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“*All you think about…is being high*” – Phenomenology of Experiences Surrounding Heroin Detoxification

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by

Michelle Therssen Joy

2012

Abstract

"*ALL YOU THINK ABOUT…IS BEING HIGH*" – PHENOMENOLOGY OF EXPERIENCES SURROUNDING HEROIN DETOXIFICATION
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Heroin addiction is a chronic, relapsing disorder often attempted to be addressed through detoxification; nonetheless, it poses a substantial economic and societal burden. There has been little psychiatric research into the lived experience of persons struggling with this addiction. The aim of the present study is to characterize the subjective experience of heroin addiction in patients presenting for inpatient detoxification through methods of phenomenological inquiry. Narrative interviews of twelve participants presenting for detoxification were recorded and thematically analyzed for their meaningfulness to the individuals. The findings indicate that the experience of heroin addiction entails focusing on the present with a diminished ability to think of one's past or future. During characteristic transitional moments, such as within the inpatient detoxification setting, a person is able to expand his temporal perspective. During such times, there is a conflict of self that is experienced as contradiction between a past-embedded drive to use and the potential choice to reduce heroin use in the future. Findings indicate that the ability to move forward toward recovery may be facilitated by maintaining temporal perspective and recapitulating personal narrative – including past and future - in positive terms. This process is supported by the person's ability to connect with something beyond the self that can provide a model narrative framework. Potential sources of extra-personal connection and models of recovery include peer support, empathy, self-disclosure, spirituality, and artistic endeavors. Discussion of their current and potential implementation in detox and other settings is addressed.

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Table of Contents

Introduction
- Background of the Problem 1
- Hypothesis 7
- Specific Aims 7

Methods
- Philosophical Background 8
- Study Design 12

Findings
- Interview and participant characteristics 19
- Details of the Common Experience
  - Desired Feelings 19
  - Focus on the Present 20
  - Living as an "Addict" 23
  - Transitional Moments 26
  - Extrapersonal Connection 30
- The Context of Detoxification 31

Discussion
- The Present 37
- Addiction Without Choice 43
- Fractalated Minds of Transition 44
- Periods of Transition 48
- Language 49
- Moving Forward 51
- Modeling History 53
- Modes of Assisting Recovery 59
- Timing/Placement of Assistance 60
- Peers 62
- Empathy and Self-disclosure 64
- Spirituality 69
- The Art of Music 72
- A Note on Medicine 74
- Why Recover? 77
- Conclusion 79
- Limitations 80

References 81

Introduction

Background of the Problem

Detoxification as a method intended to address opiate addiction has been employed since early emergence and awareness of the abuse problem in the United States in the nineteenth century. Though the methodologies at this time ranged from "going cold turkey" to continual weaning over months – with or without the use of complementary substitutes, sedatives, emetics, and other compounds – removal of opiates from the body was considered to be the definition of *treatment* (1). Though some details of the approaches have changed in the last two-hundred years, detoxification is still widely used in the United States as a tactic for addressing opiate addiction. However, the specter of America's drug problem is far from vanishing. The economic cost of drug abuse is annually reported to be hundreds of billions of dollars and includes such expenditures as healthcare for substance-related complications, loss of productivity, administrative costs, and substance abuse treatment itself (2). In this country, nearly 1.6 million people are said to be dependent on or abuse prescription opiates, while for heroin the number is approximately 323,000 people; approximately 80-85% of these people do not receive treatment (3, 4). The specific economic impact of heroin addiction alone was estimated to be $21.9 billion in 1996 (3). It is important to note, however, that many of these are secondary costs of addiction may also be tied to its legal and societal status (5).

The United States Department of Health and Human Services – through a Federal resource panel – has claimed that detoxification by itself is an inadequate use of monetary resources in attempting to treat addiction (6). It is reported that when patients enter inpatient detoxification, a large majority may be quickly lost to follow-up and relapse to

using, often within days, and many do not even finish the detoxification process (7-9). No matter what the method, rate, duration, setting, or adjunctive medication of detoxification and follow-up treatment, studies indicate that there are high rates of recidivism both to opiates and to detoxification itself (7, 10, 11). Adjunctive treatment with methadone and, more recently, buprenorphine, has provided somewhat more promising treatment outcomes, but medication adherence and illicit drug abstinence remain problematic (12-15). Indeed, relapse is very common in treatment for addiction (16, 17). Furthermore, recidivist patients who use opiates may only enter detoxification treatment in crisis scenarios when they cannot afford to purchase illicit drugs, and alternative treatment options may reduce such costly, repeated inpatient visits (18). Such information underscores the importance of examining patients' experiences in entering, and oftentimes reentering, detoxification centers. There is also a lack of information regarding why some patients enter detoxification without complementary maintenance medication or involvement in follow-up treatment such as group meetings, counseling, or even inpatient rehabilitation programs. In fact, detox has been characterized as a straightforward practical procedure that requires integration into the currently lacking psychological, social, economic, and institutional aspects of follow-up treatment (19).

Current research on psychological pathology tends to focus on signs and symptoms by using tests and experimental formats (20). Overall, most recent studies have failed to address the views or opinions of the very people struggling with opiate and other addictions, and it is important to include such a perspective in order to both understand reasons for recidivism and to improve systems for treating such patients (10, 21-24). White has claimed that the empirical, scientific search for objective truth is somewhat at

odds with the addict's need for passionate, metaphorical understanding (1). However, qualitative methodological approaches have been used for other compulsive behaviors including cigarette smoking and online gaming (24, 25), as well as for other recidivist populations with mental illness (26). Without seeking to understand the perspective of the persons being studied, these individuals are further relegated to the status of passive and helpless – a position that is already underscored by the current status of mental illness, including substance use disorders, within clinical practice (26). Indeed, psychiatric literature and training, as a whole, have largely failed to incorporate the subjective nature of experience along with its objective portrayal of pathology (27, 28). Keane claims that addicted persons have been considered a fringe class of people viewed to be without possession of subjectivity (5).

Of note, however, there have been some inquiries into understanding the lived experience of addiction in fields like sociology and anthropology. For example, Finestone wrote a well-known essay on class and lifestyle characteristics of 1950's opiate users in Chiago (29). Chein completed a study of heroin users in New York City during that time, describing physical, social, psychological, economic, historical, sociological, and cultural factors related to this population (30). There are also a number of personal accounts of heroin addiction, such as *Junky* by Burroughs and *Manchild in the Promised Land* by Brown (31, 32). *Righteous Dopefiend* is a newer anthropological ethnography on San Francisco's homeless heroin-using population (33). Such inquiries nicely complement other work but nonetheless remain somewhat different from the focus of most psychiatric studies.

The scant psychiatric literature that does seem to consider the perspectives of persons with substance use disorders tends to employ retrospective methodologies. These studies primarily look at prior users who have recovered, and the research thus seeks to demonstrate what was most successful in facilitating and maintaining prolonged recovery. Much of this research shows natural courses of recovery and spontaneous remission in people who identified as "ready" and did not use the assistance of conventional treatment modalities (34-37). This literature often describes the processes of change: from motivation to action to maintenance (36, 38). As will be further discussed, the process of abstaining often entails the creation of a new identity that distances one from his or her prior self as an addict (39). In the process, many aspects of the person change such that a retrospective inquiry may be confounded by incorporating the perspective of the new identity. In addition to the general effect of time on altering memory, prior users may seek to distance themselves from their previous identities by reformulating the past in a more generous, harsher, or somehow different light (36). While it is important to understand how people *have recovered*, it is also necessary to understand how people *may recover*. Overall, little psychiatric research exists on recovery, of which there is said to be a "critical need" (40).

A question that thus remains is how to better understand the very struggle of addiction in order to help people who remain within its trenches. While there has been some research into measuring and predicting readiness to quit, particularly regarding tobacco smoking, there has been less literature about how to further such preparation (41-44). Research in motivational interviewing is a prominent exception, as this intervention technique is designed to help people overcome ambivalence regarding behavioral change

through non-authoritarian counseling (45, 46). Studies usually show modest to moderate results in changing some addictive behaviors – though the results vary beyond this range – and clinicians are often without adequate tools with which to encourage change (47-49). Much of this research has focused on alcohol abuse, and there has been a notable lack of evidence that motivational interviewing is as effective for opiate and/or injection drug users (50-52).

In addition, there has been little evidence on how to best transform a person's desire to stop using opiates into concrete action (53). Some authors have shown that such users frequently want to stop in order to change their "life patterns" (23). Nonetheless, the pattern is perceived as just that, a *pattern* and thus repetitive, recurring, and resistant to change by definition. The underlying way in which one interprets sequences of their own behavior influences the future outcome of these behavioral patterns, a concept Baumeister saw exemplified by *crystallization of discontent* in which one interprets negative life features in a way that drives change (54). It is therefore necessary to characterize how the patterns of addiction are experientially lived in order to realize how that experience might be made receptive to change. This necessity does not entail solely approaching recovery from the perspective of the community, but it does call for at least it. Even if not fully embracing each recommendation or desire of study participants, the perspectives are considered in hopes of formulating effective interventions. One may ask: "What does the person struggling with opiate addiction think, feel, and live, and how can such insight translate into effective help?"

Before continuing on, it is important to understand the use of the term *addict* within this text. This is a term that has been constructed historically and culturally to

define problems of conduct embedded within society (5). Within this study, the term does not specifically intend to categorize persons according to the DSM-IV criteria for substance abuse or dependence (55), though it sometimes refers to them. In fact, the DSM-IV has no listing for *addict* or *addiction*. Instead, the term here is intended to indicate the participants' physical and social experiences as "opiate addicts." Opiate addicts, in this sense, are people who regularly use and need licit or illicit opiates and who are socially defined by this need (56). Importantly, these were terms used by the each participant in the study. It has been said that construction of addict identity is a gradual process involving narrative history, social lived experience, neuro-genetics, and a self-labeling process (57).

Hypothesis

This is a narrative research study intended to address the question: *What is the lived experience of heroin addiction in patients presenting for detoxification?* There was not an *a priori* uniting hypothesis to be either proven or disproven. The aim of this initial project was to gather information in order to further characterize the experience and perspective of persons in detoxification treatment for opiate abuse. It is hoped that this study will allow for piloting of further investigations into decreasing use of detoxification services by offering additional options that are desirable and useful to patients.

Specific Aims

This qualitative study gathered information from people who were receiving detoxification for opiate addiction. Psychiatric research has typically approached matters

of opiate detoxification through randomized controlled trials, epidemiological approaches, or cost analyses, but there has been little research conducted that involves the thoughts and perspectives of the patients themselves. The aims of this study included generating a richer description of the subjective experience of using and then detoxifying from opiates and to subsequently apply this understanding to the generation of future interventions. Within this text, the purpose of the study was to examine the lived experience of persons who present to detoxification from opiates. This work differs from most of the existing literature by focusing on participants' perspectives instead of more measurable or "objective" markers of addiction. The broad goal of such work is to reduce ineffective and inefficient treatment approaches for opiate addiction by replacing or supplementing them with newly designed and more effective approaches.

It is also hoped that this study will be useful for clinicians who are involved in the care of patients with abuse of or dependence on opiates. Because the nature of this study is to provide a rich description of the experience of opiate addiction, this work may supply readers with an increased understanding of the life of those persons who may or may not want to change their opiate use behaviors. This study may also have benefits for medical education. A lack of substantial training for physicians in the treatment of substance use disorders has been identified (58, 59). While the current study did not seek to serve as a supplement to education, knowledge garnered during its implementation may be useful for integration into educational curriculums.

Methods

Philosophical Background

This research was framed as a *qualitative study*, which is a general term used to describe certain systematic methodologies characteristically employed in the social science disciplines. Though the specifics of these techniques are vast and varied, one uniting feature is that qualitative research has a focus on the meaning of experiences (20). The methodological basis of a qualitative study is to use inductive logic within a descriptive context and to employ an emerging study design which is continually revised with gained experience (60). Examples of qualitative research paradigms include narrative, grounded theory, ethnographic, case study, and phenomenological research (60). Such research typically aims to investigate phenomena within natural settings (21). The terms "realistic," "deep," and "rich" are often used to describe qualitative research, while "hard," "objective," and "factual" may describe its complement: quantitative research (21). The qualitative approach seeks to gain understanding of perception and interpretation in pursuit of understanding behavior (21). In the study of substance use and abuse, this is an important approach because it can serve to counter stereotypes and myths about addiction (21, 61). In the implementation of such approaches, the researcher becomes the instrument through which data is collected and analyzed (62). While the present study employs qualitative means for its specific purposes, it nonetheless acknowledges that qualitative and quantitative approaches are often complementary to one another, providing different perspectives that can mutually inform one another.

The purpose of this study was to investigate the lived experience of a particular group of persons – those currently in detoxification treatment from opiates. A qualitative research method frequently employed to facilitate understanding the experience of other persons is called *phenomenological research*. Though *phenomenology* is referenced as

far back as the year 1765, the research method is said to have its philosophical roots in the abstract work of German mathematician Edmund Husserl (1859-1938) and later development by French philosopher M. Merleau-Ponty (1908-1961) (60, 63, 64). The method calls for investigation into *lived experience*, or how a person experiences the world prereflectively before categorizing it into labeled signs and symptoms (65). Phenomenology employs subjective, first-hand knowledge as its data in order to understand experience (22). This approach is founded on the assumption that reality has a base in subjectivity and that in order to know truth, the foundation of realities within subjectivity must be accessed (66). Inherent in this approach is the ontological assumption that there are multiple realities (60). A phenomenological approach focuses on commonalities within a group of persons experiencing a certain human phenomenon, using demonstrative quotations and themes (60). The word *phenomenon* has its roots in the Greek *phaenesthai* (to show itself, to appear), giving *phenomenon* a meaning of "the totality of what lies before us in the light of day" (63). It is this focus on seeing the full essence of things that is at the heart of phenomenological inquiry. In the current study, the human phenomenon of interest is opiate addiction within the context of detoxification. Moustakas suggests that a research problem is suited to phenomenological inquiry when it is important to understand complex, shared experiences of a given phenomenon, often in order to develop practices or policies surrounding them, making this a well-suited methodology for the present study (63).

Though not the focus of this work, it is nonetheless important to further discuss some of the philosophical presuppositions of the phenomenological methodology (60, 63), particularly as understanding philosophical approaches to mental health can bring

depth to the field (67). Such conversation is particularly important given concerns that qualitative researchers often limit their work by lack of adequate explanation and justification of their methods (21). At its most basic, the phenomenological approach seeks to describe essences of experiences, rather than explanations or analyses thereof (60). Researchers have described four philosophical characteristics of phenomenological inquiry (60, 68). One such feature is the attempt to suspend judgments about reality while investigating it, which has its basis in the epistemological question of the relationship between researcher and that which is researched. A second claim is that reality of a thing is intimately related to one's consciousness of that thing, such that an additional claim follows: there exists no dichotomy between subject and object. While the philosophical underpinnings of phenomenology are alone worthy of volumes of discussion, this paper seeks only to briefly introduce them in order to provide a structure for understanding the current methodologies employed.

Alternative approaches to generating first person accounts of psychiatric experiences include autobiographical narratives or case studies. Though employing phenomenological inquiry has its own limitations, that will later be discussed, so too do the other potential routes of data generation have their shortcomings. Autobiographical narratives, for example, are limited to a group or class of persons who are able and willing to write personal accounts. This approach may restrict the sample to more intelligent, verbal, or successful persons (69). Similarly, case studies seem to be generated of those persons who might have the resources, stability, desire, and level of functioning to maintain an extended relationship with a clinician (69). Furthermore, they do not incorporate the perspectives of the persons to an appreciable degree.

Phenomenological inquiry, therefore, was selected in part for its ability to be used in a time-limited detox setting garnering first-person accounts of persons potentially without significant resources.

Study Design

After seeking an understanding of the assumptions of qualitative research and the theoretical lens of phenomenology selected to investigate opiate addiction, the specific study was designed as follows. The approach was largely taken from the methods of Davidson and colleagues (20, 26, 69, 70).

The investigation was framed as an inquiry into the experience of opiate addiction, as close as possible to the experience itself (69, 70). For this reason, an inpatient detoxification setting was chosen as the location for interviews. Persons entering detoxification treatment are in a unique position of both being actively addicted to opiates while simultaneously seeking treatment. It is a situation that can determine future course; patients may become abstinent, reduce their use, seek additional treatment, or relapse after this period (7, 71-73). Detoxification can thus give access to both the experience of seeking treatment and active addiction. To seek to understand the experience of patients in this setting is different from eliciting retrospective entirely accounts of addiction and treatment seeking. Strauss describes the effect of experience on consciousness of that experience – with regard to mental health professionals' perspectives being altered by their training – by saying, "And even if we were to reflect, passing through the tunnel itself begins to alter our vision of the nature of what we are seeing" (27). In that sense, one's account of an experience such as addiction may be

altered by having overcome it, and one's account of seeking treatment may be altered by ending it. In order to truly access the lived experience of both of these states, a detoxification unit was selected as the setting of this study. Despite the limitation that any discussion of past or future may by distorted by effects of time, detox seems a particularly valid setting for looking at addiction and recovery. This claim stands because during detox, people may be actively experiencing drives to both use (with opiate positive urine being an admission requirement) and reduce their use (as a reason for seeking treatment) rather than either one or the other.

Narrative interviews were conducted with participants detoxifying from opiates in the urban setting of New Haven, Connecticut in July of 2009. Recruiting patients, negotiating informed verbal consent, and recording of interviews occurred at South Central Rehabilitation Center, which operated a twenty-nine bed medically-monitored inpatient detoxification unit at the time of the study. The project received exemption from HIC committee review.

Patients who appeared to have free time, either wandering around or sitting on the unit, were individually approached by the investigator or clinical staff; they were asked if they would like to participate in a research study on heroin use and detox. No economic incentives were offered for study participation. Study inclusion requirements were that each patient had to be actively detoxing from heroin and to have had at least one prior completed detoxification at any inpatient facility. Participants often asked about the interviewer's position and were told the interviewer was a medical student and that the information obtained would not be relayed to their current treatment team or affect their treatment in any way. This statement allowed for opportunities for patients to be more

uninhibitedly honest about actual reasons for seeking treatment. The project was framed, however, as intending to improve existing treatment options. Such statements may have affected the content of the interviews in that participants may have felt compelled to describe aspects of their current or previous treatment that they wanted to see changed. This potential for change may have also motivated patients to participate in the study.

Narrative data was obtained by audio recording of interviews, of which participants were informed. The interviews were conducted on the same day that patients were approached for participation. In order to encourage a descriptive account of their stories, participants were asked open-ended questions about their stories. The interviewer was a first year medical student (this writer) with little background knowledge about addictions. This relative inexperience may have helped deter preconceived notions from interfering with the elicitation of a more unbiased story, a possibility described by Davidson with regard to an inexperienced medical student conducting qualitative interviews of individuals with schizophrenia (69). At the same time, the current interviewer's lack of extensive experience in learning how to conduct qualitative interviews and less familiarity with literature on substance use than a seasoned researcher may also be a potential limitation of the study in terms of the quality of the data generated. Of note, however, the interviewer was familiar with the specific setting and patient population from observing the work of physicians and nurses at the rehabilitation center over the course of months prior to the interviews, which led to its choice as the context for the study.

The initial question for each interview was: "How did you end up here [in detox]?" with an invitation for the interviewee to proceed in telling his or her story,

beginning wherever she or he felt most comfortable. The interviews were flexible and conversational, and no question after the initial was prefabricated or standardized. Every attempt was made to follow the participants' conversational leads. It was assumed that the participant did not have to take on any role other than as himself or herself telling a story about living with opiate addiction (20). The interviewer was trained in how to ask good qualitative questions using principles such as asking one question at a time, asking specific questions, and communicating respect, comfort, and interest, as well as other techniques described at the following reference (69). Follow-up statements and questions were articulated to elicit clarification and elaboration. Follow-up questions were often begun by using the words "How" or "In what ways" and were framed using reformulations of participants' own words.

Though the interviewing techniques as described above attempted to maximize trust and rapport, interpersonal issues nonetheless likely affected the content of the interviews. An interviewer of a different age, gender, style, or ethnicity perhaps with different interests, goals, or background experiences may have elicited different interviews from the study participants. It is also important to acknowledge the influence of the specific context of one inpatient detox unit on the content of the interviews conducted as well as the findings generated. The lived experience of heroin addiction described by the present study is context-dependent and must be viewed as that of a specific group of persons seeking a specific treatment setting and interviewed by a single person within a given time frame.

The first person interviews were reviewed and thematically analyzed according to methods described by Davidson (20) and Wertz (74). The goal of the data manipulation

was to understand the meaningfulness of the participants' addiction experiences from their own perspectives. The interviews were first transcribed verbatim by this writer and a volunteer research assistant with a bachelor's degree in psychology. Each narrative was then read multiple times in order to more fully understand the story within. Attempts were made to place the reader in the participants' shoes in order to grasp their own meanings. This writer and the research assistant both received training in the next step of data analysis, which involved the selection of particularly illuminating passages of the texts. In this regard, quotations from each transcript were highlighted based on their ability to convey insight about the narrative and the experience of opiate addiction. A unit of meaning was partially selected for its seemingly necessary inclusion in telling the story of a given participant. Both researchers then separately distilled the many pages of each transcribed interview into a one page, first person narrative summary in the participant's own language. Each summary was organized around a framework of connecting the previously selected meaningful quotations within a coherent story. The narrative was arranged in an order that reflected the chronology of a participant's life, most frequently beginning in childhood or early adulthood and finishing with thoughts about post-detox future, though this varied among participants. Creating individual summaries was performed keeping in mind the idea that stories appear as everyday life (75). The two investigators then compared their summaries for each interview, discussing approaches, similarities, and differences between them. Through this assessment process, a composite summary was cowritten from each paired set of narratives such that each transcribed interview had one summary. Afterwards, this writer constructed a summary of the common psychological experience understood across the group of twelve

individual summaries. This step was directed by noting general features of the individual structures, seeking similarities among individual narratives, using imaginative variation to achieve desired generality, and explicit formulation of generality as described in Wertz (74). Wertz also notes a difficulty often encountered in describing the exact process by which a researcher discovers and creates a study's psychological construct given his or her required immersion into this largely intuitive experience (74). The detailed and explicit statement of the common psychological experience includes selected quotations from the participants and is shown in the findings section of this manuscript. Unfortunately, given requirements of participant anonymity, the study did not involve presenting participants with a copy of the structural summary, as recommended by Davidson (20). When possible, this step may enhance the validity of findings by offering possibilities to amend them through discussions with interviewees.

Davidson suggests that the findings of qualitative research conducted in the described manner should be judged by the manner in which they appear obvious to the reader (69). He notes that this rubric is unique to qualitative – versus quantitative – studies and occurs as a result of allowing the reader to access the meanings of participants' lives (20). The findings should thus allow a reader to understand why a set of persons in a particular context makes decisions and acts in the manner in which they do (20). For the current study, a reader should be better able to understand why people might use and continue to use heroin despite the fact that the reader may not have had the same experiences or made the same decisions.

Given the context-dependent nature of the psychological findings, a second data analysis was performed with a specific focus on the setting of detox. Narrative summaries

were reviewed for instances in which "detox" was mentioned by participants. Quotations were extracted and then grouped in themes. Themes common among interviewees are described, with illustrative quotations, within the findings section of this manuscript following the psychological structure subsection. Rather than describing a psychological experience, the detox subsection describes themes of logistical experiences with treatment options surrounding and including detox. Understanding patients' interactions with the context of detox provides further insight into framing the psychological experience of heroin addiction and using that data to improve treatment options.

Study conception and design, patient interviewing, interview transcription, data analysis and interpretation, and writing of the thesis were all performed by this writer. For assistance with transcription and analysis, one volunteer research assistant was recruited. Both this writer and the research assistant received training from a Ph.D. level clinician in phenomenological data analysis.

Findings

Interview and participant characteristics

Twelve persons participated; eight participants (66%) were male, and four participants (33%) were female. Eleven of the participants (92%) described heroin as their drug of choice, while one participant (8%) noted freebase cocaine to be his drug of choice. No person who met inclusion criteria and was approached for the study turned down the opportunity to be involved. The interviews ranged from 25 to 65 minutes (M = 39.5, SD = 12.5). Eleven of the interviews were conducted in one sitting, while one

session was briefly interrupted for medication administration but resumed within a half hour.

Details of the Common Experience

Desired Feelings:

There are diverse manners by which a person starts to use opiates (e.g., a doctor's prescription, incidentally with friends, to experience the described high of opiates) as well as reasons for switching to heroin for those who began using a different opiate (e.g., easier access, cheaper cost, desire for a more intense high). For people who go on to live with an opiate addiction, this multiplicity of paths eventually converge on the experience of liking the way heroin makes them feel.

…it made me feel exactly how I wanted to feel, which was nothing. I didn't want to feel; all I wanted to feel was the drug. And that's how it made me feel. And it made me, in normal situations, it made me feel like complete. It made me feel like it was the answer that I'd been looking for. Like I said, it made me be able to look people in the eyes; it made me feel content and feel, um, like whole. That's what heroin did for me.

When one begins to repeatedly use the drug, he or she seeks a positive feeling. The specifics of this desired state differ among people. The experience can be independently positive (e.g. pleasurable, blissful, warm, exciting), positive by virtue of removing negative elements (e.g. physical pain, boredom, negative thoughts, anxiety, depression), or positive by a combination of these factors.

I liked that relaxed, laid back feeling. It was just euphoria. Your body doesn't hurt. You get tingly, you feel like "ooooh."

and

When I came out for being like knocked out from the surgery…they prescribed me Percocets… And one time the pain was a little bit too much, so I took two and it didn't help, so I took three, four, five. Next thing I know I was high. I was like, "Wow, this is a really good feeling."

Focus on the Present:

During these experiences, there is an initial appreciation of the manner in which opiates can make one feel good or simply better. There is a focus on the present of that experience; people remain wholly within the positive experience of singularly feeling heroin.

I like heroin cuz it, it's definitely, that's all you think about when you're high…is being high.

Using heroin becomes a valued absorption into the present and a focus on solely the experience of heroin. It appears as a concentration on the immediacy of the instant, to the exclusion of consideration of past or future.

The minute I got high and felt that feeling…everything changed. It took over my brain. All I could think about. And it's still like that right now. No matter what I'm doing, that's all I'm thinking about.

and

The nod and the feeling you get, you just feel so good, it's like you don't give a shit about anything.

The beginning of an addiction is predominantly a positive present. The individual wants to solely live the present experience because he likes that present.

And, uh, it was just like, like they call it 'being touched by god.' Like that was the actual feeling…and I…just been doing it ever since.

Over time, however, people describe the experience of doing heroin becoming different than getting a high. The positive valence of the experience begins to draw more of its value from being "less negative" than from being inherently positive. Often the negative aspects that are sought to be avoided are related to the continued use of heroin itself.

I started sniffing more and more just to not get sick; I would barely get high.

and

I would try to go out and get high…to kind of block everything out, the fact that I don't have anywhere to go, that my family's not talking to me, that I didn't get into a treatment center.

As heroin use continues, the content of an individual's life increasingly concerns heroin. People spend more and more time high or merely warding off withdrawal, both of which are experienced as present. Less of life's mental content consists of remembering the past or imagining the future (e.g., previous abilities and accomplishments are forgotten, savings are spent, goals are abandoned).

It was a couple hundred thousand dollars I had saved. That was money I really, really, truly kind of wanted to retire on. But we went through all that. And then we went through my material stuff.

Living as an "Addict":

Continued heroin use becomes more than a singular satisfying activity embedded within the context of a life. Instead, heroin use becomes experienced as its own unique lifestyle. This lifestyle is referred to as living as an "addict," partially defined by the amount of time spent concerning heroin.

You know, cuz like when you wake up as a drug addict, it's like, you're just sick and you're just tired, and you don't feel like, even if you're high, even if you get ten bags in you, you're still not having a good day. You still had to do whatever to get those ten bags. It's always like you're waiting for something.

and

And if you're a drug addict, you're gonna go get high. It's as simple as that.

Central to the assumed identity of being an addict is the experience of an uncontrollable desire to use heroin independent of context or consequence. This drive becomes experienced as integral to the individual's identity as an "addict."

I think of myself sometimes as not an addict, but I am. I know I am. Because I can't stop this one drug.

Life as an addict becomes experienced as a cycle of using and obtaining heroin, and this cycle seemingly occurs without choice.

Once you're in the cycle of getting high, and especially once you have it in your system, there's nothing that can stop you. It's like you absolutely have no choice.

and

I don't know what happened; *Sometimes you relapse for no reason. It makes no sense.*

People do things to obtain heroin (e.g., robbery, liquidation of assets, violence) without having a feeling of choice over their actions. In this way, life occurs within the present of addiction without being able to consider past or future.

You know, I was looking forward fifty years for my life…I had a brand new computer, flat screen TV, couches, leather couches. Everything I had was brand new – nice stuff. And I lost it all. I didn't worry about anything but getting high. Absolutely nothing.

There is an emphasis on the veracity of living this identity. People may feel they are "true addicts" or "full blown heroin addicts" in experiencing the persistent desire to use heroin without choice or possible mediation of circumstance.

Cuz if you don't deal with what's gonna make you just pick up once, once you pick up, if you're an addict or an alcoholic, that you can't choose to not do it anymore, once you pick up one, you're gonna start running. What makes someone an addict or alcoholic? I mean, really, truthfully, it seems like most of the people that I meet that I would say are truly addicts and alcoholics, when you, that's like the "no matter what." Once you use, you're gonna keep using, no matter how, how badly you want to stop, no matter how beautiful some girl is that doesn't like you doing drugs, no matter if the judge says, "If you drink, you're going to jail for five years…," an addict will say, "Get my bed ready

cuz I'm gonna drink again." You know, there's nothing you can do about it. I think a problem drinker or problem alcoholic, a normal drinker, drinks when they have a problem, drinks when, they can stop when that problem's resolved. That's like the "good day, bad day" thing. If you drink cuz it's a shitty day out or because it's a nice day out, every time's it's a nice day, you wanna go drink, I don't think that you're a true addict. I mean, it's a nice day, you want to go out and drink. But if you drink because it's a nice day and a shitty day and an okay day, you know, like, if everything's an excuse to drink, you're probably an alcoholic or use opiates, you're probably an addict.

Transitional Moments:

Despite this lived identity, people may also experience certain points in time (here referred to as "transitional moments") that allow a vantage point outside of the present cycle of uncontrollable addiction. These periods are experienced as having a possibility of personal control. Despite feeling the cycle of addiction to be uncontrollable, the same person feels an element of personal responsibility in recovery.

Ultimately, it's up to the individual whether they're tired of using drugs or not.

and

I'm the only one who could stay clean. It's my choice.

During these moments, the mind is fractalated; one experiences both the present without choice and a notion of temporality with choice. ("Fractalated" is a term used in this text to indicate a mind wherein parts represent the whole, avoiding connotations that the mind is somehow "broken.")

One might imagine a model in which addiction is depicted as a person swinging back and forth on a trapeze onto which one jumped from a high platform. The swinging is the lived present of heroin and is the focus of the experience. Only occasionally, at the edges of the swinging trajectory, does the person rise high enough to again see the platforms – behind, past and ahead, future – and it is during such transitional instances that the person may feel a locus of personal control to step onto the platforms and continue walking on a horizontal path connecting past, present, and future. Unfortunately, gravity can quickly pull a person down from this point of view, again obscuring past and future. But during these moments, a person might see a path leading from this platform from a positive past and into a positive future.

And then I came to a point where I was like, "Okay, I could either go one way, I could go back to that person I was before my addiction, or I could go to that addict place."

At such times, individuals may attempt to enroll in a detox, to find a long-term recovery program, to get prescribed substitution treatment, or to engage in other methods to stop using heroin. Experiencing transitional moments may be manifested through contradictory language, such as the dichotomy between addiction being simultaneously controllable and uncontrollable or heroin being simultaneously desirable and undesirable.

It’s crazy like, I want to stop in a way, but I don’t, and I don’t know why.

and

This drug has fucked up my life so bad. I don’t know how I’ve let this take control like it has. It’s like you care and you don’t. You think, ‘Why would I keep doing this?’ but then you go back to it.

An incomplete inventory of experiences leading to such transitional moments includes transgressing one’s personal limits, experiencing loss or injury, being punished, and forming new extrapersonal concerns such as pregnancy or romance. The transitional moments of considering the past or future, however, may be brief.

I ended up going into an [overdose]. I split my eye open. That actually did scare me because I never actually hurt myself before. And I really thought I was gonna stay sober, but two days later I was using.

Gravity may once again exert its effects upon the trapeze, and the individual again feels pulled down into a present. This metaphorical gravity may take many forms, including addict identity, stigma, sickness, and geographical, economic, and structural limitations. Additionally, once the individual is able to see past and future, she may feel quickly sequestered back into the present by viewing only a negative past and negative

future. He may feel guilt and shame for his past actions, may feel that the only possible future is a bleak one, and so desire to quickly retreat into the present of addiction.

I think I sabotage myself too. Like I don't deserve to be happy because I did this to myself. It makes me angry with what I've lost, and what could have been and what should have been. What was, what I lost, everything.

and

It hurts cuz I had so many dreams, and I know I'm smart. I could do anything. Now I feel like I can't do anything cuz I fucked up my life, screwed up all my possibilities. When you feel like you're trapped living a blue collar life, I might as well just use. I fear I'm gonna be a loser.

The addict identity carries an associated tendency to cast past and future in negative terms. During transitional moments, however, this framing is contrasted with an articulated desire for normalcy.

Like it's…it's too much. I want to have a normal life. And it's like an addiction I'm going to have to battle my whole life on top of it, which is really hard.

and

I just want to wake up in the morning and not feel like I need to go get dope to not get sick. To function. I want to live that life again. I don't remember that life…I just want a normal life.

Positive futures may include goals such as education, traveling, employment, staying out of jail, community service, stable housing and food, experiencing feelings, or having a family. There is a focus on a desire for normalcy that is set in opposition to living as an addict.

I'd lost my kids at this point. And I just didn't want to…I want all that other stuff back. And I can't get it back if I'm using. And I want…I just want a normal life.

Extrapersonal Connection:

During transitional moments, people look for something outside of themselves to which they can connect in order to help move forward on the future-containing path of recovery. Other people represent possible sources of such connection.

So I know there's other people like me now in that world, and I could communicate with them and actually understand them, without actually getting high cuz I'm part of that same society with them. I don't have to worry about filling up things or getting high because they actually have the same feelings that I have.

What appears to be important is the availability of something to meet the individual at her transitional moment and carry her beyond its brief upsurgence and onto a path of recovery. A connection, as such, links the present self on a timeline with a past and a future before it falls back into the encompassing present. The strength of such a connection lies in its ability to help integrate an acceptable past and positive future into the individual's personal narrative by providing a model of positive interpretation.

I like the meetings and stuff, they had, keep you, you know…The guy yesterday kind of made me, you know, kind of hit me…I mean, he's an alcoholic and I'm a drug addict, but the way he said it to me, I was like, "Wow, I could totally relate to that." He lost everything too. "I got all my stuff back" – that's what I want to happen to me.

The experience of possible change is encapsulated by the idea of hope – the connection of the current self with a conceivable and desirable future self.

Just hearing some kind of hope at a detox is needed.

The Context of Detoxification

Persons entering detox will largely fall into one of two broad groups. Some people will enter an inpatient detoxification consciously recognizing that they are utilizing the services for reasons other than wanting to sustainably decrease or end their opiate use. The setting provides such persons with resources, particularly when they have run out of money, including opiate replacement therapy, food, shelter, and rest.

[I'll] probably [use] when I get out. Like the same day, honestly. It's just…I don't…this was like a nice break for me. I let my veins heal. I let my body heal. I actually got three meals in me. I actually had a bed to sleep in. It was awesome for that.

Though such reasons might not be articulated to staff, these motivations are represented in a real proportion of people who enter inpatient detoxification units.

The second group consists of those who actively hope, desire, or believe that their current inpatient detoxification will lead to a reduction in their opiate use. At some point in the decision to enter treatment, these people transition from the present to consider a future reduction in opiates. Often, however, there are logistical considerations that people seeking reduction in opiate use feel interfere with their ability to recover. The remainder of this section focuses on this second group of patients.

For one, there may be a lack of engagement within the inpatient detox. Patients may feel bored or without anything to keep themselves occupied. This feeling contrasts with the desire for change that motivated treatment seeking.

People feel like they don't want to walk in [detox] and leave the same way they came in.

and

People in detox are in a position to be helped.

While inpatients, people often feel they have the time and motivation to further facilitate their future reduction in opiate use. Patients feel they may benefit from *more* services (e.g., more time with counselors; more psychiatric help; more twelve step, relapse prevention, coping skills, art therapy, and exercise groups; chores with reward systems; reading choices). There is a feeling of needing something constructive with which to fill the time. Without appropriate support, people may utilize available time in ways that return them to the present of addiction. In connecting with other patients, people will often end up relating to one another by discussing drug use.

Yeah, [people talk] about using and just all the war stories from you know when they were using. You know, a lot of people glorify it, so then they start thinking, like, how good it did feel or like… they'll think about, you know, "It felt so good this one time. Or "I remember when I got this really good dope." And then they'll just start thinking about that, and that's what they start thinking about when they leave here, and that's the first call they'll make when they walk out the door.

Patients may also feel that a logistical lack of support extends outside of the inpatient detox setting itself. Difficulty entering detox is felt to be a barrier to treatment in that there may be such a long wait that hopes of reducing opiate use are overcome by the drive of addiction before successfully entering a facility.

It was very frustrating even being in the room waiting. I was tempted to leave right there cuz, especially heroin addicts who use IV…they love instant satisfaction. If you keep them

waiting for five, six hours, they're gonna say, "Screw it, let me go find a bag; let me go get high." You know, I was really tempted, and if I was there for probably four more hours, I was gonna leave…And a couple people in here have told me they had to wait over twelve hours…I think that drives a lot of people away.

There is felt to be a need for available support during the seeking of detoxification treatment, both at a specific facility and while finding available programs.

I tried three weeks to get into somewhere before I just cold-turkeyed myself and said, "I'm gonna get high again, just to get into a program." And my girlfriend even did more than the counselor did. We sat there on the phone for hours. Just calling places, calling places, a lot of them like I said, a lot of them wouldn't take me cuz I was on the methadone or there's a bad waiting list. That's the thing, there's a lot of waiting lists around the area.

In addition to this need for support being present before and during detoxification, there is consistently felt to be a lack of available support after detoxification.

There wasn't enough support afterwards. They kind of just boot you on your way, and there's not enough follow-up.

and

Just trying to, you know, set you up with an aftercare or a lot of people, you know, are trying to get into programs, but they'll say, "Oh, okay, well, we can get you into this program, but it's not gonna be for three weeks." And it's like, "Okay, I'm shit out of luck for three weeks?"

There is often a futile difficulty experienced of being released from detoxification without additional arrangements for the near future. Participants feel that any waiting period between treatment settings has high potential for relapse.

I went to detox and um like my plan was to go to a rehab and to go to a sober house, for six months rehab and go to a sober house and like change. You know, do what they asked, what they think I should do. And that's basically what everyone told me I should do. And I didn't get into a rehab. And…I went home… I had to wait to get into one, so I ended up going home. I had a bed at a rehab in like a week and a half. Going home and that was it. I never went back.

and

I don't even know where I'm going right from here. Hopefully, I can go right to a treatment center, but I don't think that's how it's working out because I'm leaving…she told me Monday. Then just now she told me I'm leaving Sunday, so…I don't even know if I have somewhere to go on Sunday. So, it's… I mean, I would, if I really didn't have anywhere to go, I would…I would try to go out and get high

People feel that detox itself is not what is important but rather that it offers a potential stepping stone to more resources when and if they are available.

Detox doesn't work. I mean, it works. It works to help you get off whatever you were using. But you need a long term treatment program.

Despite a desire to move forward with reducing opiate use, there is often an acknowledgement that the detox setting is not a perfect solution as well as a frustration with the lack of additional options.

I haven't talked to a counselor here or anything, I don't know like what they really talk about…but I mean, pretty sure it's pretty widely accepted that five days is not gonna change your life, you know, this is the time, you know, when you're desperate, when these views need to come across.

and

The detox needs probably, how do I put it, needs more ways of dealing with the addict besides just distributing the medication.

and

It's funny they want to arrest you, and they want to lock you up for possession of drugs or whatnot, but if you go and try to find help, it's nearly impossible unless you have the resources, unless you have money, it's nearly impossible. Cuz if you don't have a phone, you're not gonna be able to make these phone calls. It's not just one phone call; you have to sit there for a couple days.

Discussion

The Present

The primary finding of this inquiry has been to describe heroin addiction as it relates to processing of time, which requires further discussion as to the nuances of the experience. The findings demonstrate that to experience addiction is to only experience the present. Applicably, German philosopher Frederich Nietzsche described living unhistorically as "[disappearing] entirely into the present, like a number that leaves no remainder" (76). In this quotation, one is presented with the idea that to live unhistorically, that is, without past or future, it to live wholly enveloped in the present. For the person who uses heroin, this initially entails total bliss or total lack of negativity, as described above. In fact, opiates, as a pharmacological class, are typically defined, in part, by their ability to induce euphoria (77, 78). Nietzsche goes on to describe the connection between living wholly in the present and euphoria:

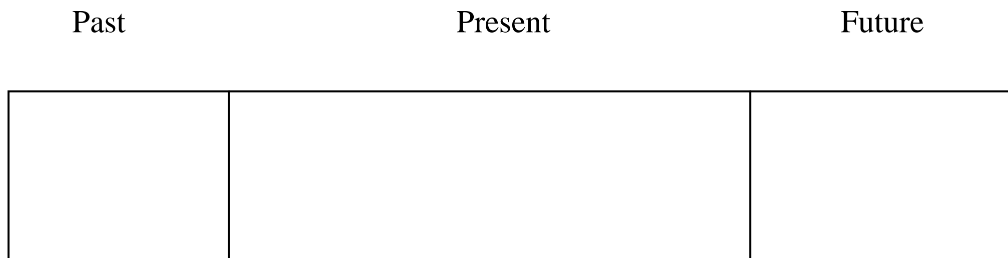
The smallest happiness, if it is uninterruptedly present and makes one happy, is an incomparably greater form of happiness than the greatest happiness that occurs as a mere episode…in the case of the smallest and greatest happiness, it is one thing alone

that makes happiness happiness: the ability to forget, or, expressed in a more scholarly fashion, the capacity to feel unhistorically over the entire course of its duration (76).

These quotations provide us with an illustration of the experience of heroin. It is a happiness of heroin and only heroin, of that present and nothing else, no past and no future. Nietzsche, however, made these statements in the context of his moral philosophy related to what he described as a “herd mentality;” the point of the references is to neither support nor critique his philosophy, on which more information can be pursued at the citation (79). The quotations merely serve to further illustrate the experience of opiate addiction. In fact, Nietzsche goes on to describe living unhistorically as being “tethered by the short leash of its pleasures and displeasures to the stake of the moment,” (76) a fitting description in light of the findings of heroin addiction to be a pleasurable present.

One might imagine the experience of any life as a two dimensional rectangle of established area, consisting of the remembered past, the experienced present, and the considered future:

LIVED LIFE (Fig. 1)



Living is done among these three subdivisions, and one's experience may consist of different proportions of past, present, and future. Specifically, conscious experience is an amalgamation of thoughts and feelings about past, present, and/or future that may be categorized as being made up of various proportions of these three subcategories of time. A literary analogy may be found in Wallace Stevens "Thirteen Ways of Looking at a Blackbird": *I was of three minds, /Like a tree /In which there are three blackbirds (80).* The overarching framework of the tree is *lived life*, and within this structure there are three birds – past, present, and future – and experience is lived amongst these three minds. All three are accessible and transversable, an idea that may be represented in the figure by sliding the vertical line segments horizontally in either direction, such that the relative areas of the three rectangles are altered. To merely feel hunger or to think, "I am hungry," for example, is to live the present of hunger, whereas thinking, "I am not as hungry as I was yesterday" is to live between past and present. To live among past, present, and future might be to say, "I am not as hungry as I was yesterday, so I will wait before I eat my next meal."

To have initial, positive encounters with opiates is to have experiences entirely within the present such that lived life may be depicted as such:

LIVED LIFE (Fig. 2)

Past Present Future

In this picture, the thickened bars on the edges of the rectangle show that the vertical line segments have been pushed to the left and right edges and that life is being lived wholly in the present. It is worth noting that the overall area of Lived Life remains constant in the figure. This fact avoids implying a potentially morally hazardous inference that a person using drugs utilizes less of her mind. Instead, the mind is just allocating its resources to living the present. Initially, this present is entirely the experience of the substance in the body and not of other concerns, described previously, such as physical pains or psychological anxiety. Present of experience is the only songbird heard – albeit louder – as the harmonies have dropped out.

As a person comes down from the high of heroin, Figure 2 reverts back to Figure 1. Addiction, however, means that the person wants to spend increasing durations of life in the present of opiates. This idea is similar, though not identical, to the commonplace depiction of an addiction as taking over one's life. To an observer, the physical content of a person's life changes in addiction – more time is spent using the drug and attempting to acquire and recover from the drug. In fact, the DSM-IV-TR criteria for substance dependence include "A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects" and "Important social, occupational, or recreational activities are given up or reduced because of substance use" (55). In distinction to being definitionally true, the findings indicate that experience itself experientially entails spending a higher proportion of lived life in the present; less experience concerns either the past or the future.

To the extent that the future is considered, its trajectory is pursued only to the point of being able to re-merge it with the present, for example, how to obtain money for a fix. Only a small sliver of the box in Figure 2 becomes future; this bird's song is a quiet accompaniment. Addiction is lived within the present, as in Figure 2, but the present of addiction comes to comprise experiencing the drug and living as an "addict."

To further understand this present, it is worth examining whether there are other similar experiences. Hungarian psychologist Mihaly Csikszentmihalyi introduced the concept of *flow* to describe optimal experience (81). In his work on this subject, Csikszentmihalyi relates happiness and to the perception of time. Though not writing about drug use, the psychologist describes *flow* as a state of concentration in which there is complete absorption into the present with an absence of other concerns, such as time, self, etc. Csikszentmihalyi focuses on situations which involve skill utilization, but his description of the state of flow seems also to apply to working, having sex, playing music, or, in this case, taking opiates. As such, there is a narrowing focus, a distorted sense of time, and a loss of self-awareness. Csikszentmihalyi notes that people find such experience to be "optimal" in that it is high quality (82). While some have thought flow to be too vague of a concept, (83) its fundamentals are applicable to heroin addiction, particularly in the initial, more pleasurable phases. Over time, the experience of addiction loses some of its positive valence but retains the absorptive qualities of flow. Csikszentmihalyi himself notes the possibility of finding flow in addictive behaviors and describes the limits of this facet of positive psychology in the addiction to flow wherein "everything else pales by comparison" (84). Therefore, it is not the presence of

absorption in the present that characterizes addiction, but rather the time spent in and value placed on it that distinguish addiction from more productive flow activities.

Further elucidation of the mechanism between absorption in heroin and the effect of altered time is provided by examining qualities of the substance-induced experience itself. Gray (2005) has suggested that the novel sensations one encounters when first taking a psychoactive drug prolong time. They do this by directing one's focus of attention on the basic sensations that arise, precluding thought (85). In this sense, and as it appeared in this study, to live within the present is to fully experience the present, but not necessarily to *think about* the present. This idea has also been described as a conflation of time into the here-and-now (86). In such substance-induced experiences, Gray relates, the sense of time is subjectively lengthened by a focus on the new sensations. With such consideration, we may refer back to Figure 2 of this manuscript, wherein vertical bars slid horizontally to expand one's lived experience of the presence. Gray's description is consistent with the figure's area of Lived Life remaining constant. Life is not necessarily lived to a lesser degree; the present lengthens to subsume the experience.

Over time, the findings suggest that persons addicted to heroin still live life within the present, though the novelty and euphoria of the experience wanes. The specific finding of waning novelty and euphoria is consistent with well-established concepts of drug tolerance (87-89). Here, it has been found that users still live within the present but instead of a positive high, they seek the experience of an absence of negatives. The idea that the desired effects of heroin are more instantaneous than its more distant negative

consequences (90) combined with the finding of a persistent focus on the present helps to explain the driving nature of this addiction.

Addiction Without Choice

To live so wholly within the present is characterized within the study as experiencing addiction to be without choice. The idea is consistent with complete immersion into the sensations of experience, as described above, such that thought is precluded. The experience of living heroin addiction is experienced as pre-reflective immersion. In this sense, such living is experienced with a "prenarrative quality" (91). To characterize addiction as being "without choice" is not necessarily to say that the experience is one of actively feeling compelled, going against better judgment, or being driven by external forces, but rather that it is *done* without having the active experience of consciously willing it to happen. The experience is lived rather than thought about, contemplated, weighed, or considered in the context of a temporal narrative. Participants note being able to focus only on heroin. The temporal nature of addiction is that once the action becomes corporeally known, it is experienced as *present* and thus without conscious consideration or situated perspective, experienced as being *without choice*.

The characterization of heroin addiction as difficulty moderating short- and long-term gratification (92-96) is consistent with focusing on the present and not the future. While people addicted to heroin may very well appear to choose short-term rewards over larger delayed rewards, this difficulty does not characterize how the experience of addiction is lived. The difference is that participants describe not being able to even consider the future in order to make such comparisons that constitute a choice; they feel

without choice as they are instead driven to focus on the present. Nonetheless, impaired ability to delay gratification has been previously related to more quantitative findings of altered time perception ("shortened time horizons") in heroin addiction (90). Generally, the abilities of people to inhibit and regulate human behavior has been associated with ability to consider past, present, and anticipated future (86). Nietzsche again provides an illustrative quotation, this time about ahistorical living as a cycle without choice:

…his memory turns inexhaustibly round and round in a circle and yet is still to[o] weak and exhausted to make one single leap out of this circle. It is the most unjust condition in the world, narrow, ungrateful to the past, blind to dangers, deaf to warnings; a tiny whirlpool of life in a dead sea of night and oblivion (76)

Of note, within this text, the term *choice* is employed as it is conversationally applied to mean the active experience of choosing. The usage of the term here avoids broader philosophical arguments of the existence of free will. A relevant discussion here can be found at this citation (97).

Fractalated Minds of Transitions

Within the same interview, participants who emphasized lack of control would also speak of personal responsibility and an ability to choose. The articulation of choice always requires a sense of the future in that it entails choosing a different future than one's present experience. Some scholars have also characterized the idea to stop using opiates as one of choice (34), though by referring to the participants' own language, this

study attempts to avoid associating use of heroin with morally inferiority or weak will. The seemingly contradictory nature of articulating both choice and lack of choice occurs as a momentary stepping outside of the interiority of addiction to both characterize its inside as experienced without choice and to feel personal responsibility for the possibility of change. During such transitional moments, individuals are of multiple minds: past, present, and future. Other research on addiction has made similar characterizations. For example, persons addicted to alcohol have been characterized as experiencing the self as divided against the self (98). Phenomenology of alcoholism has, in fact, been therein characterized as a division of the self into multiple parts each with different perspectives. Higgins too has claimed that the self may be comprised of different domains that are conflicting or incompatible (99). In Keane's book, she describes the dissonant state of compulsive cravings that indicate "not wanting to want what you want, and not wanting to do what you do" (5). Regarding cigarette smoking, certain cognitive contradictions have been noted, including needing to quit versus wanting to quit and not wanting to smoke versus not wanting to stop smoking (24). Again, the focus differs, though these findings do approximate a similar fractalating.

How then do we further characterize and explain such fractalation of the mind? To examine this division, one must refer back to the present-subsuming nature of addiction. Some guidance in this regard may be derived from the work of philosopher psychologist William James. Shinebourne and Smith describe James' thoughts on the construction of identity (99). The *I*, or *personal identity*, is experienced as a "sense of sameness" that maintains internal continuity and separateness from others (99). This identity is who a person was, is, and will be (100). Immersion into addiction, however, is

noted to disrupt such continuity, for focusing on the present expands a person's subjective experience of that present time (again relevant to Figure 2 in which vertical bars slide horizontally to expand reflect more of one's total experience being of the present, which may also indicate the pictorial representation of lengthening the subjective experience of time).

James notes that changed thoughts may develop about one's experiences as their intensities wane (85), as might happen during transitional moments as the present of heroin fades. This repeated act of immersion and distanced reflection creates gaps in self-continuity (85). Within the present of addiction, one's focus is on living the experience; only when the focus is later placed back on the self does the alteration of time create misalignments in the temporal self. One's thoughts about the self are influenced by the degree of consistency between the past self's actions and one's present self-concept (101), which may thus be reflected in conflicting speech as the difference between living the life patterns and drive of addiction and wanting to change. Because one's body, possessions, relationships, and experiences all contribute to a sense of self over time (99), alterations in these facets while one is enveloped in the present distort the self once reflected upon during times such as transitional moments. Gray has noted that gaps of time in knowing and feeling the self, serve to divide it (102), thus accounting for this study's finding of fractalation of self into possessing and lacking control or desiring and not wanting heroin. Dissociation from self has been characterized by possible suspension of its social constraints, desires, feelings, and behaviors (103), facilitating the many changes that people may later look back on with incredulity, such as noted violence,

robbery, etc. Reflection then is enacted from the distanced vantage of that different self (85).

This division is similar to what has been characterized as subjective "the self as knower" and the objective "self as known" (101) as the self as knower looks retrospectively at the past self as currently known. This conceptualization of differentiation also helps to explain how, in retrospect, people feel as if they had no choice in their using of heroin. In looking back at a self that feels in part distanced from one's current self, the past self as an object would be imbued with less connection to the current self, less connection to agency and to subjectivity and is thus described as being without choice. While using heroin the person may not even consider the idea of choice with such language because he is so immersed in the prenarrative living of the present; but it is in so looking back on that distanced experience that it is reflected upon as having occurred without choice.

In fact, all of human experience might be some combination of prereflective living and conscious consideration of past and future that arrives during particular moments (67). The effect of the various types of mental illness on this common process might be to intensify the experience of the present as well as the need for reflection (67). Altered relationships among self and time have also been noted for the lived experiences of mania, multiple personality disorder, and schizophrenia (67).

Periods of Transition

Further research should seek to characterize the periods during which expansion of perspective outside of the immediate present occurs. As noted, they involve the

possibility of choice and a sense of future. Predominantly retrospective inquiries have previously revealed some information about the nature of periods of transition that led to successful recovery for persons with addictions. Biernacki claims that one quits using drugs when his addict identity conflicts with other identities that he possesses (37). This concept is consistent with the idea that during the enveloped present, changes occur such that the self is altered and becomes fractalated. When potential transition moments arise, the ability to reflect on these changes of self occurs and presents as seemingly contradictory articulations. This conflict of selves, as Biernacki suggests, might then lead to substance abstinence (37) or reduction.

Other researchers have similarly characterized these moments that lead to recovery. Persons' self-schemata have been said to be altered during such times, and there is a cognitive emotional shift of seeing and interpreting one's position (104, 105). Baumeister refers to such focal incidents as involving *crystallization of discontent*, allowing for new interpretation of elements (e.g. roles, positions, situations) of life about which one is unhappy (54, 104, 106). Colloquial depictions of this idea are *rock bottoms*, which are metaphors for intolerable personal low points that oftentimes lead to modification of behavior (22). This notion is consistent with the idea that experiences during the enveloped present that are later reflected upon are found to be inconsistent with the self or one's expectations for it. On the other hand, some study participants describe positive catalysts such as pregnancy for expanding perspective. Indeed, situations may be positive or negative but are typically tied to a specific event (107). Though such descriptions were largely elicited through retrospective analysis after abstinence, one could easily envision the characteristics of transitional moments

elucidated in this study (expanded temporal perspective and feeling of choice) as developing into successful narratives. Transitional moments may proceed to recovery or resumed use. The important point is learning how to identify such presentations as they are occurring in real-time and to assist in turning the possibility of recovery into success.

Language

The structure of language and thought are inextricable (108), and the manner in which a person tells a story partially provides its meaning, including what is emphasized and how that is done (24). This process is said to represent the world in which a person lives (109). It has been previously noted that people still using substances will tell their stories in a more fragmentary, contradictory, and uncertain manner that often lacks coherence and an ending, for example (110). It may thus be possible to identify linguistic markers of transitional moments indicating true expanded temporal perspective, stepping outside of addiction, and ability to change. This ability might be particularly useful in detox, as it was previously noted that persons using heroin frequently utilize services for reasons other than an active desire to stop using, including needing food or shelter.

Additional research may seek to describe the language of persons in transitional moments. Arciuli points out that analyzing language is a valid way to differentiate general deception from truth-telling, particularly when looking at multiple linguistic cues concurrently (111). It would be reasonable to conduct a research study using narratives such as those elicited in the present study to analyze linguistic behaviors of those admitting to malingering (as participants did) versus those truly seeking a reduction in heroin use. For example, the prevalence of “choice” or “hope” or perhaps use of

contradictory language may be potential markers of transitional moments. The tendency to narrate with a third-person perspective when describing actions that conflict with a person's current self-concept has been described as a valid clinical indicator of change in the self and optimism for future behavior (101). Compared to other individuals, people in transitional moments might be expected to more frequently switch between first- and third-person perspective and between subject and object pronouns when speaking about their heroin use. These approaches would focus on use and structure of language rather than behavior or articulated intention, as do some current approaches for identifying readiness to change (112). The intent of such inquiry would be to eventually train practitioners to identify transitional moments and better allocate detox and follow-up resources, whose scarcity is noted to be a logistical barrier to treatment in this study. Those persons noted to be using detox primarily for secondary gains could be connected with other sources of support more appropriate to their presenting needs, such as motivational interviewing or harm reduction counseling.

Moving Forward

The next question is how to help people capitalize on those situations that truly allow for expanded perspective, whether in detox or elsewhere. In the moments when a person's ability to reflect upon fractalated selves arises, it appears that much of recovery entails being able to navigate such conflict. In general, life changes may be acclimated or negotiated through personal self-interpretations (54). For recovery, the process appears to entail synthesizing conflicting domains of self into a narrative with a future – while not

completely reimmersing into the present of addiction. Recovery might entail a reunion of self into a unified and coherent whole (85, 113) organized around a temporal structure.

People struggling with heroin addiction are, however, no strangers to attempts to erase conflict of self during moments of an experienced ability to expand temporal perspective. When this occurrence does not extend to recovery, participants spoke of many factors such as addict identity, stigma, sickness, and geographical, economic, and structural limitations that can quickly pull a person back into the present. These factors may negatively frame considerations of past or future. This finding is consistent with reports that the stigma or label of being an addict may push one back into the present by negatively affecting self-esteem with regards to alternative future outcomes (114) or by imposed expectations for behavioral consistency in the form of continued use (54). During transitional moments, people may feel in conflict with who they want to be, but without alternatives, such clash is reconciled by re-absorption into the present.

In order to bypass this extinction of temporal consideration into the present, the current study suggests that substitute considerations of past and future need to be provided. Nietzsche again provides an illuminating depiction:

It is true: only when the human being, by thinking, reflecting, comparing, analyzing, and synthesizing, limits that unhistorical element, only when a bright, flashing, iridescent light is generated within that enveloping cloud of mist – that is, only by means of the power to utilize the past for life and to reshape past events into history once more – does the human being become a human being (76)

One interpretation of Nietzsche's unhistorical living is that it is natural to forget and to live in the present – *natural* in the sense of being what is found throughout *nature*. However, with the establishment of meaning-making societies comes the ability to expand perspective, which is a useful, and possibly necessary, tool for overcoming addiction (115). In this sense, in order to flee the ahistorical present, one properly integrates one's history into the sense of self. The very notion of one's identity is characterized as encompassing past and future (105).

As reported in the findings, one participant described a transitional moment as noting a choice between going "back to that person that [she] was before my addiction or..to [her] addict place." It is within the context of such experiences that narrative frameworks would be helpful in forging a history outside of an "addict place." Following identification of such moments, recovery from addiction may be facilitated by providing alternate frames of interpretation that allow for integrating past and future into a coherent narrative, and successfully providing helpful frames of reference might be an aim of a successful treatment program. To revisit the previously articulated metaphor, the person on the trapeze swinging through the present briefly pauses at the top of his trajectory – platforms of past and future in sight. This study suggests that something may then be provided onto which the person can grab before falling back into the present, allowing her to move forward on a historical path with integrated past and future. The importance of providing this something was garnered through the interviews as the significance of connecting to something beyond the self. This desire is consistent with conceptions of the need to form interpersonal connections or a sense of belonging as a fundamental human motivation that helps to define the self (116, 117). The specifics of such connection may

provide an alternative framework for interpreting one's history. The connection requires an exterior force, but through connecting to something within the individual, it may enhance a locus of personal responsibility felt as choice. Thus, the person individually may move forward to recovery with the outside help of translating one's history.

Modeling History

The finding that the possibility of change is felt as an ability to expand temporal perspective suggests that this sense may be thereafter maintained through the establishment of a coherent narrative. Some retrospective recovery narratives that have been identified for different addictions include characterizations such as the Alcoholics Anonymous (AA) and the growth stories (for alcoholism); the co-dependence story (for polydrug abuse); the love story (for bulimia); and the mastery story (for cigarette smoking) (75). An exterior model, or source of connection, might be able to provide thematic alignment of one's personal narrative with similar themes. The suggestion that the sense of self is created indicates that it might be built in a manner conducive to recovery. Danish philosopher Soren Kierkegaard describes this process of creating a self:

Every moment that a self exists, it is in a process of becoming, for the self . . . does not actually exist, but is simply that which ought to come into existence (99).

Psychological literature has described that the created self is always capable of and subject to revision (67) and that narrative is essential to one's self-identity (118). During transitional moments, rather than relying on the habit of defining a person's self a

certain way, outside sources might provide new ways for the self to come into existence to enable behavioral alteration. Positive interpretations of potential futures ("optimism") are thought to be beneficial in enacting real change (101, 119). External models might be expected help an individual to recognize which other aspects of the past and future are important to give attention to in order to positively frame them. A patient might be informed as to how to link together personal time points in a way that makes sense when compared to the progression of other narratives. Outside stories can serve to give value judgments and explanations that might be amenable to recovery. Different vocabularies, relationships, and roles can be learned such that a story makes sense for a given purpose, such as recovery (105). It is in this way that outside sources can help to establish a person's persistent identity. Some examples of this process from the retrospective addiction literature that may be applicable to offering at transitional moments include reinterpreting drug effects as not enjoyable, redefining fellow drug users as false friends, and perceiving the addict lifestyle as negative (107). Research with alcoholism has noted that outside models can serve as metaphors for trying to understand the emotions and experiences that otherwise might escape comprehension (99). Alcoholics Anyonymous, as a community-based intervention, is largely based on sharing stories of addiction and recovery to enable identity transformation of members (120, 121). On the other hand, the findings of this study indicate that patients resort to positively framing heroin use – past and present – by discussing "war stories" and acquisition plans while in detox; this process is antagonistic to positive reframing for change and might be expected to decrease if more alternative models are offered. Retrospective accounts of recovery indicate a need to alter an existing identity and a desire for a new reframing of self as

central to changing (104, 107), which again underscores the similarity between successful retrospective recovery narratives and the potential recovery narratives in this study. There is, in fact, a literature written concerning what is called the *narrative identity*, or the self, the I, that can create its identity through the telling of stories (67). In a sense, this identity is the organization of temporal experience (67). Scholar Peter Brooks writes of the integration of time into a personal history:

We live immersed in narrative, recounting and reassessing the meaning of our past actions, anticipating the outcome of our future projects, situating ourselves at the intersection of several stories not yet completed (122).

The suggestion of providing alternate models of construing one's past and future is thus consistent with retrospective analysis of overcoming addiction as using new modes of self-interpretation (123). The suggestion also echoes the relevant idea that narrative models might provide those struggling with addiction with needed temporal markers, measurement temporal experience, and feeling of control – processes that are disturbed by addiction (124). Perception of negative elements of self may be altered in order to link them together with an underlying cause (54) in a way that is similar to the psychoanalytic recommendation of adopting explanations for past occurrences that can enhance one's view of himself (100). Because one's interpretation of past and future influences assessment of current ability and self-worth that influences decisions and behavior (100), models of alternately understanding these time periods would be expected to imbue a better sense of one's ability to personally enact a more positive

future. This general process is noted to be particularly effective when shifting from consistent and uncontrollable causes to more varied and controllable explanations (100). During a transitional heroin moment, such a framework might thus mean explaining past use as understandable given circumstances but still open to change through choice toward an imagined future.

It may not be entirely necessary that the specific models have external validation in the sense of a strong, objective evidence base. Instead, what may be important is that the individual is granted access to a narrative of which she feels to be an element, underscored by the articulated desire for connection in this study. The construction of a personal history seems to be responsive to feasibility instead of logical verification (108, 125). For some, the very creation of a narrative is described as the act of converting raw experience into a somewhat fictional structure that gives it meaning (67). This idea correlates with the postmodern therapeutic notion of not seeking to recognize "correct" answers or to impose them on clients (126). Cultures or subcultures can provide models by presenting collective histories woven by communities of individuals sharing with one another; such collective memory is able to mobilize action by giving meaning to a past (125). The group identity can be translated into a personal identity, the group narrative into a personal one (127). The narrative might then be used as a guide for the future; identity is formed by one's interpreted history of actions (128). Modes of successfully providing such narratives should be an aim of interventions to help one reduce their opiate use when they present during transitional moments.

The idea of creating a history is also related to the construction of normalcy. As participants' temporal perspectives expanded, much of the resulting conflict developed

from the contrast between the present "addict life" and a past or future "normal life." *Normalcy* or *to be normal* is a socially constructed idea that manifests a dominant paradigm. French philosopher and physician Georges Canguillhem thus described normality as being established through an individual's actions and as an idea that cannot be objectively defined (5). Nietzsche, too, wrote that the concept of normal health for an individual is related to each person's goals, desires, and ideals (129). This concept is particularly interesting in regards to the phenomenon of addiction because it is, even more overtly, a socially defined condition with many symptoms being defined as societal offenses in most cultures (130). One criterion for substance dependence in the DSM-IV-TR is that "an individual persists in use of alcohol or other drugs despite problems related to use of the substance" (55), and these problems appear to be defined relative to American cultural standards. Such criteria as giving up "important social, occupational, or recreational activities" and spending "a great deal of time" partaking in substance-related activities (55) cannot exist outside of a societally-defined framework.

Unlike many other medical and even psychiatric disorders, addiction oftentimes has illegal elements. Stigma further estranges those struggling with drug addiction from perceived normalcy (57). Indeed, addiction and drug use are often characterized as having an additionally imposed moral burden (131, 132). In fact, the finding of the experience of conflicting self was often described as an opposition with normality. In a chapter entitled "Further and Further from the Normal World," Keane describes that adopting the addict identity entails the conflicts of "wanting, but not wanting" becoming a mode for organizing the self by providing a way for distancing from desires and behaviors deemed troubling by others (5). This conception of addiction's conflict being

related to external perceptions further calls for the assistance of other external factors in helping to redefine the experience. External models – both in and outside of the detox setting – might provide assistance in creating a new narrative, as the individual attempts to integrate conflicts of past, present, and future into a history they can view as normal. Furthermore, in order to not merely further impose dominant views of normality onto struggling individuals, it becomes important to investigate what these people truly desire. For example, it becomes necessary to consider that the claim "I want to stop using so that I can have a house" might really be founded in the speaker's acknowledgment of what she feels society thinks she should have. Particularly in light of James's claim that a person may be discordantly split into as many selves as there are groups of people whose opinion he seeks wherein setting determines self-identity (101). Establishing a sense of connection outside of the self can be used help to safeguard against externally imposed viewpoints in ensuring that the person identifies with the recovery assistance; for example, if the speaker felt that her experience was being understood, she might not feel compelled to otherwise seek connection through a statement perceived to be appropriate but perhaps not truly felt.

Modes of Assisting Recovery

It is likely that the provision of extrapersonal connection through models that is supported by this study can take myriad forms. Others have also spoken of the role of connection in recovery as (133) for example:

… the yearnings and aspirations for a sense of connection or belonging to some idea beyond the sense of a solitary self. This might be experienced as a sense of connection to a group. The group identity then facilitates a feeling of connection. The unifying factor might take the form of a feeling of connection to a higher power, such as God or a universal energy source. Transforming divisive feelings to a sensible unity experienced in group identity or connection to a higher power is the premise of most 12-step recovery programmes (85).

The purpose of the following sections is to briefly describe support for existing or potential modes of assistance and to call for further research and funding into these areas. The current findings place particular emphasis on using such resources to supplement what exists in the detoxification setting. The theoretical bases for these proposals are their potential abilities to provide connections and the possibility of remodeling an individual's history during a transitional moment. The hope is that by fostering extrapersonal connections, persons will be better engaged and supported in care and better able to bridge to a desired future. The following pages provide an overview of possible and existing sources of assistance and are not meant to be an exhaustive account of such prospects or their current prevalences. Further, because there is no fundamental consensus that there is a common psychology or personality of all addicted persons, different people may be receptive to different sources of assistance (124), particularly in light of the need for feeling a connection, the successful sources of which may be quite personal and varied amongst individuals.

Timing/Placement of Assistance

Given the key finding of this study regarding the occasional occurrence of expanded, conflicting temporal perspective that may lead to recovery, a suggestion is to further investigate the timing and context of these occurrences both as they relate to presenting for inpatient detoxification and otherwise. It is particularly important to note when and where these transition moments might arise in the setting of interactions with health care providers. As noted, study participants' transitional moments occurred during instances of transgressing one's personal limits, experiencing loss, being punished, and forming new extrapersonal concerns such as pregnancy or romance. Further characterization might reveal that ideal times and places for positioning effective assistance might include, for example, confirmation of pregnancy by a medical professional, substance-related emergency department visits (such as trauma or overdose), initial diagnosis of a complication in a primary care setting, or initial interaction with the justice and/or legal system. Given the finding of detoxification sometimes being inadequate to help bridging to the future, investigating other possible locations and times of transitional moments would be fruitful for better situating assistance. Some of these recommendations are not entirely new but are mentioned in order to further encourage their support given the current psychological findings. For example, there has been a recent growth in the amount of services offered for pregnant substance abusing women, through avenues such as counseling, home visits, cultural activities, self-help group sessions etc. (134). Additionally, in the following pages there are recommendations of the specifics types of interventions that may be successful in such contexts and at such times.

The transitional moments, however, will likely be brief such that optimal integration of services would occur at early time points of presentation. In the case of the legal system, for example, it might not be enough to order treatment services at a sentencing, but instead make them available concurrent with arrest. Studies from the UK indicate that arrest referral systems which provide early drug treatment services and information to arrestees have positive effects on reducing future drug use (135, 136). There has also been literature indicating that screening, brief intervention, and treatment referral from the Emergency Department have positive effects on reducing negative consequences of substance use (137, 138). It may also be important to focus assistance efforts on “first” presentations with the assumption they would create move conflict among identity and better spur transitional moments, and further research could investigate this claim. For example, the first time someone is arrested may offer more possibility for change than subsequent occurrences because the person experiences the conflict between “I was someone who had never been arrested” and “I am in handcuffs.”

Peers

The study supports the offering of assistance through peer support during transitional moments. *Peers* are persons who have themselves struggled with addiction, thus providing both a source of connection and a potential model for historical revision. Peer support has been a growing facet of mental health services over the past decade, often suggesting comparable or superior effectiveness when compared to offering professional services for persons with chronic mental illness (139). Within the realm of addiction, peer-services are somewhat regularly employed, including sponsors, recovery

coaches, and addiction counselors, appearing in both professional and non-professional settings (140). In fact, peer support in the recovery of addictions dates back to the eighteenth century, and it is expected to increase in the coming years (141). As times have called for providing evidence for usefulness of these interventions, peers have been shown to be effective for persons with addiction in community-based programs (16).

The present study provides further support for the theoretical bases of such interventions. In addition, it calls for assistance to be specifically provided during transitional moments in order to further support future recovery. This study supports the idea that peers may be able to assist in acute contexts and help span the present of addiction into the future of recovery through person-to-person connection and a model narrative for recovery. One example might be for peers to deliver screening, brief interventions, and referrals in contexts such as the emergency room or outpatient office; the administration may somewhat vary from professional delivery of such services, for example, with sharing of the peer's personal story. Brief interventions delivered by peers in outpatient settings have been found to increase abstinence from heroin and cocaine in a randomized, controlled trial (142).

The present study also supports the existence of representation from mutual support groups in such settings. *Mutual support groups* are composed of non-professional groups of peers who share advice and encouragement, largely in the form of sharing recovery stories (143). While such groups have been shown to have some efficacy over time (143, 144), this paper supports the use of their assistance during transitional moments. Such groups do already appear in some clinical settings such as detox, and research indicates that participation is an effective predictor of positive

outcome following some forms of treatment (145). Counseling from peers associated with mutual suppport groups during inpatient detox has been associated with increased post-discharge attendance at self-help group meetings (146).The finding that patients feel the availability of such groups to be limited in their experiences of different detoxes calls for further integration into existing settings of care and more research into their prevalence. Other research has also called for increased inclusion of such groups in treatment settings noting that the cost of integrating them into, for example, the criminal justice system would be nominal (147). Another potential source of assistance might be a peer-support hotline; individuals suffering from addiction could be given numbers to carry in their wallets for when transitional moments do arise. These hotlines could be structured in a number of ways, including sharing stories and providing referrals.

Empathy and self-disclosure

Another type of interpersonal connection may be fashioned through providers' interactions with people struggling with heroin addiction. Providing empathy is a way that clinicians can connect to their patients, and patients to their providers. The empathic connection can then provide a point through which a provider could help someone to rewrite their narrative by providing adequate interpretive models for the person to use. *Empathy* entails understanding, being sensitive to, and vicariously experiencing the feelings, thoughts, and experiences of another (148, 149). Some methods to communicate understanding include smiling, nodding, leaning forward and linguistic or paralinguistic gestures (149, 150). In some sense, the connection may serve as the interpersonal linking desired by study participants. Gray too noted this of recovery for addicted persons:

A sense of unity might not only be felt within the self; it might also extend to a feeling of unity with others. A subjectively experienced feeling tone of connection with another or others, when its intensity prompts awareness, can be described as empathy. (85).

In this sense, doctors and other healthcare professionals need to foster a sense of connection with those struggling with heroin. Some authors suggest having providers write first-person accounts of their client's stories in order to help gain an empathic understanding (70). In addition, exposure to treatment settings such as long-term treatment outpatient facilities over emergency and acute facilities has been shown to have a positive effect on the attitudes of psychiatry residents toward people with substance use disorders (151). Some medical and other schools are also investigating use arts and the humanities as methods to foster empathy in trainees, even particularly surrounding issues of addiction (152-154). Despite the training that does exist, this and other papers call for additional exposure to learning to cultivate authentic empathy in the provider-patient relationship (150, 155, 156). Cultivation of empathy is particularly important given recent findings that empathy tends to decrease with the experience of medical training (157-160).

Counselor empathy has been used to predict relapses among persons with alcoholism in a number of studies (161), while the therapeutic alliance has been found to predict engagement and retention in substance abuse treatment (162). An alternative mechanism of these outcomes, however, might be that eliciting empathy for a member of a stigmatized group can improve attitudes toward that group, which can then translate

into helping action on behalf of its members (163). Additionally, much of the positive outcome of therapeutic intervention has been characterized as attributable to the nature of this relationship and occur, as *common factors*, across multiple flavors of intervention (150). However, the importance of empathy as it relates to the present study is in forming a connection with a person struggling with addiction. This point of connection may anchor the individual from slipping back into the lived present as it allows for consideration of past and future. Once connected, the provider can help the person to consider hope for the future, to reinterpret the past, etc.; through an empathic relationship, the clinician might, for example, help the person understand their past actions as understandable but explain how he has also seen many patients in similar situations successfully recover over the years and thus has present hope. This study thus supports the training of providers in narrative approaches to medicine, learning how to interpret and help patients interpret stories, a discussion of which exists at the following reference (164).

We might also ask whether some degree of self-disclosure on behalf of healthcare providers would be beneficial for patients in terms of fostering an extrapersonal connection and providing an interpretive framework. There may be potential benefits of patients knowing that their doctors or counselors went through something similar or identify with their feeling. Of course, this is an integral part of peer support but also requires further examination in the context of professional delivery.

The field of allopathic medicine in particular values and creates the ability to maintain some composure, detachment, objectivity, and distance from patients. Such facets have been characterized as at odds with emotional sharing (165). Further, there has

been some thought that self-disclosure will distort the patient-provider boundaries (149) or be potentially disruptive (166), though other reports characterize different types of self-disclosure as potentially boundary-violating versus rapport-building (167). While detachment and objectivity may be important at certain times and settings, perhaps other facets of medicine call for a different type of person, a different type of relationship. In fact, psychiatrists have been shown to have more empathy than practitioners in anesthesia, radiology, and various types of surgery (168). Another study, for example, found that physician self-disclosure was associated with higher patient satisfaction in a surgical setting but lower primary care satisfaction (169).

A literature now exists on error reporting in medicine, suggesting that patients benefit in from disclosure and honesty from their physicians (170). Nonetheless, most of this focuses on mistakes within the *realm of medicine*, committed by *doctors* in terms of risk management. But doctors are people too, and perhaps patients would benefit from knowing this in terms of fostering a connection and points to the possibility of sharing parts of one's life history – events and emotions that a patient may relate to. Some initial investigation has shown potentially positive effects of spontaneous displays of emotion and vulnerability on patient-provider interactions (171). Regarding the field of addiction treatment thus far, Kurtz has said:

Real pioneers…all have something in common…had experienced tragedy in their lives. They all had known kenosis; they had been emptied out; they had hit bottom …whatever vocabulary you want. They had stared into the abyss. They had lived through a dark night of the soul. Each had encountered and survived tragedy. [The] 'kinship of

common suffering' can transcend such labels as 'alcohol' and 'non-alcoholic'…what may be important in the professional arena is, not only technical knowledge and skill, but also a similar authenticity of emotional content (1).

If a patient is struggling with, for example, losing their significant other due to her own battle with addiction, it might help her to hear that her provider struggled when she had a miscarriage and how similar emotions may be at play in both stories, even if the contexts are not the same. Or perhaps there could even be a sharing of similar contexts with the provider sharing a story of personal or familial addiction. By feeling connection through such expressed similarities, a patient might feel that it is possible to achieve and change with the narrative example of a working professional who might have also endured hardship. Rather than attempting to balance a duality between the other's experience and one's own lived experience, perhaps practitioners can look for the similarities between them and to be open to discussing these likenesses. In fact, empathy is said to be transmitted by providers imaging being in the patient's situation by relating it to events in the provider's personal life, though such similarities are typically not explicitly shared (149). What is at stake here is perhaps allowing the patient to see the doctor as another human being rather than as a removed professional. What is at stake is potentially opening up an avenue of connection that may be hidden by a white coat, an embossed name tag, or a mahogany desk so that patients can feel that they relate to their providers and find a way out of the isolating present of addiction. It may work to combat the narrative created, in part, by stigma. Indeed, within the arena of postmodern narrative therapy, practitioners have described increasingly working toward minimizing the

provider-patient power dynamic as well as providing clients with insight into their own thoughts and experiences as compared to previous practices (126). The findings of this study call for more research and additional understanding on the types and effects of potential professional self-disclosure, including within the setting of detoxification and the context of heroin addiction. A current area of inquiry into “relationship-centered” health care also supports the idea of potential physician self-disclosure and expression of empathy as being positive (172).

Spirituality

Another possible avenue for extrapersonal connection is that of spirituality with its potential for associating with the future. In addition to having long-standing connections to healing, the concept of *spirituality* is beginning to appear increasingly in the literature of healthcare and addiction (173). It has been a prominent feature of AA for the last seventy years and is now being sponsored in research projects by the National Institute on Alcohol Abuse and Alcoholism (40).

Spirituality is an idea that is difficult to define or measure, but recent attempts have been made (40). In a systematic review of twenty-five years of publications on addiction and spirituality, Cook describes thirteen distinct conceptual components of spirituality: relatedness, transcendence, humanity, core/force/ soul, meaning/purpose, authenticity/truth, values, non-materiality, religiousness/non-religiousness, wholeness, self-knowledge, creativity, and consciousness (173). Of importance to the present study is that the component of *relatedness* (with *transcendence*) was most frequently described in the publications; it entails a sense of connection, connectedness, or interconnectedness

(173). Reviewing the literature on spirituality and general healthcare, Wills too describes a primary component of connection between the self and something outside of the self (174). Interestingly, the author also notes that the literature on health and spirituality equates spirituality with a sense of forward movement (174), which makes it particularly useful as a potential tool for bridging to a desired future. Spirituality is also described as inherently related to constructing meaning of life events (40) and is implicated in unifying the self (85). In terms of the importance of extrapersonal connection and facilitating consideration of the future into a coherent self narrative as described in the present study, spirituality thus exists as an important means of assistance.

The definition proposed here is thus: Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values (173).

Though some people in recovery may not seek spirituality, many persons report retrospectively that such connection was instrumental to their change (40, 133). A growing body of addiction research implicates spirituality in improving sense of life purpose, length of sobriety, treatment outcomes, and resistance to relapse (40, 173), as

well as decreased heroin and other illicit drug use (175). And in one study of inner-city HIV-positive drug users, it was found that a large majority of participants desired treatment that involved spirituality, believing it would be helpful in reducing cravings, following professional advice, and increasing hopefulness (176); the anticipation of increasing hopefulness translates into helping to see a potential for a positive future.

These ideas also provide support for additional inclusion of spirituality through the 12-step movement, with its articulated values of connecting to a higher power and to other people (173). In fact, 12-step programs have been described as cost-effective and useful in promoting recovery (40). It is important to note that spirituality may or may not entail organized religion. The present study supports further integration of 12-step or other spiritual resources, such as religious advisors, nature, or even art (as follows), into professional healthcare settings such as detox, particularly in moments where transitional moments may arise. Further characterization of possibilities for integrating spirituality into addiction is thus called for.

The Art of Music

Art may also serve the role of allowing extrapersonal connection and refinement of narrative for persons with addiction. Of course, there is a wide variety of types of art – music, painting, writing, etc. – as well as limitless variety within each domain. The following can only serve as a very brief introduction, with a particular focus on music given more abundant research on this art form. Firstly, music has an ability to foster connection. For example, there is an interpersonal hypothesis of music developed by psychiatrist Ferdinand Knobloch that posits that the artistic event allows for a sense of

unity and identification between creator and perceiver (177). Music has been described as having a somewhat spiritual ability to inspire “deep interpersonal connection” (178). Over the last forty years, literature has shown musical activity’s ability to engage isolated individuals into groups (179). It has also been specifically demonstrated to improve interpersonal communication and social interaction (180). In its ability to connect persons, music has demonstrated a specific buffering effect on social isolation in substance users (181). What appears evident is music’s potential ability to offer the extrapersonal connection underscored by the findings of this study.

Listening to music also provides an avenue for the creation of a narrative self. It is noted that meaning in music is both open-ended and constrained, allowing for construction of one’s identity through appropriation of musical listening (128). The same author points out that at times people may listen to music long enough to challenge a given identity or to disrupt pre-internalized social messages (128). Music can arouse memories and life stories and so help define one’s personal, social, and ethnic identity (182). In using music as a therapeutic intervention for substance use, it has been noted that it allows persons to explore temporal connections among past, present, and future (183). One might imagine that connecting to a song with lyrical narrative about having overcome addiction or similar hardship would be a potentially valuable tool for recovery.

The act of songwriting or creation of other narrative art forms might serve the function of allowing for historical reanalysis. This idea is related to the idea that the very act of telling of stories allows one to produce solutions to mental health problems (126). In a single session of songwriting and lyric analysis, for example, substance use clients were found to significantly replace guilt, regret, anxiety, and blame with positive feelings

(184). Such positive framing in light of music's ability to participate in forming self-concept and social self (185) may allow for individuals to rework their personal narratives in ways that are more conducive for recovery. Non-music related narrative art in incarcerated women, for example, has been noted to help reformulate past events and expectations for the future with an emphasis on feelings of normality (186).

Further research would need to clarify which types of musical or other interventions are most conducive to assisting in recovery. Within music, for example, the possibilities of integrating effective passive listening, group singing, or lyric writing need further analysis but are supported by this study for potentially positive effects on transition moments. In a detoxification setting, music groups of lyric analysis or group singing might be increasingly implemented, whereas passive listening to recorded music might be more feasible for an emergency room setting. One randomized-controlled trial has shown positive effects of music therapy on readiness for change in an inpatient detoxification setting (187). Among other reasons, the high frequency of substance use references in popular music (188, 189) requires additional research into the potential of both positive and negative effects, such as assisting coping versus enhancing craving.

A Note on Medicine

As much of the above discussion was not specifically biomedically oriented, it is important to note that health extends beyond such margins. The World Health Organization, for example, defines the concept of *health* as encompassing the "physical, mental, social, and spiritual aspects" of well-being (174). In the process of understanding what it is like to live heroin addiction, many mental, social, spiritual, and structural facets

came to the forefront. This fact does not, however, undermine the validity and potential of biomedical assistance as well. It may be however, that the lived experience of an illness is somewhat distinct from the objective, medical view of it (190) such that it did not frequently arise as a subject during this study.

The biomedical model of addiction states that it is a chronic, relapsing medical disease of the brain with altered neural circuits (191, 192). This model may serve as another source of potential narrative reworking if individuals feel connected with it. The idea of addiction as a medical disease may help to relieve stigma, blame and responsibility for individuals, the medical community, and the general public (5, 57). It allows for comparisons with other chronic diseases like diabetes and hypertension (191) and thus may potentially remove some of the guilt or shame associated with a more moral depiction. Nonetheless, medicalization may be an inadequate model to entirely describe addiction (5). Though it does not specifically negate social, mental, or spiritual qualities of the experience, it often does not address them either and thus may not offer a point of connection for some people. Furthermore, the medical model has potential negative consequences, including causing individuals to develop a distinction between themselves and other, normal people because of having a different kind of brain (57). Given the articulated motivation for normalcy, such perception may have negative treatment outcomes such as relapse, which is a potential association requiring further investigation.

One potential way to integrate the biomedical and other aspects of addiction in detox and other settings might be using the proposed avenues of assistance to facilitate other scientifically-based treatments. For instance, both methadone and buprenorphine are regarded to be effective pharmacological treatment interventions (193, 194).

However, treatment retention and relapse are still problems (195). Other approaches with scientifically-regarded foundations include cognitive behavioral, community reinforcement, motivational enhancement, and contingency management methods (16). Given the scope of the problem, however, the United States still significantly struggles with the problem of heroin addiction. By connecting patients to assistance through peer support, empathy, art, or spirituality, they may better adhere to medical interventions if they desire them. For example, there is a developing literature that music therapy improves motivation and engagement in substance abuse treatment (179, 196-198). And in general it is noted that provider-patient relationships seem more positive in fields of complementary and alternative medicine, possibly explaining the relative preference of these modalities by some individuals (149). Thus integrating complementary modes of assistance into more conventional treatment settings may help connect patients to established treatment modalities and simultaneously to sources of revised, future-oriented narratives. This idea also helps to resolve the distance between participants' identification of logistical deficiencies as primary barriers to treatment and knowledge that there are also psychological, social, neurochemical and other elements affecting possibility of recovery. The desire for connection, if so addressed, might become a way for persons to more effectively enhance their own motivation for recovery (through psychological and social means) and to even engage with existing structures of treatment, including neurochemical ones.

At the same time it is important to note that an almost equal number of people achieve recovery without formal addiction treatment as do those who utilize services (141). This fact indicates a possibility for existing treatment programs to incorporate

effective elements of natural recovery. It also signifies that providers may refer patients to or suggest social support systems perhaps considered outside the network of formal treatments, such as peer networks or spiritual groups.

Why Recover?

Before concluding, the paper will examine potential reasons for *why* someone should want to recover and *why* we should conduct research into answering this question, drawing on information from the implications of the current study. The economic costs detailed at the beginning of this paper are significant, with around $21.9 billion USD spent on heroin addiction and related costs in 1996 (3). While this portrayal may be true, it may not feel relevant or persuasive for the individual person using heroin such that personal justifications for recovery should be investigated.

There is, in fact, an argument for recovery that relates to the basic findings of this study. By experiencing an expanded temporal perspective of life that appears incompatible with addiction, one is more able to experience the unique life of a human being. Why not escape pain of past and thoughts of a bleak future by immersing into the present? By drawing on the philosophies of Locke and Nietzsche, Poole provides an answer: perhaps because accepting such facets of life also opens the possibility of experiencing a more meaningful and fulfilling existence (127). With perspective and the ability to change comes a sense of worth accompanied by a sense of responsibility (115). In addition to experiencing the first-degree privilege of being able to use higher cognitive functions, there is also the idea that the existence of certain emotions is dependent on being able to be projected into the future, as exemplified by future-oriented love as

different from present-focused lust (115). Poole's ideas directly relate to the temporal perspective described in this study:

It is because I have the kind of consciousness that places me in the past and also in the future, that a certain range of emotions and commitments become possible; I can have deeper and more satisfying relations with others than is possible for a being who does not have that kind of consciousness. But a price for entry into this form of life is that one acquires the burden of the past, responsibilities that remain in the present (127).

The very meaningfulness of life may in fact be a function of projecting into the future (67). This idea can potentially call up an entire bioethical and philosophical literature on quality of life; this paper does not intend to address the arguments of whether a life of reduced cognitive function is inferior to those of others, for example, in the prototypical example of an infant born with trisomy 13. This work does, however, suggest that a valid argument may be that one would benefit from experiencing higher cognitive functions *if* that option is neurobiologically available. There is the idea that a fundamental difference exists between pleasure (or fulfilling bodily needs and drives) and enjoyment (which has the element of expanding existence, with effects on growth and motivation) (199).

Also, these claims only stand if the life of the person can actually be improved by abstinence, substitution treatment, psychiatric services, etc., which many participants felt would not be available to them. It has been previously noted that many people with mental illness do not desire to live a life full of engagement in community based

programs (200). However, research has indicated that longer recovery times from heroin and cocaine are generally associated with lower stress, higher quality of life, and more life meaning (40). In that way, the potential value of a person being able to consider problems of the past may also be to avoid pain or achieve better outcomes in the future.

Conclusion

In conclusion, the lived experience of heroin addiction is an enveloped present. Moments may arise in which a temporary consideration of past and future are undertaken. It is thought that these moments can be facilitated into recovery by providing forms of assistance with which people can connect. Such connection would open an avenue for maintaining consideration of past and future in reformulating a personal narrative. Currently, some patients feel that detox settings do not successfully provide this needed support.

With transition, the future can be approached in a more positive light, which is the idea of *hope*, frequently desired by study participants. Hope has been defined as positive expectations for the future (174). It involves a sense of connection between the self and something external (200). The term encapsulates both the process and goal of assistance interventions. With connection there may be history, and with history there may be hope:

We shall call them historical human beings; a glance into the past drives them on toward the future, inflames their courage to go on living, kindles their hope that justice will come, that happiness is waiting on just the other side of the mountain they are approaching (76).

Limitations

As in all research, there were limitations to this study. Attempts were made to enumerate them throughout the current manuscript when applicable to the methodologies or other considerations. In general, however, by employing qualitative techniques, this study may have sacrificed some reproducibility and generalizability in pursuit of validly describing the human experience (21) of a specific group of individuals presenting to a single detox. Small sample size and opportunistic sampling can lose some breadth and scale of qualitative findings (21). With self-report, there is always a concern about bias, misrepresentation, and poor recall (21), though careful attention to established methods was pursued. Despite these limitations, the current study represents an insight into the lived experience of heroin addiction surrounding detoxification and provides possible avenues of improving the available treatment system.

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