238) and allow recovery to commence. It is important to mention that effective care and support from addiction requires a safe space whereby “the complexity of our humanity can be present as we move toward healing and recovery” (Comas-Diaz & Weiner 2001, p.7). Therefore, in order for someone to *get out of* the ADDICTION CONTAINER they must first be given the opportunity to enter the SAFE CONTAINER. However, whether a person is able to sustain recovery and return to their original bodily state of a CONTAINER OF THE SELF will depend heavily on their ability to resist the force of the MIND of the ADDICTION CONTAINER when released from the SAFE CONTAINER. The SAFE CONTAINER provides a short-term space in which to build a foundation for long-term recovery, it gives temporary relief from the ADDICTION CONTAINER offering the addicted person “the opportunity to face up to and deal with the relational and behavioural problems that their addiction otherwise leads them to avoid” (Mistral 2016, p.42).

“...[the effectiveness of treatment and therapy] **depends on what the individual brings (.) if they bring an absolute...energy and motivation and a desire to do whatever it takes...the more of that that they’ve got the more likely they will find recovery...**I tailor it to what the client needs rather than just using a one-size-fits-all model because **for some people it might**

not be the right model which could cause them to feel quite frustrated and contained by it...” (CP)

Whether a person is able to *get out of* the ADDICTION CONTAINER and remain out of it, is, for ‘CP’, determined by “*what the individual brings*” to the SAFECONTAINER in order to reach their GOAL (recovery). ‘Brings’ in this sense is something which is internal to the currently addicted person: “*if they bring an absolute...energy and motivation and a desire to do whatever it takes...the more of that that they’ve got the more likely they will find recovery*”. The latter part of the utterance ‘*find recovery*’ generates the conceptual metaphor GOALS ARE DESTINATIONS which acts as an attributing metaphor to the complex, structural metaphor GOALS ARE JOURNEYS / RECOVERY IS A JOURNEY. Interestingly, unlike the research nurse, ‘CP’ conceptualises the JOURNEY to recovery as something which is internal, taking place within the body of the individual, rather than something which the individual externally embarks on. For ‘CP’ RECOVERY IS AN INTERNAL JOURNEY and one must travel within oneself to reach their desired GOAL (recovery). This coheres with the idea that “patients readily accept that it is possible to improve their acute addictive status...the challenge develops when they encounter the necessity for internal change” (Coombs 2001, p.356). This helps to explain why so many people struggle in freeing themselves from the ADDICTION CONTAINER as they perceive themselves as being unable to change from within because of their countless past experiences of “weakness, poor choices and overwhelming circumstances that lead to the conclusion that they cannot help themselves become drug-free” (Coombs 2001, p.356). Furthermore, the fact that ‘CP’ notes that it is imperative that the client brings an absolute ‘*desire*’ to do whatever it takes to find recovery is particularly significant since desire is the “driving force behind self-motivation” (Spitzer 1995) and is what “propels us forward” (Spitzer 1995). Thus, we can assume that desire is the thing responsible for one *moving forward* on their INNER JOURNEY and reaching their GOAL (recovery). Interestingly, Spitzer

(1995) proposes that desire differs from need in that “a *need* is something that is essential for the survival of a living creature...in contrast, *desires* are things we actively want; they might make us happier and more effective, but we will not die without them”. However, in the context of addiction this is not the case; if someone lacks the *desire* to cease their substance misuse their JOURNEY is often cut short (death) and their GOAL (recovery) is not achieved: “toxicomania (alcohol and drug addiction) often leads to an early death” (Weatherill 1999, p.60). This begs the question: “*Do some toxicomaniacs desire death and consequently want to remain in the ADDICTION CONTAINER?*”. Again, the answer is not straightforward because “desire is not necessarily observable and its object is difficult to establish” (Weatherill 1999, p.60). This being said, the answer depends on the subject’s relationship between desire, death and jouissance (pleasure in pain) since drug addiction, more than any other condition, is centred “precisely upon the complex entanglement of life, death and jouissance” (Weatherill 1999, p.60). Moreover, ‘CP’ notes that he tailors sessions with clients to meet their needs rather than utilising features from a specific model of addiction as for some people “*it might not be the right model which could cause them to feel quite frustrated and contained*”. This suggests that structuring sessions around what the facilitator feels is the most accurate model of addiction can cause the model utilised to become the CONTAINER in which the client becomes captured, restricting movement and consequently obstructing one’s INNER JOURNEY to recovery. Thus, “no one model provides a complete understanding of all aspects of alcohol and drug use” (Miller 2013, p.10) and therefore we should urge addiction professionals to focus on establishing rapport with clients, rather than socialising them to any one model, to ensure a trusting relationship is formed whereby they feel supported in making the behavioural changes necessary to enhance their “psychological and emotional growth” (Rosenthal 2010, p.31).

For ‘CP’, “**the key to recovery is learning emotional resilience (.) emotional intelligence...people most often relapse by the way that they feel (.) I feel angry (.) I pick up...or I feel really good about something that’s happened (.) really excited (.) and I always used to pick up on that stuff so I pick up...if somebody wants a stable recovery they have got to learn emotional...intelligence (.) emotional resilience (.) and to become comfortable emotionally with who they are...**”

‘CP’s’ utterance “*the key to recovery is learning emotional resilience (.) emotional intelligence*” indicates that he is conceiving of recovery as something which is INTERIOR to the addicted individual (embodied), and is an ISOLATED STATE that needs to be unlocked. However, it is not something which needs unlocking by those with the “keys to medical knowledge” (Shaughnessy and Barnard 2019), but instead needs to be unlocked by the addicted individual through the process of learning *emotional resilience* and *emotional intelligence* during their INNER JOURNEY to recovery. Nevertheless, the noun ‘*learning*’ suggests that it is not something that takes place in complete isolation, but instead “occurs within a system that is established in relationships” (Smith et al. 2014, p.70). When referring to traditional theories of learning two metaphors come to mind: “the acquisition and the transfer metaphors” (Álvarez-Bermejo et al. 2016, p.365). As humans we are unable to think without using metaphors founded on our embodied experiences or in what we have learnt. Therefore, when a young child starts to explore the world around them they learn through “testing and then predicting the environment” (Álvarez-Bermejo et al. 2016, p.366). After that, those who “promote growth using simplistic metaphor” (Álvarez-Bermejo et al. 2016, p.366) ask the toddler questions so that they can get to grips with new concepts that will later be refined. Thus, using simplified contexts (Kövecses 2015) within the SAFE CONTAINER is a helpful technique for those facing complex scenarios whereby they have no prior skills. Learning ‘*emotional resilience*’ and ‘*intelligence*’ in recovery from addiction can be

understood as a substantial complex scenario whereby the affected individual might not have any prior skills, hence ending up in the state of addiction. It is therefore appropriate, at this stage of an individual's recovery, that the person(s) assisting them in becoming "*comfortable emotionally with who they are*" utilises metaphor in order to aid this transference of knowledge. Interestingly, 'CP' notes that "*people most often relapse by the way that they feel (.) I feel angry (.) I pick up...I feel really good about something that's happened (.) really excited...so I pick up*". The idea that two contrasting emotions can prompt the same behaviour, in this case substance misuse, coheres with Aziz-Zadeh & Gamez-Djokic's (2016, p.276) observation that "emotions such as joy or anger can often activate the same set of brain regions". Thus, metaphor can be considered a powerful rhetorical tool when teaching *emotional intelligence* and *resilience* because it is thought to heavily influence decision making (Landau 2016, p.46) and subsequently has the potential to impact whether the individual acts on their thoughts of substance misuse in response to their feelings.

Furthermore, the use of metaphor, because of its abstract domain, encourages the client to draw upon their own embodied experiences and thus enables the learning process to be relevant to their individualistic recovery journey. Given that people use metaphors to think, and not just 'talk', the process of the addiction professional prompting the client to alter negative source representations should "cue metaphorically associated thoughts, goals, and feelings regarding the decision task and the surrounding situation, which in turn should influence decision making" (Landau 2016, p.276). Although there is no specified route to learning *emotional intelligence* and *resilience*, the above suggests that implementing metaphor is a good place to start. Essentially, *getting out of the ADDICTION CONTAINER* can be understood as a "position, rather than a cure and the 'journey' metaphor being one that can take different directions" (Shaughnessy and Barnard 2019).

4.3.3 Participant 'PC'- Senior Consultant in Addiction Psychiatry:

“...there are possible biological or pharmacological interventions...psychological interventions and social interventions...they might be...taking the substance because of some underlying psychological or a psychiatric issue (.) it could be depression or anxiety and if that’s the case then again pharmacological intervention targeted at the underlying condition will help...whether it’s CBT or motivation enhancement...there are a host of interventions...it is a combination of these therapies that often work...theory doesn’t often translate well into practice...it’s an ongoing journey...addiction is a chronic brain disease so I will say that it is not a course of intervention...its lifelong” (PC)

The preliminary part of the utterance: *“there are possible biological or pharmacological interventions...psychological interventions and social interventions”* is particularly interesting conceptually as the noun *‘interventions’* activates the idea that the already addicted individual is going along a PATH (ADDICTION IS A PATH), when something intervenes (an OBSTACLE). Given the frequent systematic, underlying conceptual mappings of the JOURNEY metaphor from the domain of time onto the spatial domain (“A MOMENT IN TIME IS A LOCATION ALONG A PATH...and CARRYING OUT INTERMEDIATE TASKS IS REMOVAL OF OBSTACLES” (Amin et al. 2017)), we would ordinarily conclude that, in the case of recovery from substance dependency, an OBJECT (the addicted person) moves along a PATH removing OBSTACLES to reach their destination (recovery). However, in this instance there is a conceptual realignment of the OBSTACLE as something positive instead of something negative. In this context, the OBSTACLE works to restrict movement forward on the ADDICTION PATH giving those who choose to enter the OBSTACLE (CONTAINER placed on the ADDICTION PATH), the opportunity to join a new and more hopeful, RECOVERY PATH. Furthermore, the *type* of OBSTACLE (intervention) best suited to the addicted person will vary depending on the reason as to why they have come to be on the ADDICTION PATH: *“it could be depression or anxiety*

and if that's the case then again pharmacological intervention targeted at the underlying condition will help". Thus, if an unsuited OBSTACLE is placed on the addicted person's PATH (an intervention targeting a mistaken underlying condition), then it could cause a switch in how the OBSTACLE is conceptualised and in turn be potentially problematic (PROBLEMS ARE OBSTACLES), restricting one in accessing the RECOVERY PATH. However, the idea that there are a *"host of interventions"* and that *"it is a combination of these therapies that often work"* suggests that often interventions (OBSTACLES) on the addicted person's PATH are positive. This is conceptually unusual given the universal conceptualisation that PROBLEMS ARE OBSTACLES. Nevertheless, in this instance INTERVENTIONS are conceptualised as OBSTACLES that help to stop someone from continuing their LIFE JOURNEY on the ADDICTION PATH, and instead work to redirect them toward a more optimistic RECOVERY PATH. This way of conceptualising recovery from addiction is interesting in terms of the agentive aspect; it is not the addicted person's responsibility as to whether the correct interventions become available, but is instead the professional's responsibility who is helping to guide the addicted person's recovery. This brings the TIME IS SPACE metaphor to the fore because it is a rarefication of choices (whether he/she decides to enter the OBSTACLE), as something which is a physical movement. The noun *'interventions'* suggests a force dynamic whereby something is forcibly acting on a thing. Moreover, 'PC's' claim that *"theory doesn't often translate well into practice"* implies that some interventions (OBSTACLES) only appear on one's PATH if certain variables are at play. For example, the difficult and chaotic life circumstances of those who suffer from addiction often means that they do not have health insurance, and given that "in many countries there may be a cost associated to accessing healthcare" (Prasad 2016, p.10) it can make accessing certain key interventions (OBSTACLES) unachievable to a large number of addicted individuals. Finally, 'PC's' concluding remark that *"addiction is a chronic brain disease so I will say that it is not a course of intervention...its lifelong"* is extremely significant conceptually when considering whether it is possible to get out of the state of

addiction as it suggests that “no time-limited intervention is likely to cure the illness” (Ries et al. 2009, p.362). From this perspective the addicted person is never fully recovered and will continue for the rest of their life to face OBSTACLES (interventions) available to them on their RECOVERY PATH that help decrease, or suppress, their desire to use drugs. This conceptualisation has the potential to suggest that addiction is “deterministic with limited ability for the user to change other than adopt faith in a higher power” (Malhotra and Santosh 2016, p.82). Nevertheless, understanding addiction as a chronic disease which has its origins in “individual vulnerability and which behaves similarly to other chronic disease processes” (Malhotra and Santosh 2016, p.82) has initiated a shift in the approach to, and treatment of addiction. It has assisted us in realising that early intervention, particularly in young users, is of utmost importance: “harm reduction has been found to be a developmentally congruent approach to the primary and secondary prevention of risky behaviour adolescents” (Malhotra and Santosh 2016, p.82).

“...it is partly a person’s own responsibility because without the person’s motivation to recover and without the person wanting recovery there is very little that can be done...then of course...other agencies...can offer services and if the person is motivated enough he can say yes to those interventions...if my next door neighbour is an addict I don’t think it’s my responsibility to enforce myself upon him saying...I can help you (.) if the person knows that these sources of help are there if need be...but some pointers or some nudges at the right point in time in the right direction might help...but yes...the person is responsible for getting better like having any other illness or disorder they have to think it is kind of up to me to take the first step” (PC)

Although from a professional perspective, like that of ‘PC’s’, one might be inclined to “install motivation in a client” (Miller et al. 2011, p.103), what really matters is the client’s own

motivation for change: *“it is partly a person’s own responsibility because without the person’s motivation to recover and without the person wanting recovery there is very little that can be done”*. Nevertheless, ‘PC’s’ use of the adverb ‘*partly*’ suggests that it is not the addicted person’s responsibility entirely and that external agents also have some role to play in making recovery achievable: *“they can offer services and if the person is motivated enough he can say yes to those interventions”*. However, the question we must consider is: *“What happens if the external agent(s) involved in the addicted person’s recovery do not deem certain interventions as ‘appropriate’ or ‘acceptable’ and therefore do not place the correct interventions (OBSTACLES) on their PATH?”*. Given the range and controversial nature of many pharmacological interventions for substance dependency, there exists differences of opinion about some of these treatments throughout the medical sector and even between “staff members within the same service” (Rosenberg et al. 2002, p.6). Acceptance and availability are a function of multiple influences, including: the cost of a drug or intervention, “availability of a prescribing physician, staff member’s knowledge of and experience with a medication or intervention” (Rosenberg et al 2002, p.6). Therefore, whether someone is successful in achieving abstinence will rely heavily on their relationship with the person(s) helping them throughout their recovery. For example, if the service provider has different beliefs to their service user about the acceptability and appropriateness of a particular intervention then they may decide to put a different OBSTACLE (intervention) on their PATH to what their service user would have considered the most advantageous in assisting their recovery. This could potentially cause the INTERVENTION to be reconceptualised as a BARRIER rather than a way of accessing the RECOVERY PATH, highlighting the importance of the individual being given the opportunity to be able to direct their own recovery. ‘PC’s’ use of the hypothetical conceptual mapping, *“if my next door neighbour is an addict I don’t think it’s my responsibility to enforce myself upon him saying...I can help you (.) if the person knows that these sources of help are there if need be”* reinforces that he is conceptualising

recovery as ultimately being the individual's responsibility, provided that they are aware of the interventions available to them. The above utterance illustrates how 'PC' maps the target situation (that it is not always appropriate to suggest that they need help with their addiction) onto the well-learned schema of his neighbour, having a neighbour being something that most of us have an awareness of from our embodied experiences. Thus, 'PC' uses the source (his neighbour) as a "template for reasoning about possible actions to take" (Landau 2016, p.18) (not telling his neighbour that he can help him with his addiction). The idea that 'PC' conceptualises ADDICTION as a PATH and subsequently RECOVERY as a separate PATH is further supported towards the end of the utterance when he states: "*some pointers or some nudges at the right point in time in the right direction might help*". The use of the nouns *pointers* and *nudges* are interesting conceptually in relation to spatial orientation because they suggest that an external agent plays a role in the direction (PATH) that the addicted person takes.

Furthermore, the use of the noun 'nudges' indicates that the external agent is gently pushing the individual down a particular PATH. This conceptualisation is coherent given that the people who are in recovery from addiction are vulnerable and consequently need handling with care. Finally, 'PC's' concluding remark: "*like having any other illness or disorder they have to think it is kind of up to me to take the first step*" further supports his understanding of addiction as a disease since he is suggesting that in the same sense the addict is powerless to be cured from their addiction; they have "100% control over the management of their disease, as does the Diabetic" (Egan 2011, p.170). Moreover, the idea that it is the addicted person's responsibility to '*take the first step*' suggests that they must take ownership of their addictive behaviour and actively seek recovery before an external agent is in the position spatially to be able to direct them along the right PATH.

5. Conclusion

The analysis has demonstrated how professionals' varied conceptualisations of substance misuse are positioned within the diverse models of addiction, which "frame and shape the understanding and handling of the addicted person" (Clark 2011, p.55). For example, constructs of substance dependency, as they transpire from the 'Disorder of Choice Model' (Mercadante 1996; Skog 2000; Heyman 2009); 'Brain Disease Model' (Miller and Chappel 1991; Leshner 1999; Lubman et al. 2004) and 'Behavioural Model' (Darke 2012; Szalavitz 2016; Lewis 2018), have the potential to be disempowering particularly when they emphasise the vulnerabilities rather than strengths and agency of the addicted individual. The JOURNEY metaphor and its related concepts are utilised by professionals throughout the data in both empowering and disempowering ways; working in potentially empowering ways when used to portray substance dependent individuals as having a sense of purpose, degree of control over their illness, and positive self-identity.

The counsellor and psychotherapist's conceptualisation of addiction as something which is determined by negative embodied experiences that are metaphorically represented by the act of pouring PAINT (traumatic embodied experiences) into an empty PAINT POT (the sufferer's body) can be considered particularly empowering. Its success is twofold in that it can be utilised to explain to the client why they have come to be addicted, emphasising that it is a "normal reaction to abnormal events" (Najavits 2017, p.265) rather than some sort of hedonistic practice; it is also advantageous in educating both society and those in the traumatised person's life on how they can help deter the affected person from becoming addicted. In addition to the nature of distressing embodied experiences, the way in which others in the affected individual's life and society in general respond to trauma can either have "a detrimental or ameliorating impact on how the traumatized person experiences the traumatic event" (Carruth 2013, p.6). Traumatic events have the potential to cause severe

disconnections in relationships, sometimes resulting in their complete breakdown. Thus, by those closest to the traumatised person reacting in an empathetic way “offering hope, comfort, a sense of safety, acceptance and compassion” (Carruth 2013, p.7) it could stop someone from turning to addiction altogether. However, if the person has already become addicted it can help them to realise that their reaction is normal, rather than a personal failure. Therefore, ‘CP’s’ conceptualisation of addiction helps to encourage other substance misuse professionals to provide an environment in therapy within which the traumatised individual feels “safe enough to be vulnerable, rebuild connection, and repair damage to his/her sense of self” (Carruth 2013, p.7), a context which is conceptualised by ‘CP’ as the ‘SAFE CONTAINER’. In contrast, ‘PC’s’ conceptualisation of the process of becoming addicted relies heavily on the biopsychosocial model, which understands addiction as being dependent on a combination of biogenetic attributes and psychosocial factors. This conceptualisation provides an integrated and comprehensive model of addiction, inviting a holistic and personalised approach to treatment because of its emphasis on the complicated factors that interact in order for someone to become substance dependent. However, given the nature of the biopsychosocial model being multidimensional it is undoubtedly complex and therefore difficult for those of us who are non-medics to fully comprehend. This being said, perhaps it isn’t the most successful way of explaining the cause of addiction to the affected individual. Nevertheless, I am by no means suggesting that ‘CP’s’ conceptualisation of addiction should replace the biopsychosocial model entirely; I am instead advocating that medical professionals should consider implementing similar methods of describing addiction to substance users and their affected others. When clinicians start to explain addiction in ways that the patient can relate to and comprehend they are subtly forming a trusting relationship whereby the patient is more likely to effectively engage in the recommended treatment or therapy.

The research nurse's understanding of the recovery process as RECOVERY IS A JOURNEY that has a *final destination*, rather than something which is never-ending, emphasises how individuals who were once VICTIMS of the ADDICTION CONTAINER can eventually return to their LIFE JOURNEY as a SURVIVOR. This conceptualisation is extremely empowering as it can be used to help recovering addicts envisage a different sense of self and one which contrasts with the sort of person they were perceived to be while using drugs. This brings Catherine Emmott's idea of 'split selves' to the fore since "splitting is associated in many narratives with moments of crisis or trauma" (Warner 2013, p.95) whereby self-discovery is linked to an individual being "divided and/ or duplicated in any way" (Emmott 2002). In this instance the latter is applicable given that the individual who was once a VICTIM is later duplicated as a SURVIVOR. Identity transformation has been identified as a key component of the recovery process (Rodriguez & Smith 2014). Therefore, constructing non-addict identity narratives with clients by encouraging them to reconceptualise their former substance using sense of self can enhance self-efficacy through validation of a positive, non-using identity, which in turn works to increase motivation for recovery (Johansen et al 2013). In contrast, the counsellor and psychotherapist's conceptualisation of recovery as something which takes place within the body of the individual, RECOVERY IS AN INTERNAL JOURNEY, whereby the addicted person is positioned as a TRAVELLER in charge of their own journey can also be considered empowering since it encourages the client to exercise control over their own illness experience. Addiction causes the sufferer to lose control, and this lack of control results in a feeling of powerlessness whereby the substance dependent individual loses the capacity to influence their own life because of the dominant force that addiction exerts (Straussner and Brown 2002, p.267). Thus, by healthcare professionals prompting clients to reconceptualise their recovery journey as one which they are in control of, it has the potential for the client to experience a sense of ownership and will help the individual regain power over their own life.

The psychiatric consultant's understanding of recovery works to somewhat remove the agentive perspective as it is no longer entirely the moving person's responsibility. From 'PC's' perspective the substance user is on the ADDICTION PATH when something intervenes (an OBSTACLE), and if the individual chooses to *enter* the obstacle then they are given the opportunity to join the RECOVERY PATH. However, for 'PC' the RECOVERY PATH is one which is lifelong, meaning the addicted person is never fully recovered and will continue to require obstacles (interventions) to block them from their drug using behaviour. This conceptualisation has the potential to be harmful when explaining the recovery process to clients, since understanding addiction as a life-long disease means all affected individuals are considered to be either actively using or in recovery which contributes to a permanent state of victimhood. In fact, Carr and Steel (2012, p.109) in their research into the 'Meaning Made from the Cancer Experience' found that those who more strongly endorsed 'survivor' and 'person who has had cancer' identities rather than that of the 'victim' were more actively involved in activities which positively impacted their illness experience. Furthermore, 'survivor' identities correlated with better overall psychological well-being, while 'victim' identities correlated with poor overall well-being. We should therefore urge healthcare professionals to conceptualise the recovery process in ways that generate labels which empower rather than disempower those who are in recovery, pointing them in the right direction to how they can heal from their addiction. Furthermore, constructing positive self-identities will help promote honesty, the notion of sharing with and helping others, a realistic understanding of control, and other prosocial values (Evans and Sullivan 1995, p.209). Through addiction professionals helping the client in successfully creating a new non-victim identity they will be steadily enhancing their self-efficacy which will ultimately benefit them in the future in progressing beyond their recovery / survivor identity. Unfortunately, many addicts suffer "serious victim stance thinking" (Evans and Sullivan 1995, p.209), perhaps reflecting their service providers' conceptualisations of addiction. Thus, how those who work

with people who are in recovery from a substance dependency conceptualise addiction has a lasting effect on how the client understands themselves and their illness. A victim identity, if uninterrupted, is something that can stay with the individual throughout their life, and therefore it is imperative that we encourage those who are in recovery to see themselves as survivors as opposed to victims. While seeing oneself as a survivor and not a victim may appear to be a subtle reconceptualisation in worldview, it is most certainly a “strong and empowering one” (Evans and Sullivan 1995, p.209) for all those who have suffered at the hands of addiction.

Finally, given that the data consisted of three participants, quantitative evaluation was not appropriate for this study as an analysis of the frequency of emergent conceptual metaphors was not necessary in order to achieve its research aims: “as the size of the corpus grows, so does the analytic contribution of quantitative analysis” (Carver & Pikalo 2008, p.107). However, in the future I would like to carry this research forward to a PhD in order to obtain a larger sample and combine qualitative and quantitative approaches. The PhD would build on my MRes study in order to explore the relationships between the different ways in which addiction can be conceptualised and the language people - from sufferers, to family and friends, to the media and healthcare professionals - use as a result. Taking the form of a three part case study, the doctoral project would examine the discourse of addiction as it manifests in relation to: illegal narcotics, prescription medications, and gambling. Although these concepts are related, there are substantial differences in how they are culturally represented in popular media and this contributes to how ‘safe’ they are understood to be and how much stigma those who engage in these practices face. With this being said, these three iterations of addiction would offer me an ideal combination in order to explore key themes that have arisen from this piece of research, including dis/empowerment, legitimacy, blame and responsibility.

The data collection would be structured into two phrases:

- 1.) Collection of key government refined documents, including recent parliamentary reports centred around illegal narcotics, prescription medications and gambling
- 2.) An anonymous online survey targeted at those who have direct experiences of at least one of the three above mentioned addictions

Phase one would assist me in acquiring a sense of official attitudes towards these three prevalent addictions and to what extent, if any, they are treated as a 'problem'. This phase of the data collection would enable me to uncover how they are conceptualised from a government perspective. Based on the conceptualisations evident in phase one of the data collection, I would generate an anonymous online survey targeted at people who have direct experiences of one of these three addictions. The survey would take the form of a comparative questionnaire which will look at popular media representations of all three types of addictions and participants responses to these representations. Furthermore, I would specifically target these individuals as they are a high impact group whose voices often go unheard. Given that I have been fortunate enough to work alongside Professor David Best over the past two years as part of a multi-disciplinary team for the consultancy 'ACT Recovery', I have worked closely with leading addiction support services such as GambleAware. The trusting relationships that I have formed through these networks means that I would be in a position to target these individuals directly.

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Appendix A

Transcript with Research Nurse referred to as 'RN'

Me: So the first question that I have for you is what causes someone to become addicted?

RN: Erm (3) I think that there's probably more than one cause and erm (2) I think people find it as an escape from their problems and erm they may not have support elsewhere and (4) I think that (.) I know there's theories about you know addictive erm (3) families where addiction is a pattern through generations (.) I don't know if I believe whether there's a predisposition to addiction or anything like that (.) I think it's about support and lack of support and the struggles that people are faced with

Me: Yes (.) another question that's just come to mind as you were giving your response is do you think that the substance chosen reflects the individual's struggle? Because obviously opiates can create kind of a complete block out whereas ecstasy is thought to be more of a party drug

RN: It's not something that I've really considered before (2) I mean like you get people which use like you know uppers when they go to parties and things like that (.) erm and you get people that use alcohol (2) so I'm not really sure whether it reflects what they are struggling with mentally

Me: That's fine thank you (.) erm (.) what does the term addiction mean to you?

RN: Erm (.) that someone needs something and they feel like they can't manage without and erm it's not something that they can just snap out of (.) and it's a (.) it's an illness (.) despite how it's perceived in society as being something that people can control I think that people need help to control it and need sustained help to control it

Me: Yes (.) do you think that when someone suffers from addiction without that support they will always be addicted? Or do you think that sometimes people recover from addiction independently?

RN: I guess it's possible that people can get themselves out of it but I can't imagine how they would achieve that (.) erm I haven't really got any examples of people or you know well known personalities that I know that actually have erm been able to get themselves out of it (2) like sports personalities you know can use exercise and things like that to refocus and bring their mood up and things can't they but erm (.) no but I think it's something that they need support with to be able to move on from

Me: Thank you (.) so the next question is: Do you think that you have to be a certain type of person to become addicted? I know that you touched on this in your response to the first question about the genetic theory and that you don't think that's necessarily the case

RN: Yes (.) I don't know what evidence they have to try and erm support that but erm (.) I think that anyone can be addicted to things (.) it's like sexual violence you know anyone can be subjected to that and people might have these stereotypes of you know certain kinds of people that you know that have problems with substances but erm no I think that you know any age (.) erm background yeah

Me: Do you think that there's more stigma attached to addiction in relation to substance dependency than say gambling for instance or alcohol?

RN: Erm (4) I don't know if there's like more (.) it's like more well-known and it's more talked about whereas like gambling addictions I can imagine that they're quite prevalent but they're just not talked about in the same way (.) I've not got anything to go on but that's just my opinion (.) I haven't got any evidence (.) but often different forms of things are as prevalent as each other it's just that the media or you know they are talked about more and people have more ideas so probably there is more stigma attached to substance use

Me: I guess as well with gambling it's advertised on TV constantly so it's almost kind of more normalised

RN: Yeah I don't watch much television but erm (2) but yes (.) it probably is yeah

Me: Yes (.) so the next question I have is who is responsible for someone becoming addicted?

RN: Erm (2) well I think that we're all responsible for our own actions erm but I think as a society we are all responsible for the wellbeing of our fellow peoples' (.) erm and so there should be funding available to support and (.) erm (.) like people who are coming out of prison and what have you don't have the (.) though they are offered support but they can't see a way out so you know they find it difficult to sustain that when they (.) you know if they have like a programme in prison then come out they can find it difficult to sustain that because of the challenges that they're faced with you know in life after prison for example (.) erm (3) so yeah but I think that we as individuals are responsible but I think that there's lots of factors that lead people to become erm substance misusers in the first place

Me: Yes (.) and the second part of that question is whose responsibility is an individual's recovery?

RN: Ok (.) erm (.) so yeah I think that you know society generally has a (.) erm (.) should help people erm you know because I'm a mum and I've got a child and you know him being a potential substance misuser in the future is one of my you know greatest fears because I've heard other people talk about the problems that they've had (.) or their families had (.) and you know of people trying to support other people (.) and erm (.) actually yeah my aunty two of her sons were erm (.) alcohol and substance users and that broke down their whole family and (3) so (.) yeah I mean there are organisations out there trying to do things but you know they're not funded and there's not enough out there so you know I don't know if there's any countries that do things better (.) like Sweden and some of the Scandinavian countries do other things better in terms of you know the area that I've worked in sexual violence so it would be nice to think that we will improve our response which at the moment is obviously lacking

Me: Thank you that was really interesting (.) drawing on areas that you've worked in (.) what treatment and therapy do you think works best and what interventions are most effective for people who are in recovery from addiction?

RN: I work as a research nurse (.) but we erm ask patients if they have any problems with erm substance or alcohol misuse but the clinical trial company ask us to ask that just because it's something which they think will impact on their ability to come for their visits if they're trialling a new medicine for example (.) so talking therapies are always good but you know

that's probably got its place in a line of other approaches (.) I don't know what the current approaches are out there for erm substance misuse (2) but anything that promotes wellbeing (.) relaxation (.) but there's a lot of whole physical experiences that they have when they're withdrawing so

Me: Do you think that professionals primary focus should be on the physical side of addiction or the psychological side of addiction and the emotion attached to substance dependency and recovery from addiction?

RN: In my nurse training we've been taught to nurse a person as a whole so it's not just the physical it's the psychological (.) so you know they go hand in hand (.) if I am nursing someone and I have nursed people with erm mental health problems (.) like swallowing batteries swallowing razors and things like that (.) but I haven't worked on the ward (.) and there's certain wards on the hospital that I work at where you know erm where they care for people who have substance use problems (.) but erm historically we know that there's not enough focus on the psychological and there's a tendency to just focus on the physical aspects rather than the psychological

Me: Yes (.) definitely (.) so the next question is: Do you think that how addiction is socially constructed impacts on how the individual thinks about themselves and their addiction?

RN: Yes (.) definitely because the messages that are sent out then filter down into different levels in society (.) so like when a woman's raped there's messages out there that the women are to blame for the behaviour of the attacker and all that kind of thing so (.) in the same way it wouldn't be any different for someone who is suffering from substance misuse so you know they're undervalued and not prioritised and not given support or given a chance

Me: Exactly yes (.) how do you think members of the public understand addiction? And do you have any professional instances where an individual has faced discrimination because of their substance dependency?

RN: Well when I worked at an urgent care centre erm there was a lady who appeared to be drunk in the waiting area erm and it turned out that someone decided to actually test her blood sugar and it turned out that she was actually having a hypo so (.) but they just assumed that she was drunk and they should have known better because they are a trained medical professional and they know the symptoms you know are very similar (.) but they still made that assumption (2) every day I encounter discrimination towards people with depression (.) so I work in long term chronic conditions (.) I work with patients that have long term chronic conditions and that impacts on their abilities to erm (2) feel well emotionally and so they have a lot of depression and low mood and things and you know the consultants that I work with sometimes you know you're reminding them that they can't just you know (.) be positive and erm get on with it (.) and that yes there may be people that are worse off than them but for them it is very difficult to think differently because you know of their world that they're in and the things that they're dealing with and so there is discrimination all the time and erm these are caring individuals you know but you're reminding them that it's very difficult for them to do that because they are in a different mind-set and they're depressed you know

Me: Yes (.) that's a really interesting point that you make (.) do you think that consultants and GP's (.) because they don't necessarily specialise in addiction (.) obviously GP is a general practitioner (.) have less of an ability to perceive sympathetically?

RN: Well yeah because like when I have worked in a community health centre and I was erm quite surprised at the lack of training that GP's had around mental health (.) and erm you know all the GP's that I know work really hard and work really long hours you know it's a very demanding job there's a lot of suicides and all that kind of thing from GP's sadly (.) but erm but yeah I was surprised about the lack of understanding amongst some of the erm medical professionals around mental health and erm (.) not only in relation to addiction (.) but I've noticed that in relation to sexual violence and also other areas as well so (2) that's just reminded me yeah erm so (.) when I worked at the health centre there was a substance (.) a lady who had substance misuse problems (.) and erm (.) see I was doing it I was calling her a substance user but she's a person she's a woman she's a mother (.) she's struggling to keep her family you know (.) so I'm just as bad! But yes this lady who's a mother erm and is struggling to keep her children because they've been taken away from her before and she's got them back now (.) erm and the social services visit her and she comes for her dressing changes erm (2) yeah and I remember her she would like sit in the car and sometimes she would come to her appointment and have her dressings changed and sometimes she would sit in the car and just not feel able to come into the building and have her dressings changed and (2) and then sometimes she would come in (2) and erm (2) I mean it was new to me (.) I was learning about her dressings but I also hadn't nursed anyone who had those problems before and (.) the nurses that I worked with were saying that they had to learn to distance themselves from her because she became quite manipulative and so I think they were kind of saying you have to be careful because she will manipulate you and things like that (.) and I just thought you know you'd have to be careful to not become as hardened as they had (.) I guess it was their coping mechanism I'm not really sure but erm (.) and then you're thinking they need supervision for them you know (.) but I think that's one answer is for supervision for people working with and you know caring for people who are substance misusers

Me: Yes (.) I agree (.) the final thing I'd like to ask you is are there any metaphors that you've come across in your career working with vulnerable people that you find particularly useful?

RN: Well I don't know what metaphors people who have experienced these things find useful (.) in rape they talk about people who are survivors and some women or men like that erm and some don't (.) and in cancer care they talk about it being a journey and again there's some discussions around you know is that helpful? Erm so I don't really know what metaphors are used in substance misuse erm (3) because like if you've been raped (.) you might not always see yourself as always a survivor but with the substance misuse problem you might see yourself (.) I mean I'm just going on what I've seen on American films and things like people say once you're an addict you're always an addict (.) I'm not sure if that's true or if that's a belief that's held or not (.) erm but that's a stigmatising label in itself isn't it so (.) I don't whether people see themselves you know (.) as once you're an addict you're always an addict (.) people talk about addictive personalities so you know they might give up drinking and then you know start gambling instead you know that kind of thing (.) but I don't know I'm not sure how helpful it is to erm label people in those kind of terms (2) like with surviving sexual violence it's about I think the thing that people find (.) some people find helpful is learning that there are new versions of themselves and so you know they're never going to be that person that they were (.) when I did interviews with survivors of rape they talked about loss was a key theme but then they talked about hope for the future and just having a new self-identity and positive things that could come from you know a new self and learning about valuing things and cherishing things in life which they hadn't have done if they hadn't have been what they've been through

Me: And how do you think they construct this new self-identity?

RN: Well I think it's one step at a time and its accepting (.) erm (2) and talking and learning about themselves and giving themselves time to move forward and thinking about what makes them feel better (.) I think it's accepting that you've got to let go of the past and move forward (.) because it's like with any you know grief cycle you've got to do that haven't you to leave things behind so (.) maybe theories of grief and loss tied in a lot when they talk about moving on from sexual violence so I don't know if that's something that's informed talk about healing from addiction (2) that just reminded me (.) one of my colleagues when we recently started working on this trial we asked the patients do you have any problems with drugs or alcohol misuse (.) erm well they call it substance misuse (.)and she was recounting a story to us (.) a couple of us nurses about this person who came in for the trial screening appointment and erm answered yes (.) and (2) she was like ok (.) and then she (.) I don't know why but she thought he was joking and then the person whose partner was in the room with him said yeah we both are (2) and she was like oh right ok (.) and then she told us this and I thought well why would you think they're joking (.)and erm when I ask the question I always say do you mind me asking (.) because you know that seventy year old gentleman there I don't know what he's doing and what have you so I don't (.) I try not to make assumptions but as I've reflected on earlier in the interview I've lapsed into bad things (.) erm but yeah it's interesting because she's an experienced nurse erm so why did she think they were joking you know (.) so clearly she wasn't prepared for the positive answer from him that yes he was a substance misuser

Me: That's really interesting (.) the idea that people just don't expect someone to say in fact yes I am or you know I do have a history of substance misuse

RN: Because my aunty had two sons and she lost both of them to erm substance misuse (.) and she went from you know sticking with them and not kicking them out of her house but having them with her (.) to erm then being (.) erm living on the street and then to her losing her home and joining them on the streets and erm (3) yeah so I don't know whether they were just addicted to alcohol or substances as well but erm yeah she lost both of them over time (.) and I don't know whether they were offered help

Me: Yes (.) I think that when someone is in that state of mind as well it's hard for them to know where to look for help (.) it's a question of where do you turn when you're in that situation

RN: And that's (.) well just from watching documentaries and things I've seen on the television you know sometimes they just can't see a different self so when they are offered help they may not necessarily you know see that as something that is achievable and you know erm something that they could accept and benefit from which is really sad (.) they can't envisage another way of being

Me: Yes (.) I think that's very true there definitely needs to be more done to help vulnerable people in constructing a new self-identity (.) thank you for all of your really interesting responses to those questions and taking the time to talk to me (.) I really do appreciate it and it's been great listening to your experiences

Appendix B

Transcript with Counsellor and Psychotherapist referred to as 'CP'

Me: So the first question that I wanted to ask you is (.) what causes someone to become addicted?

CP: Erm (.) I feel that there's no simple one answer to this question and I feel that it's multifaceted and can have a real complexity (.) having said that I think sometimes it can just be one obvious you know in your face reason too (.) erm (.) but the metaphor I like to use when I talk about this with clients is if you can imagine lots of different pots of different coloured paints and if you imagine an empty pot of paint for an individual person so some of these different pots of different coloured paints might be stuff like childhood trauma (.) abandonment issues (.) it might be mum and dad separating or splitting up and the trauma of that for a child (.) erm it might be that mum was violent or dad was violent (.) so you know I think that there can be lots of different reasons why people grow up in an unsafe and unstable environment (.) and I think that this is quite often a determinant of whether people might go on to have an addiction (2) erm but of course there can be other reasons too like peer pressure (.) which is more of a here and now of an issue (.) erm so if you imagine lots of different coloured pots of paint so an individual might think to themselves well that brown colour over there which for example might be childhood sexual abuse that happened to me and I really feel the impact of that so I'm going to put a lot of that colour in (.) and then they might think something like erm (.) well actually financial anxiety growing up well mum and dad weren't well off they were always worried about money I couldn't have what I wanted so there was a sense of this anxious environment (.) financially anxious environment (2) or someone might think actually mum and dad were quite well off so I'm not going to put any of that colour in (.) and if you went through all the different coloured pots of paint and put in accordingly what should go in what shouldn't go in how much should go in how much shouldn't go in then a person would end up with lots of different colours and if you mix it all together there would be a uniqueness to the reason as to why they (.) have come to be the addict

Me: Yes (.) that's a really fascinating way of thinking about what causes someone to become addicted (.) thank you (.) erm the next question I've got is do you have to be a certain type of person to become addicted or can anyone become addicted?

CP: I feel that anybody if they have been in certain conditions (.) so it's either what's happened to them or maybe what hasn't happened to them (.) they might not have felt love by mum and dad (2) it might not necessarily be something that happened to them but instead something that didn't (.) happen to them you know yeah (.) so if they didn't feel nurtured or supported and loved which is really important for a child (.) erm (2) so yeah I'm going off a little here but I feel that anybody who's (2) been in certain environments (2) and has had certain challenges and certain traumas in life I feel that everybody has the propensity to become an addict (2) sometimes it's to more typical addictions whether it's alcoholism or drug addiction (.) for others it might be you know less obvious addictions (.) you know they might clean too much or they might gamble too much (.) or they might over eat (.) and use food as a fix rather than a different kind of a drug (.) so I feel that everybody has the propensity to become an addict

Me: This isn't one of my questions but I'm just curious after listening to your response to that question (.) do you think that the type of drug chosen by the individual whether that be opiates or a different addiction like you were saying drinking or gambling (.) do you think that reflects the reason why they have become an addict? Because obviously opiates create a complete block out (.) whereas a substance like MDMA or a gambling addiction to some extent creates more of an excitement and uplifting feeling (.) do you think that has anything to do with it?

CP: I think that's a really good question Ellie (.) and I feel that whether it's an opiate a depressant kind of drug which kind of blocks out and people use that for escapism (.) but actually the zippier kind of drugs like MDMA or cocaine or whether it's gambling the ones that get more (.) erm (2) adrenaline pumping (.) they still block out (.) because whether you go to an exciting place (.) an up and exciting place (.) or a low and detached place it still takes you away from what you might need to escape from (.) just in a different way

Me: That's really interesting thank you (.) erm the next question is who is responsible for someone becoming addicted? And whose responsibility is an individual's recovery?

CP: I firmly believe that the person who has become addicted has to take responsibility if they want to get well (.) when you meet people who are in denial it's everybody else's fault (.) they don't like to take responsibility and ownership over the choices they've made (.) so it HAS to be them (.) saying that it doesn't mean that treatment shouldn't look at the reasons why they came to be an addict and other people might have played some kind of a part in that (.) and they need to have the feelings about how other people might have played a part in that but still taking responsibility for their own choices as an adult at the same time

Me: That's great thank you (.) and the next part of that question is whose responsibility is an individual's recovery? Do you think that doctor's play a role in a person's recovery? Or counsellors? Or any other professionals who comes into communication with the person who is in recovery from addiction?

CP: It is always the individual (.) and I feel that (.) I mean it's really helpful to the individual if they can find the right support (2) I think that most often it's about the relationship with the person who is helping them (.) if they can be in a deeply safe and trusting relationship (2) then that's going to be the biggest support (.) you know that's going to create the safe container to do the work that they need to do (.) I feel that doctors don't have the time (.) or very often the patience (.) manner (.) or sympathy to build the relationship that the person who is struggling with addiction would need and I think that most often they don't have the knowledge of how to work with addiction either (.) it is a specialist area of work (.) a GP is a general practitioner (.) it is a specialist area of work (.) erm (.) ultimately it's the person's responsibility in how they direct their recovery and who they choose to be a part of their recovery

Me: Yes (.) I see what you mean (.) erm do you think that when someone has been through it themselves that gives the individual who is in recovery the ability to open up because they know that they won't be judged (.) whereas from a doctor's perspective there is a focus very much on the person's body as a physical thing rather than the emotion attached to addiction (2) erm so do you think that when the service provider has experienced it themselves it makes recovery more sustainable because of that open relationship?

CP: I think that when someone has experienced addiction for themselves (.) I think that what can be given back to the client is a deeper level of empathy and that empathic response and that empathic relationship can really deepen and support the relationship (2) however there

are pitfalls too particularly when counsellors (.) therapists (.) support workers in drug services who are really into their own recovery erm sometimes they might overshare (.) sometimes they might share for the wrong reasons (.) so if I share something about my history I have a filter and I'm always checking (.) why am I saying this (.) is a service of the client (.) or am I saying this for me (.) it can take a lot of experience and time to figure that out sometimes

Me: Yes (.) I can imagine it does (.) that's great thank you (.) erm so what treatment and therapy do you find works best broadly speaking?

CP: I often use motivational interviewing (.) but I don't feel that there's any one-size-fits-all modality when working with a client (2) I am an integrationist as a psychotherapist so I will use whatever model whatever erm (.) I feel is most appropriate in that moment with the client (.) I have no allegiance to any one model but instead I am just really responsive to the client in the moment of what I feel that they need (2) so for example I will use motivation interviewing often when clients are in denial (.) or when they are in transition between (.) they might have one foot in denial (.) but one foot into wanting change (.) so I might use motivational interviewing when they are at that kind of point to help them to move into wanting to make active change

Me: How does motivational interviewing work then? What kind of things do you say to the client during motivational interviewing?

CP: MI is quite a broad modality (.) but much of motivational interviewing I feel is to examine the consequences of what happens if you don't change (2) so quite often there's a classic pros and cons list (.) so what are the pros of continuing to use (.) and most often they might say one or two things like (.) well I like the buzz (2) what are the other pros? Well there aren't any (.) ok so tell me about the not so good things about using (.) well it affects my physical health it affects my mental health (.) it affects my relationships with the people that I love (.) and then as a therapist I have an agenda so I want to fatten all that stuff out (.) so I keep feathering out from each one that they are saying so that they can see the weight of the reasons why actually they need to change (.) so yes that would be a classic MI example

Me: Thank you (.) so what do you think the effectiveness of substance use treatment and therapy are? Do you think they are highly effective or?

CP: I think it depends on what the individual brings (.) if they bring an absolute (.) not just a wanting to change because there needs to be more than a wanting (.) but an energy and motivation and a desire to do whatever it takes to find recovery (.) then I feel that's the biggest determinant of whether someone will find recovery or not (.) so it's not necessarily the choice of treatment or therapy (2) erm I can use all my experience and work in the best way that I can but if somebody is not ready for change it's not likely to happen (2) but if somebody comes along incredibly motivated it makes the work so much easier (.) I can work with that (2) I think the more motivation and the more desire of wanting recovery (.) but also the energy and motivation to do whatever it takes (.) the more of that that they've got the more likely they will find recovery (.) I think that there can be an importance to whatever the therapy or treatment is and that's why as an integrationist I tailor it to what the client needs rather than just using a one-size-fits-all model (.) because for some people it might not be the right model which could cause them to feel quite frustrated and contained by it so (2) I think the treatment or the therapy has an importance but it will still always come back to the most important determinant being how much they want it and what they are prepared to give to the process

Me: Do you think that how addiction and substance use are conveyed socially and in the media has an effect on how someone thinks about themselves and their addiction?

CP: I think that depends mainly on where someone is in their stage of recovery (.) if they have found a really secure base in their recovery and have built a self-confidence and a self-assuredness (.) then how addiction is socially conveyed no longer matters (2) but if they're still in early or early-ish recovery and they've not found that self-assuredness then yes they're likely to be impacted by (2) how they think other people view them (.) they might see societal judgement (.) but again if you've found a secure place and a self-assuredness in recovery then you know I guess there becomes an irrelevance to all that kind of stuff (.) I think it depends heavily on where the individual is at in their road to recovery

Me: Before we finish I just wanted to ask you whether there are any other metaphors that you tend to use with clients (.) I know earlier that you mentioned that you often refer to the paint metaphor when people ask why they have become addicted (.) that was really fascinating (.) so I just wondered whether you tend to use any other kind of metaphors with your clients?

CP: I often use box metaphors (.) it's a funny thing I've found that I often use boxy metaphors (2) I very often use metaphors from sport and boxing (2) I can remember going to a treatment centre (.) I think I was probably about seven or eight years into my recovery (.) in Thailand because I was interested in the work that the Buddhist Monks did there so I went over and I emailed the Abbot at the monastery and I said could I come over and spend some time with you and he said yeah come over (.) and so I went over for a couple of weeks and spent some time with these guys and they use metaphor so much (.) erm one of the metaphors I can remember one of the monks using when he was talking to one of the other guys who had gone over there (.) who was very angry he was holding a lot of anger and I always remember one of the monks saying to him it's like the warrior riding his chariot (.) and imagine if you've got seven or eight horses pulling the chariot and if one of those horses goes wild and runs in the wrong direction (.) and you know I think what he is referring to is maybe that was the emotion of anger with this client (.) then it topples the track the chariot (.) then he you know talked about wanting to keep emotions (.) erm (2) and for me you know it's my belief absolutely that the key to recovery is learning emotional resilience (.) emotional intelligence (.) and people most often relapse by the way that they feel (.) I feel angry (.) I pick up (.) I feel afraid (.) I pick up (.) I feel guilty or ashamed (.) I pick up (.) or I feel really good about something that's happened (.) really excited (.) and I always used to pick up on that stuff so I pick up (.) I wasn't talking about me there I'm talking generally (.) so you know I guess what the monk was referring to was something that I hold dear to my work (.) and that is that if somebody wants a stable recovery they have got to learn emotional (.) erm (.) intelligence (.) emotional resilience (.) and to become comfortable emotionally with who they are and that can take some work

Me: That is really inspiring and interesting (.) feel free to not answer this question but from a personal perspective I noticed that on your website you offer counselling for post-traumatic stress as well as recovery from substance use and I know that you openly talk on your site about both of these two things affecting you at some point during your life do you feel that suffering from post-traumatic stress contributed to your substance use?

CP: I'm more than happy to talk about that with you Ellie (.) I think (.) for me (.) well I served in the Gulf war so that is where my interest in PTSD come from (.) but I feel for me personally if we go back to the pots of paint (.) I would probably put a splash in for that but certainly not the big dollop (.) I think that there is something about that but I don't think it is a massive factor (2) I feel that my two biggest pots of paint are (.) abandonment by my father

when I was three and watching him beat my mum up (.) before he went (.) erm I mean I still feel that emotionally now as I say it (.) so you know I know that it's still there (.) and so I would say that is the biggest influence for me (.) and I feel that also growing up with an anxious mother from her experiences of my father being an alcoholic (.) which made her anxious and unavailable (.) so I didn't get my needs met by her

Me: Thank you for talking so openly with me about that (.) I really appreciate you taking the time to talk with me about your own personal experiences as well as your thoughts about what addiction is and what causes people to turn to substance use (.) so yes thank you again it has been really fascinating listening to your responses

Appendix C

Transcript with Senior Consultant in Addiction Psychiatry referred to as 'PC'.

Me: What do you think causes someone to become addicted to a particular substance?

C: I suppose it's a combination of factors that maybe would lead someone to become addicted (.) there's not just one reason (.) it's a combination of biological (.) psychological (.) and social factors and as we know under each of those headings there could be erm biological reasons it could be part genetic there could be some risk that the person is born with (.) it could be something to do with the person's brain in terms of chemical (.) so the way parts of the brain are connected (.) so all of those things come under biological factors and these also include the person's personality (.) coping resources and so on (.) erm social factors such as peer influence (.) availability of the drug or substance (.) accessibility (.) and you know cultural issues things that (.) so broadly speaking biosocial issues are at play and often there is an interaction or interplay of these factors that ultimately determine whether a person gets addicted or not

Me: That's great thank you for that response (.) the next question that I have is what treatment and or therapy do you think works best broadly speaking?

C: I think that current understanding and practice would suggest that erm again the way we look at treatment should be along similar lines (.) there are possible biological or pharmacological interventions (.) or erm psychological interventions and social interventions (.) pharmacological obviously means the use of drugs or medications to either treat the condition itself so if you're looking at the use of either alcohol or drugs there are medications that might reduce the cravings of these substances and it could also in some addicts be that they might be using or taking the substance because of some underlying psychological or a psychiatric issue (.) it could be depression or anxiety and if that's the case then again pharmacological intervention targeted at the underlying condition will help (.) it could come under medications or medical interventions (.) psychological interventions either with the person or erm (.) and again there are many interventions that can be done with the family and the person whether it's CBT or motivation enhancement and things along those lines (.) other social interventions erm such as social behaviour network therapy and again some things fall in between the two interventions such as the twelve step interventions where it's for the addicted person and for families (.) so again there are a host of interventions and I think in practice what we find is often that it is a combination of these therapies that often work (.) it is not just medication alone or therapy alone so where possible and where time and other resources permit and again that varies widely because I worked in the UK for a bit and now I work here in India and often theory doesn't often translate well into practice so if in the UK I saw ten patients a day whereas here if I see one hundred patients a day and I just cannot not offer psychological interventions because we do not have that opportunity you know I don't have the time often and neither does the person have the money to pay for it so theory is one thing and practice is one thing (.) but generally speaking the more interventions that you can offer the more comprehensive a package of care is in terms of what you offer and will work for the patient and family and the psychosocial things that you can change offer sensible interventions whereby it will increase the chances of that person recovering or getting better and it's an ongoing journey (.) it is a chronic condition (.) addiction is a chronic brain disease

so I will say that it is not a course of intervention (.) like it is not fourteen days or twenty-one days or its life long

Me: That is really interesting (.) thank you (.) so the next question that I have for you is how do professionals who frequently come into communication with people who have a substance use problem perceive them and what is the general attitude from medical professionals toward addiction?

PC: Of course there is a degree of stigma attached (.) but that again varies from country to country or even within the same country (.) you know it depends on various factors (.) whether you walk into the priory or whether you walk into your GP in the middle of say Birmingham or you know the city (.) so I think that there are too many variables but I think a few points will be of course it is a stigmatizing condition and again that varies by the substance taken by the person (.) you know a drinker does not carry the same amount of stigma as an injecting heroin user (.) and perception I think among other factors also depends on the exposure that the professional has had (.) so say a junior doctor who has never seen an injecting heroin addict might think you know that he's bad or terrible or dangerous and so on and so fourth (.) but a different GP may have different views (.) erm so I think it depends on the patient and the professionals experience as well as where it is happening

Me: Yes (.) I see (.) you mention GP's in your response to that question which is really interesting (.) do you think that they are trained only to be concerned with the individual's physical health or also their mental health? because as we know addiction is by no means entirely visible

PC: I am not a GP so I can only talk about what I think (.) but I would think that they are more inclined to focus just on the physical side of things (.) because number one they don't have the time because say they are given six or seven minutes per person they will spend three or four minutes with the person and then they will have to fill out all the paperwork which takes time (.) so if you or I were to put ourselves in their shoes in four minutes we can't really get beyond the physical side of things and find out about the person's coping resources or upbringing or personality traits or whether he goes to AA (.) so you know I'm not kind of coming up with excuses for GP's not focusing on the emotional side of things but I think that GP's more often than not solely focus on the physical side of things (.) partly because I think they have to prioritise (.) if I am a GP and I have an injecting user in front of me my first questions would be where is he injecting is it going into his neck or his groin or is it his arm? Is he sharing his needles? Has he had his HIV tested? And so on rather than finding out you know how is his partner doing and how are they coping (.) but yes for all kinds of reasons and also partly because they are training from more medical rather than psychological background (.) so they might not have as much of an awareness training or exposure because not all GP's have to have a psychiatric or similar posting in the specialty so they have never been exposed to injecting substance users so all they are interested in is the medical complications of substance use

Me: Thank you for sharing your thoughts with me on that previous question (.) the next question is does it take a certain type of person to become addicted to a substance?

PC: I think it varies (.) no one knows (.) there is no precise answer to that question because if there was it would make work much easier because if we knew what causes addiction or what might be the possible cause we would also have possible solutions in place so I don't think that there is a specific type or profile of a person who is an addict (.) anyone who has these risks that we talked about earlier in the interview (.) be it biological be it psychological or

social or a combination of those (.) any person who is exposed to those risks or carries those risks and erm if other factors are at play can get addicted (2) so I don't think we can construct a stereotype or you know kind of predict whether a person carries these types of risk factors is more likely to get addicted (.) but I think that the more experience that you have or the older you get working with addicts I think you realise that more and more (.) there are very few things that you can generalise so each person has their own individual characteristics or difficulties (.) and I think that as practitioners for us it's important to kind of acknowledge that and not put these addicts in boxes and not say ok he is such and such a person coming from such and such background so it is more likely that this will work for him (.) so no the implication of that is that more time needs to be spent with addicts to find out how he or she is different and then target your interventions and approaches appropriately to meet those specific needs because not all drinkers you know might be wife beaters and not all addicts might be depressed or have a history of childhood sexual abuse

Me: Yes (.) I agree entirely (.) the next question is who is responsible for someone becoming addicted and whose responsibility is an individual's recovery?

PC: Well I think that whoever's responsibility it is it cannot be changed because it has already happened (.) the person is already addicted (.) so rather than looking at whose responsibility it is I would be more focused on trying to find out what can be done now so the second part of the question might have a bit more practical significance from my point of view as a person who treats addicts (.) I would say that it is partly a person's own responsibility because without the person's motivation to recover and without the person wanting recovery there is very little that can be done (.) so the person has to have that degree of individual responsibility and then of course you know other agencies might have (.) I don't know whether it's a responsibility (.) but a duty of care (.) or just be there in the sense that they can offer services and if the person is motivated enough he can say yes to those interventions or first off help (.) but I don't think it is for example say if my next door neighbour is an addict I don't think it's my responsibility to enforce myself upon him saying you know I can help you (.) if the person knows that these sources of help are there if need be (.) so in that sense I would say erm that it is definitely the person's own responsibility to get better but some pointers or some nudges at the right point in time in the right direction might help (.) but of course seen as it is a public health issue (.) addiction being a public health concern because it is not just the addict that is affected it effects families and society be it crime or employment or you know the other impact that it can have other than the medical issues (.) so from that sense it society has a role to play whether it's responsibility or not the wider society has a role to play in helping the addict and those affected by the addict whether it's the addict's immediate family (.) colleague and so on and so forth so I think that in that sense responsibility is a bit more shared by these other people in the person's network as well (.) but yes I think the person is responsible for getting better like having any other illness or disorder they have to think it is kind of up to me to take the first step

Me: Thank you (.) that leads me onto the final question which is do you think that how addiction is socially defined impacts on how the individual thinks about themselves and their addiction?

PC: I do think that it has a role to play and it could but I don't think that it's the most important thing (.) you know that would depend on the person and how easily they are influenced but yes some people are more suggestible and prone to kind of external influence

Me: That's all my questions (.) thank you for taking your time out to talk to me it has been really interesting for me to listen to your responses and I really do appreciate it so thank you again