

**THE MEANING OF HEROIN ADDICTION: A PHENOMENOLOGICAL STUDY**

by

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## ABSTRACT

Heroin addicts are often misunderstood and stigmatised. The aim of this investigation was to provide the reader with a description of the life world of heroin addicts who seem unable to recover from their addiction. The phenomenological method was used in order to achieve the aim of this study.

Themes which emerged were that heroin traps the addicts in a paradox - creating meaning for them and robbing them of it at the same time. They develop a personal love relationship with the heroin, which turns into an abusive relationship. Recovery holds no guarantees as the addicts experience the process of recovery as a never ending cycle.

This study highlights the value of the phenomenological method in describing the life world of the heroin addict undergoing treatment. Recommendations are made which may be of value to the professional working with the heroin addict.

Key words: Heroin; addiction; meaning; phenomenology; relationship; abuse; paradox.

Student number: **441-050-5**

I declare that:

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is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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## CHAPTER 1

### INTRODUCTION

The format of this chapter is taken from the suggestions by Creswell (1998), De Vos (2002) and Moustakas (1994).

#### 1.1 GROUNDS FROM WHICH THIS TOPIC EMERGED

This study is concerned with heroin addiction and the people experiencing it. Heroin is one of the substances that are used worldwide. Heroin is viewed as the 'end of the road' drug and the users appear to be more isolated than other addicts. They also carry an aura of status in the drug abuse population. This status may be one of dread for non-users or that of admiration for other drug users.

Krivanek (1988) claims that according to popular views it would seem that heroin addiction appears to be the most difficult addiction to treat and recover from. A greater stigma seems to be attached to the use of heroin than any other drug of addiction.

According to many health workers in the field, the chances of recovering from this addiction is only four per cent. This may reflect the viewpoints and expectations of those professionals who treat the addicts.

Many descriptions of addiction appear to have been made by experts – professional people having researched different aspects of addiction. The findings of the research, albeit very valid and contributing to the knowledge and understanding of addiction, appear to be categorising and judging certain characteristics and processes of people addicted to heroin. Many descriptions include processes of addiction, behaviour and personal characteristics of the



addict, the effect on the physical, emotional, spiritual, and relationships with significant other and society as a whole. The medical perspective focuses on the progressive nature of the 'disease'.

## 1.2 PREVIOUS RESEARCH

Peele (1985:xii) is of the opinion that the conventional view of addiction – aided and abetted by science – does nothing but convince people of their vulnerability. It is important that we convey realistically the dangers of the substances, but very important that we convince people of the benefits of health and of positive life experiences.

Early twentieth century concepts of addiction, as described by Light and Torrance (in Peele 1985:6), which forms the basis of most scientific and popular thinking about addiction today, have not provided a good description of either drug related behaviour or of the behaviour and subjective experiences of the addicted individuals. They described addiction to a narcotic as a malcontent demanding satisfaction and reassurance, resulting in craving and withdrawal.

The conventional (medical) view of addiction as defined by Alexander and Hadaway and Dole and Nyswander (in Peele 1985:56-57), describes addiction as a metabolic disease. This definition assumes that the introduction of a narcotic (heroin) into the body causes metabolic adjustments that require continued and increased dosages of the drug in order to avoid withdrawal.

Drug use and reliance on drugs, as described by Greaves, Kaplan and Wieder (in Peele 1985:71), is a purposeful process, assisting the user in the effort to adapt to internal needs and external pressures. Drug use is described in terms of its ability to resolve psychological problems.

Both medical and psychological models, as researched from the 1970s to 1980s, provide clear indications of psychological and physical signs of addiction; these signs are seen as universal to all addicts. They do not seem to include the personal processes and experiences of the addict.

Foucault and Szasz (in Peele 1985:5) are of the opinion that the evolution of heroin addiction was part of a process that 'medicalised' what were previously regarded as moral, spiritual and emotional problems.

Peele (1985:6) quotes Levine as asserting that the modernised definition's view is that of the individual not having the ability to make choices, and that addicted behaviour is outside the realm of ordinary consideration and evaluation. This idea flows from the belief of the existence of biological mechanisms.

The above processes were then replaced by deterministic models of craving and withdrawal.

These models, which viewed the need for a drug as qualitatively different from other kinds of human desires, came to dominate the field. The image of the addict as powerless and unable to make choices and invariably in need of professional treatment, ruled out (in the minds of the experts) the possibility of a natural evolution out of addiction brought on by changes in life circumstances.

Peele (1985:2) challenges these definitions by stating his point of view - that addictive behaviour is no different from any other human feeling and behaviour

### 1.3 INCIDENTS THAT HIGHLIGHT PUZZLEMENT AND CURIOSITY REGARDING THE RESEARCH TOPIC

Recovery from heroin addiction appears to be a difficult and frustrating situation for both the addict and the treatment personnel, both medical and therapeutic.

Despite many efforts at intervention, the relapse rate among heroin addicts is still very high. Most heroin addicts who enter treatment, are determined to recover, and many appear to have meant it when they said it was the last time - that they were going to die if they did not stop using heroin.

When treatment begins, when withdrawal and craving sets in, ambivalence sets in as well. The heroin addict becomes confused regarding treatment. Some feel the craving gets too much; they may abscond from treatment and discharge themselves, claiming that they are better; or, alternatively demand more and more medication. Some even arrange for some heroin to be brought to the treatment centre. Many addicts complete the treatment programme, do well for a while, relapse and return to the treatment centre. Some surrender to the addiction and continue to use heroin.

#### 1.4 THE PROBLEM

Heroin addiction is not a new phenomenon, as heroin was used as far back as the Second World War, by German soldiers.

Various theories attempt to explain addiction as that of a progressive disease, the person having an addictive personality, genetic predisposition, lack of social and psychological coping skills, escape from reality and inability to make rational choices. Heroin addiction is also viewed as a self-inflicted injury. (See section on previous research).

Despite the many methods of treatment arising out of the above approaches, a return to heroin use occurs frequently. Utterances by families, therapists and medical staff have been that they do not understand what happened after all the effort that was invested in the treatment of the heroin addict. They do not understand how the addict can choose heroin over many other good things in life and why they choose heroin despite warnings that it will cause their death.

The addict's answer is often "but you don't understand". Many have uttered the words, "you have not been there, so how could you understand?" Some answers that are given are: "we don't have to have been there in order to understand – we have seen enough about what heroin addiction does to a person".

### 1.5 QUESTIONS ARISING FROM THE PROBLEM

Questions that arise from the above are: Do we really understand the life world of the addict? If we have seen enough of what heroin addiction does to the person, whose perspective would that be? Does this not exclude the perspective of the heroin addict?

With the failure of treatment in mind, can another dimension be added that would assist in the treatment of the heroin addict?

It would appear that the personal experiences and meanings attached to these experiences have not been answered adequately.

### 1.6 AIM AND OBJECTIVES OF THIS STUDY

Peele (1985) argues that successful management of heroin addiction may lie in the meaning that this addiction holds for the user, but before the meaning can be changed, it must be understood.

The aim of the study is:

- To provide a holistic description of the meaning of heroin addiction, as experienced by the person using heroin.

The objectives are:

- To gain an understanding of the lived experiences of the heroin addict.

- Use a qualitative study to achieve the above aims, by doing an in-depth enquiry in order to reflect the complex life of the heroin addict.

## 1.7 RELEVANCE OF THE STUDY

A wide range of healthcare practitioners have an interest in this domain of enquiry. These include social workers, psychologists, medical professionals criminologists and significant others that are affected by this addiction.

This study may be used to complement the existing body of medical and psychological knowledge of this phenomenon.

It may be useful in providing practitioners, and those involved in the lives of addicts, with a different description and understanding of the experiences of heroin addiction; these experiences are described by the experts - the addicts themselves.

The study may also provide a basis for further study, in order to develop a complementary treatment model.

Healthcare practitioners may be equipped with an alternative description of heroin addiction. This may assist them in finding new routes in their interventions and treatment of heroin addicts.

## 1.8 METHODOLOGY

A qualitative, descriptive research design was chosen for this study, using phenomenology as strategy. Since the research question is based on the client's perceptions, the phenomenological strategy is an appropriate method for this study. (Creswell 1998:292).

The qualitative approach enables the researcher to gain first hand, holistic understanding of the phenomena of interest, by providing a flexible strategy of problem formation and data collection.

Reid and Smith (in de Vos 2002:105) are of the opinion that the qualitative approach and methodology assumes that valid understanding can be gained through accumulated knowledge acquired first hand.

The researcher is able to tell the story from the subject's point of view by studying the person in his natural setting, rather than acting as an expert who passes judgement on participants.

Phenomenology aims to understand and interpret the meaning that subjects give to the experiences of their everyday lives. Creswell (1998) confirms this view by explaining that a phenomenological approach enables the researcher to describe the meaning that experiences of a phenomenon has for various individuals. The researcher eventually reduces the experiences to a central meaning or the essence of the experience being studied. The product of the research is then a description of the essence of the experience being studied. The researcher enters the life world of the subject being studied, placing himself in the shoes of the subject.

Meanings, themes and general descriptions of experiences are analysed within a specific context.

This approach is useful to use in order to achieve the aim and objectives of this study.

The term "he" is used in the text when referring to the heroin addict, representing both male and female.

## CHAPTER 2

THE PHYSICAL AND PSYCHOLOGICAL CHARACTERISTICS AND  
EXPERIENCE OF HEROIN ADDICTION

## INTRODUCTION

This study focuses on the meaning of heroin addiction - in other words, the lived experience of the person with a heroin addiction. As this study focuses on the lived experiences, the literature study focusing on the following concepts is appropriate. It would be more appropriate to speak of the person with a heroin dependency problem, than of the addict. The researcher will, however, use the more common terms 'addict' and 'addiction', as a means of simplification throughout the research report. The intention is not to label the person, but refers to the person with a heroin dependency problem.

Addiction is a complex syndrome into which more enters than just the effects of a given drug (Peele 1985:23). It is a phenomenon that consists of both the physical and psychological aspects of addiction.

Addiction to heroin is a complex phenomenon and much research has been done over the years. Various models and theories are useful to describe the complexity of addiction. Some focus on the biology (conventional definitions); others focus on the psychological aspects of addiction. It becomes clear that in order to obtain a holistic approach, both these aspects should be taken into account.

The relationship between mind and body is salient in the study of addiction (heroin), as both physical and psychological aspects are important. Keeping this in mind, writings pertaining to both aspects will be reviewed.

This chapter focuses on both the physical and psychological aspects of heroin addiction. Thereafter, a dimension, addiction to an experience, is discussed as well as the functions of addiction, the relationship with the drug, and experiences of grief and loss when the heroin use is terminated. Another aspect, the mysticism, that which people find difficult to understand, is described.

Theorists, therapists, parents, health care workers as well as the addict himself, all construct their own meaning regarding heroin addiction, resulting in many different meanings, leading to a somewhat confusing situation: that this addiction is hard to understand.

One perception of addiction is that it is a characteristic of people, and not the drug itself (Peele 1985:23). He further explains that one cannot remove extraneous psychological and social considerations, because what is identified as a pharmaceutical characteristic of the drug, exists only in the heroin user's sensations and interpretations of the effect of the drug, thus the meaning it has for them.

The heroin is the object of addiction, but it is the experience and the meaning thereof, as construed by the user, that may provide more understanding of how this addiction is experienced.

Many biographies of heroin addicts reveal an aspect of this addiction, namely, the personalisation of the drug, resulting in a personal relationship. When this relationship is severed, that is, when the addict attempts to give up the use of heroin, they experience intense feelings of grief and loss. This may be one dimension that is not easily understood by many people.



This chapter will focus on the physical and psychological aspects of addiction, as well as the functions of the heroin addiction, the relationship with the drug, and the grief and loss when the use of heroin is terminated.

## 2.1 THE DRUG

What is heroin?

Heroin is also referred to as a narcotic, an opiate, or an opioid. The description may cause confusion among people, thus, a short description is given as clarification.

### 2.1.1 **Narcotic**

'Narcotic' refers to the Greek word for 'stupor'. This name was once applied to any substance that induced sleep. As alcohol and other substances may also induce sleep, the meaning of the word narcotic has changed to "a strong morphine-like analgesic". Morphine is an opium derivative and the descriptions 'narcotic' and 'opiate' were used interchangeably. Narcotics became the name used for a variety of illegal drugs and is used mostly in legal contexts. There are various laws prohibiting the selling, buying and using of these drugs. Contravening these laws is punishable by the courts. The name narcotic is used in this context.

### 2.1.2 **Opiates**

Opiates are drugs derived from opium. A few of the natural opiates, morphine and codeine, are clinically useful as they have a powerful analgesic and euphoric effect on people.

### 2.1.3 **Opioids**

Opioids are synthetically manufactured drugs with morphine-like effects.

#### 2.1.4 Heroin

Heroin is a natural opiate, made from morphine (a natural opiate). The pharmacology of heroin is discussed in the larger context of the natural opiates and it acts primarily through its parent drug, morphine (Krivanek 1988:68-69).

Where the literature refers to opiate or narcotic, the researcher will use it in the context of heroin use/abuse.

Heroin is viewed as THE drug of addiction, the source of many evils. Yet, it is a drug like any other in medicine. Morphine is a legal, widely used drug, but there is a stigma attached to heroin, being an illegal drug.

Few other drugs are as effective as the opiate group in the management of pain (Krivanek 1988:70).

## 2.2 THEORIES AND MODELS PERTAINING TO THE DESCRIPTION OF HEROIN ADDICTION

Three models, the biological model, the social and psychological model and the phenomenological model are used to describe different aspects of the experience of heroin addiction.

### 2.2.1 Exposure theories – a biological model

Alexander and Hadaway (in Peele 1985:56) refer to the concept of narcotic addiction as the inevitable consequence of regular narcotic use. Addiction is viewed as a disease, due to the serious physical consequences it holds for the user. Underlying this model is the assumption that the introduction of a narcotic into the body causes metabolic adjustments that require continued and increasing dosages of the drug in order to avoid withdrawal. No alteration in cell metabolism has yet been linked with addiction, however. Dole and Nyswander (1967) were well known for describing heroin as a metabolic disease. They have

not, however, provided any explicit metabolic mechanism that accounts for it. Critics state that exposure to narcotics does not lead to addiction and addiction does not require the metabolic adjustments claimed for it (Peele 1985:57). The biological or medical models may explain, to an extent, the conventional definitions of addiction.

The biological model is deficient in the sense that it does not provide for a description of drug behaviour. It circumvents the psychological and social aspects of which drug use is part (Peele 1985:69).

### **2.2.2 Adaptive theories – Social and Psychological Models**

Studies (Greaves 1974; Kaplan and Wieder 1974; Khantzian 1975; Krystal and Raskin 1970; Wumser 1978) have revealed that drug use and reliance on drugs is a purposeful process, assisting the user in their effort to adapt to internal needs and external pressures. Such theories describe drug use in terms of this ability to resolve psychological problems. This includes the psychological functions that heroin use has for the user (Peele 1985:71).

The adaptive theory approach developed in response to the finding that few of those people exposed to a drug, even over an extended period of time, came to rely on it as a life organising mechanism (Peele 1985:72).

This adaptive theory approach can be adapted in defining the psychological, non-conventional definition of addiction. According to Peele (1985), a satisfactory model must be faithful to lived human experiences of their addiction.

Alexander and Hadaway (in Peele 1985) sum up the exposure and adaptive approach as follows:

- Exposure orientation (biological models) views opiate (heroin) addiction as a condition that occurs when opiate (heroin) use leads to a powerful tendency towards subsequent compulsive use;
- Adaptive orientation (social and psychological models) views opiate addiction as an attempt to adapt to chronic distress of any sort through habitual use of opiate drugs.

These models do not, however, adequately explain the progressive, self destructive nature of severe addiction (Peele 1985:134). They do, however, provide opportunities to improve understanding of the nature and significance of heroin use for the person, by providing an important basis from which to understand and treat addiction (Drummond 2001:33).

### **2.2.3 Phenomenological Models**

The mind-body duality has hidden the fact that addiction has always been defined phenomenologically in terms of the experiences of the person, and observation of the person's feelings and behaviour. Addiction may occur with any potent experience, but in this study the researcher refers to heroin (Peele 1985:25).

Studies show that addiction has more to do with subjective factors (feelings and beliefs) than with chemical properties or with the addict's history of drug abuse (Peele 1985:17).

Phenomenological models are essentially descriptive rather than explanatory, derived from the interview and observation of addicts' population. (Drummond 2001:35). It further provides a powerful description of human behaviour, one that opens up important opportunities for understanding drug abuse/addiction. (Peele 1985:2).

The strength of the model lies in the attention it gives to the human experience. These models are also useful in generating hypotheses regarding the experience of addiction (Drummond 2001:2).

This study views heroin addiction from a phenomenological point of view, which may assist in describing and understanding the phenomenon from another angle. This dimension is often misunderstood by people.

## 2.3 THE NATURE OF HEROIN ADDICTION: PHYSICAL AND PSYCHOLOGICAL PAIN RELIEF

One of the reasons for using heroin is that it relieves the suffering of physical and psychological pain. The physical effects of heroin can be related to the effect of heroin being a central nervous depressant.

### 2.3.1 **Central nervous system depressant**

The effect of heroin on the brain, mind and mood are predominantly depressant, resulting in drowsiness, mental clouding, sedation and lethargy. The user's initial experience is normally pleasant; they experience warmth, well-being, peacefulness and contentment. This is often accompanied by a dream-like state, a 'turning inwards' and sleep.

Heroin poses major potential problems as it depresses the activity of the brain's respiratory centres. At high doses, respiration may become inadequate (cough suppressant) and death due to respiratory failure from heroin overdose may occur. (Krivanek 1988:70).

### 2.3.2 **Heroin as analgesic**

Another major effect of heroin (morphine) is that of analgesia (chronic pain relief) resulting from injury or chronic illness. The person feels the pain, but is not too

bothered by it. Heroin decreases the suffering associated with pain, rather than the pain itself (Krivanek 1988:71).

### **2.3.3 Heroin and sexual experiences**

Heroin users have reported that seconds after an intravenous injection of heroin, they experience a flush of warmth spreading throughout the body, experiencing it as similar to that of a sexual orgasm. Some users have reported it to be 'even better'. The use of heroin serves not only to alleviate the anxiety relating to fulfilling sexual roles, but is actually reported to having replaced these feelings (Stimmel 1975:102).

Many male heroin users report experience impotence while on heroin, and many women report a lack of sexual drive (Stimmell 1975:64).

### **2.3.4 Illegality versus toxicity**

According to Robertson (1987:45-46) society's reaction to heroin use generally reflects the belief that once heroin has been tried, dependence is inevitable, and it becomes a permanent or fatal state. Remissions and relapses are a common occurrence in the process of recovery from heroin addiction. A remission (abstaining from using heroin for a period of time) may represent a cure, as many people believe 'once an addict, always an addict'.

It would appear that physical and personal harm from heroin use result more from its illegality, not its toxicity. The illegal heroin that is bought from dealers on the street is often mixed with other substances which can be very toxic and, sometimes, lethal. Krivanek (1988:95) is of the opinion that morphine (of which heroin is a derivative) appears to be a remarkably safe drug if used medically correctly; that is, using the correct dosages, using clean needles, and using it solely for chronic or acute pain.

There is a fairly high incidence of opiate users among medical doctors. Heroin is not often used, but morphine and pethidine (opiate group). Physicians appear to experience less harmful consequences as they use clean needles, standard doses of the pure morphine, good injection techniques; also they have good knowledge regarding nutrition (Krivanek 1988:96). Most street addicts do not have these advantages, as heroin is classified as an illegal substance; therefore, many toxic substances are mixed into the heroin in order to increase the quantity in order that the dealers earn a bigger financial profit.

The high price of heroin forces the user to compromise both their nutrition and living conditions. Heroin also has appetite suppressant qualities as well as analgesic effects, which can lead to the user ignoring ill health until the problem is very serious.

When the drug is impure, or the technique unsterile, the range of consequences is enormous. Virtually every organ in the body can be affected (Krivanek 1988:96). Overdoses, fatal and non-fatal, can occur.

#### **2.3.5 Fatal and non-fatal overdoses**

Knowledge of the dangers of illegal heroin use is often known by the potential user and even having friends who have suffered secondary complications such as an overdose, does not serve as a deterrent to the potential user (Stimmell 1975:63).

A quote by a mother in Ridley (2006:9) reads as follows: "I don't think that anyone who has not been addicted to drugs can understand what happens in the mind of an addict. If you have not been there, you cannot understand the incessant pull of drugs".

Many people believe that a heroin overdose is the usual cause of death in users. When an overdose kills, it happens by depression of the central nervous system -

the brain mechanism which activates respiration, and this rapidly causes asphyxia and death. This happens when a user administers a dose of heroin which exceeds the personal limit of tolerance.

Overdose may also occur following a loss of tolerance, when the user has abstained from drug use for a reasonable time and tolerance is drastically reduced. A known dose may be enough to cause respiratory depression. Furthermore, overdose may also occur when the heroin user takes other substances (especially alcohol) which may have depressant effects on the central nervous system (Robertson 1987:72).

Non-fatal overdoses are seldom considered as such by heroin users. Many users, at an alarming rate, report episodes of loss of consciousness, prolonged intoxication, lack of spontaneous breathing, where fellow users had to stimulate breathing, to prevent death. (Robertson 1987:73).

## 2.4 PHYSICAL DEPENDENCE

The conventional definition of dependency (addiction) is characterised by tolerance of the drug, withdrawal symptoms when the drug is stopped, and craving when the need to use the drug arises. Addiction is recognised by the heightened and habituated need for the substance (heroin), the intense suffering resulting from the discontinuation of its use, and the person's willingness to sacrifice all for the drug taking (Peele 1985:1)

The conventional definition of physical dependency (addiction) focuses on the drug (effect/potency) rather than experiences and feelings. The focus is on the physical process of addiction. Addiction is then considered to be an adaptive state, characterised by behavioural and other physiological responses.



- The heroin user has a compulsion to continually take a drug in order to experience (physically) its pleasurable effects, such as analgesia.
- The user also takes the drug in order to prevent the withdrawal symptoms. Physical bodily disturbances occur when the drug is abruptly suspended; the user feels hot and cold (as in fever), aches and pains and muscle cramps. "It is as if you have severe 'flu, times a hundred".
- Users eventually no longer receive pleasure from the drug. They take it in fear of precipitating withdrawal symptoms (Stimmell 1975:95).
- Tolerance develops when the need to increase the dose arises, in order to sustain the initial pleasurable effects of the heroin.
- Craving takes place when any of these unpleasant effects occur, or any other association with the drug is made, such as witnessing another person injecting heroin. The user knows that the heroin will relieve these unpleasant feelings (Stimmell 1975:89).

Other authors share a similar perception of the physical aspect of addiction.

Krivanek (1988:84) is of the opinion that physical dependence is not fully understood, but most experts agree that it represents some form of counter-adaptation to the presence of the drug. Where at least some form of tolerance can be explained as a decrease in the body's reactivity to a drug, physical dependence seems to involve the development of an active mechanism to counteract its action. When a high degree of tolerance is being attained, even large amounts of heroin may fail to produce any euphoric effect; the user may only feel normal. When intake is stopped, a profound derangement known as the withdrawal syndrome, quickly ensues.

- Withdrawal is characterised by bodily discomforts and depleted energy. These symptoms become the signal that a new dose is required.
- When the drug is then administered, it provides a feeling of energy, and mental efficiency is restored.

- If the administration of the drug is delayed too long, or is unavailable, withdrawal begins in all earnest, beginning with intense craving.
- These symptoms are generally the opposite of what the heroin provides; this then suggests that compensatory measures have been established against its action – the body's reaction.
- In the case of heroin, the more the drug depresses various functions, the harder the body tries to bring them back to normal. With the heroin gone, the body continues to fight an enemy that is no longer there (Krivanek 1988).

The definition of heroin addiction (dependence) emphasises the presence of both physical and psychological components (Robertson 1987:32).

Robertson (1987:33) recognises the difficulties in categorising drug problems and problem drug users, which has led to a shift in perception away from the term addiction to the wider concept of dependence. He views this move as allowing for drug use not only connected to the obvious physical consequences, but also looking at heroin (opiate) users who are not physically dependent, but who are experiencing adverse consequences differently.

A shift of attention from a specific drug or constellation of symptoms, is useful for many reasons:

- It draws attention to the individual rather than the drug.
- It allows consideration for more than just the withdrawal, tolerance and craving phase.
- It commits those involved to the longer term nature of the problem (Robertson 1987:34).

This leads us to the psychological aspects of addiction.

## 2.5 PSYCHOLOGICAL EFFECTS

There is no question that physical withdrawal is unpleasant, even if the degree of physical dependence is not great. Many of the symptoms are reduced by medically administered procedures.

Research by Robertson (1987:41) has shown that as little as 10% of heroin users become physically addicted. Krivanek (1988:90) raises the question: Why do so many heroin users persist in using heroin under conditions that give them every reason to stop? In the same way that heroin relieves physical pain, so it also brings relief for psychological pain.

### 2.5.1 Analgesic for psychological pain

The analgesic effect of heroin on the user has a psychological effect as well. The user feels the pain, but is not bothered by it. Heroin decreases the suffering associated with the pain rather than the pain itself.

Heroin eliminates the effects of anxiety relating to many problems. It diminishes sensory input, therefore alleviating psychic pain. This relief from suffering is followed by the positive feeling of euphoria, furthering heroin use. (Stimmell 1975:63).

Ed, writing in Smith & Gay (1972 :145) describes the following feeling:

*“The mellowest downer of all. After the fix, you feel the rush, then you float about for a few hours, nothing positive, just a normal feeling, nowhere. It is like being half asleep, nothing gets through to you, you are safe and warm. The big thing is, you don’t hurt. You can walk around with a burst appendix, rotten teeth and not feel the pain. You don’t need sex, food, people, you just don’t care. It is like death without permanence, life without pain.”*

### 2.5.2 Euphoric existence – escaping from reality

Field in Krivanek (1988:75) a former heroin user, reports:

- It slows down the mind, preventing anxiety that makes rational thought and, hence, solutions, so difficult.
- When financial, work or emotional problems arise simultaneously, it is very hard to separate and deal with them individually. Heroin removes this pressure and tends to minimise them; it removes the pressure for solutions.
- Heroin gives the user a general sense of self-confidence, inspiring action; “I feel like Caesar with the world at my feet”, says Field.
- The heroin user furthermore does not tolerate anyone intruding on his inner world of tranquillity that heroin has given him, which may result in outbursts should anyone try to do so.
- Users love the ability of heroin to lessen boredom.
- Heroin provides an amnesic effect, clouds memory, and enables the user to live almost entirely in the present moment. The past is locked away, and the future is far away and unimportant.
- Heroin affects the perception of time. The user experiences it differently from usual experiences of time. It is as if time does not exist at all. It is like sleeping. It gives you “time out of life” (Krivanek 1988:75).

### 2.5.3 Loss of motivation

Heroin use requires time and money. The user usually cannot hold down a job for too long, thus he runs into financial problems fairly rapidly.

The loss of motivation for most activities is almost inevitable. Work, study, friendships, love - anything that requires giving becomes too much effort (Krivanek 1988:97).

## 2.6 PSYCHOLOGICAL DEPENDENCY

Peele (1985:20) states that psychic dependency can be described as the psychological reaction to, and the meaning attached to the physical effects of the drug heroin.

Krivanek (1987:90) poses the question as to why so many users return to the drug after they have successfully withdrawn from it. Withdrawal symptoms are the least of the user's problems; they can be medically relieved to a great extent; thus the stubbornness of addiction seems also to be dependent on the psychological dependence. Once psychological dependency enters the picture, the situation can no longer be described purely in physical terms (Krivanek 1988:91).

Most often the dangers of using heroin are known to the person, even prior to use. Even though the user has friends who have suffered complications, this knowledge does not seem to serve as a deterrent (Stimmell 1975:63).

Psychological dependence can be described in the following manner:

- It is a life-organising mechanism. The user rearranges his life priorities so that a desired object, person or activity moves towards the top of his needs hierarchy. In this case, the object is heroin.
- Things seem better with heroin; the user finds more and more things that would be better with heroin, until life itself seems increasingly dull without it.

Field (in Krivanek 1988:75) reports:

- Certain events are not merely better on the drug, but cannot be faced without it.
- Each time the user surrenders to the temptation, this feeling increases, so that the next time it is harder to resist.

- Even his increasingly brief glimpses of the trap into which he is walking, weakens his resolve; the escapism that heroin provides enables him to forget what he is doing.
- The user is now psychologically dependent. Life without heroin is perceived as worse than it was before he tried the drug.

Once a user discovers that he is psychologically dependent, he starts to take control of his dependency by making rules for himself and his drug use. These rules may be to use only a half gram per day, that he would only use it at a certain hour, for example after work, that he will never inject the heroin and that he will never increase the use of the heroin. The user finds it quite easy to make these rules, but virtually impossible to keep them (Krivanek 1988:76).

The user also starts to form associations with certain cues in his environment. These cues may be the sight of an injection needle, stimuli of the street, seeing friends “shooting up”. These associations elicit powerful feelings and even physical symptoms of craving and withdrawal. The user may suddenly experience all the effects of physical withdrawal if he pairs the experience of an event with heroin use. He interprets this discomfort as craving and may even use heroin in order to relieve this feeling. The psychological process can thus keep the physical addiction going. (Krivanek 1988:91). Physical and psychological dependency are thus interlinked.

Peele (1985:2) views addiction as not limited to drug use; rather, that addiction is best understood as an individual’s adjustment, albeit self-defeating, to his environment. This fits in with the psychological aspects of addiction as described by Krivanek (1988) and Stimmell (1972) in that it represents a habitual style of coping.

Addiction is more than a physical response to drug use, and includes the subjective and personal experiences of the users. It is important to keep in mind that the users' mindset, expectations and beliefs about heroin strongly influence their reactions to the drug.

As an example, withdrawal may be seen as a self-labelling process. The user detects adjustments in his body when the drug is withdrawn, and this process and adjustment is perceived as problematic. The user expresses his discomfort by translating it into a desire for more drugs (Peele 1985:19).

According to the perspective of Peele (1985), the mind/body duality has hidden the fact that addiction has always been defined phenomenologically in terms of the experiences of the person and the observation of his feelings and behaviours. The object of addiction is the addicted person's experience of the combined physical, emotional and environmental elements that make up the involvement for that person.

### **2.6.1 Addiction to an experience**

The total addictive experience is two-fold:

- The pharmacological and physical effect on the body.
- The experience thereof is construed by the person using the drug.

Addiction is then recognised by an extreme, dysfunctional attachment to an experience. This attachment is harmful to the person, but such an essential part of his life that he finds it very difficult to give up.

The individual finds this experience rewarding because it alleviates urgently felt needs, even though in the long run, it damages his capacity to cope and his ability

to generate resources from himself and the environment, to satisfy these needs (Peele 1985:97).

The experiences are not random, but clear-cut and specific:

- **It diminishes pain, tension, awareness.** A change in consciousness is experienced, characterised by increased emotional distance from external stimuli and internal response. “Away from the ordinary, rational, self aware state, which is uncomfortable”. Having pain, anxiety or other negative emotional states relieved through a loss of consciousness or heightened threshold of sensation is a primary component of the addictive experience. Pain and tension reduction are essential functions of the addictive experience (Peele 1985:99). A crucial component of the addictive experience is also paradoxical – it intensifies the negative sensations that heroin use is sought to relieve (Peele 1985:100).
- **Enhanced sense of control, power and self-esteem.** Heroin offers the user control over areas of behaviour or emotions that they otherwise feel unable to cope with. Heroin users use the drug to remedy feelings of personal inadequacy, specifically sexual dysfunction. It may also be suitable for fulfilling an ego-boosting function by suppressing the negative self attributions by which addicts are normally weighed down (Peele 1985:102).
- **Simplification, predictability, immediacy of the experience.** This can be demonstrated in terms of intravenous users. Peele (1985:15) cites Solomon (1977) who states that ritual plays an important part in addiction, in that heroin addicts tend to reject non-injectable substitutes for heroin or other departures from their routine. They may rather accept a non-narcotic injection in place of heroin. This can reflect the value that addicts place on the simplification of the experience. The reward lies in the repetition of a highly focused activity. Users are also attracted by the immediacy and



predictability the drug offers them. They are able to bypass the anxieties of everyday living. They are aware of the effect that heroin is going to give them (Peele, 1985:103).

Krivanek (1988:93) shares a similar perception, describing the process of the excitement of the decision to use heroin. The addict, when stopping, does not only miss the effect of the drug, but the process of obtaining it as well. Some users report that if they just “shoot” water, they would enjoy it as much, and some do just that. Some go through the motions of injecting even when no heroin is available, with or without anything in the syringe. Some addicts refer to this as “skin popping”. Skin popping is also known as subcutaneous use – injecting heroin under the skin to sustain a slow release that staves off withdrawal symptoms. It is also viewed by some addicts as non-addictive. (Hanson 1985:79).

This excitement of the process of heroin use may be rooted in the functions it has for the heroin user; it supplies him with what he may be missing out on in his life in general.

### 2.6.2 Social and psychological functions of needle-sharing

- Sharing for the sake of sharing. This is an important norm found among heroin users, in that they also share food and lodging. They form a close social bond.
- Sense of fraternity. Needle-sharing provides them with a feeling of closeness and brotherliness and brings people together, like a family experience (Smith & Gay 1972 :129).
- A means of socialisation. The first-time user initially allows someone else to inject him, learning the process before he does it himself. They help each other until they can do it themselves (Smith & Gay 1972:131).

- Means of protection. The user feels a sense of security when others are around; they will be able to help him if he has taken too much heroin. Others can act as life savers (Smith & Gay 1972 :131).
- A means of achieving status. Excelling in the ritual is a means of gaining prestige among “shooters”; who can shoot (inject) the most and survive. They also see other addicts (non-heroin-users) as babies who are playing around. Society and the media also place a lot of status on the heroin user, which gives them the status of “hardcore and dangerous” (Krivanek 1988:92).

Robertson (1987:43) is of the opinion that politicians, the press and a proportion of the public are unanimous in their condemnation of heroin use as the major, if not the greatest, social evil of our time. All of this contributes to the status of the heroin user.

### 2.6.3 The addiction cycle

Peele (1985:128-131) describes the addiction cycle as follows:

- The person experiences a problem which he cannot cope with as expected. The person loses his ability to fulfil his needs and coping skills. He subsequently experiences a drop in self-efficacy and self-worth. He starts to relate to the world by believing in external forces to help solve his problems, and also relate to the world in terms of dependencies.
- The heroin provides the experience needed; thus, ritualised addictive involvement becomes more firmly ensconced as an essential source of gratification.
- Addicts seek an addictive experience to achieve a desired feeling or state of being that is not otherwise available to them.
- The experience is powerful and gratifying and ultimately becomes both necessary and distressing.

- Those addicted participate immoderately in these involvements, perceiving this excess as losing control. This defines addiction for themselves and others.
- The person receives results from this use of the drug, and it becomes continued involvement.
- Extremes of addiction are achieved when people turn to the drug to modify feelings, abandoning all functional coping efforts.
- The addictive experience becomes the sole means for asserting control over their emotional lives and becomes the core of their self-concepts.
- Having the reassurance of the heroin, users re-emerge into a world from which they have grown alienated. They experience the feeling of coping optimally.
- Paradoxical gratifications are a regular part of addiction. The core paradox of addiction is the failure of the addict to find sufficient satisfaction in an act to resort to it only when appropriate (painkillers only when in pain), or else to quit because of continued dissatisfaction (medication making them feel bad).
- Addicts become less aware of the sources of their problem, and their need for the drug greater.
- Using (illegal) heroin, they carry with them feelings of shame and guilt which then add to the motivation to return to the drug experience.

## 2.7 PERSONALISING THE HEROIN

Recent accounts and biographies have shown a tendency towards describing and experiencing heroin addiction as that of a personal relationship, an intense love relationship. These experiences are described from the perspective and experiences of the person living with the heroin addiction.

When heroin use is terminated, for whichever reason, intense feelings of grief and loss seem to be experienced as well.

These experiences may be part of the phenomenon that professionals as well as the family and friends of the heroin addict find hard to understand. It may partly explain why conventional treatment, such as medical intervention, the teaching of coping skills and relapse prevention programmes are viewed as unsuccessful.

The biological/medical models for describing addiction, together with the psychological aspects, are what most people seem to follow in their understanding

of heroin addiction. This personalised relationship may be difficult to understand in the context of the relationship that is formed with the heroin. If addiction is a disease and withdrawal can be treated medically; if the addict is taught the necessary coping skills to remain drug-free, then what may be the difficulty experienced by the addict, and what makes him return to the heroin so regularly?

The social/psychological aspects bring one closer to an understanding of the psychology of addiction. Addiction, therefore, is understood by both physical and psychological aspects described in this chapter. It would also appear that the deeper meaning of this relationship, as experienced by most heroin addicts, is not described in detail. Many of the professional descriptions do not describe these experiences accurately; they appear to be described according to the explanations by the experts given to the phenomenon. The heroin addict is really the expert, as he has first hand experience and his own explanation of this addiction experience.

The following excerpt from an article by Davis (2001:49) sheds some light on this experience:

*If you're hooked, you can't face the world without your partner. There isn't much room for anyone else in your life. When your lover is not with you, you are left with your own terror of how to move through the world alone. You don't know how to deal with people alone, you need your partner, your other half. I do not pretend I know how to live in this world. I don't – not alone, not without my lover.*

Patty Davis further describes this relationship as “*even though I was in love, my lover was cold and cruel, hardly faithful, but I never fell out of love. You will never understand drug addiction, unless you understand that it is a love story*” (Davis 2001:50).

The process of getting “hooked” on heroin, and the relationship with it, becomes clear from the following poem, author unknown, in Maartins (2006:39-40).

**With this needle I thee wed**

So, now little man, you're tired of grass,  
 LSD, Acid, Cocaine and Hash  
 When someone pretending to be a true friend  
 Says “I'll introduce you to Miss Heroin”  
 Well, honey, before you start fooling with me,  
 Let me inform you on just how it will be  
 For I will seduce you and make you my slave,  
 For I've sent stronger men than you straight to their graves  
 You'd think you could never be such a disgrace.  
 Then you'll end up addicted to poppy seed waste.  
 You'll start by inhaling me one afternoon,  
 Then you'll take me in your arms very soon.  
 Once I've entered deep down in your veins,  
 The craving will drive you insane.

You'll need lots of money, have you already been told?  
For darling, I am more expensive than gold.  
You'll swindle your mother for less than a buck,  
You'll end up an animal, violent and corrupt.  
You'll beg and you'll steal for the narcotic charm,  
And only feel content when I'm deep in your arm.  
One day, you'll realise the monster you've grown,  
And solemnly promise to leave me alone.  
If you think you have the magical knack,  
Honey, just try getting me off your back.  
The vomit, the cramps, your guts in a knot,  
The jangling nerves screaming for just one more shot.  
Hot chills, the cold sweats, the withdrawal pains,  
Can only be eased by my little china white grain.  
There is no other way and no need to look,  
Or deep down inside, you'll know you're hooked.  
You'll desperately run to the pusher and then  
You'll welcome me back to your veins once again.  
And when you return, as I have foretold,  
You'll ultimately give me your body and soul.  
You'll give up your morale, your conscience, your heart,  
And then you'll be mine, 'till death us do part.

### 2.7.1 Grief and loss

The addict's eventual primary relationship is with heroin, not the people in his life (Dayton 2000:179).

Heroin, being used as self-medication to cope with pain, can be a significant factor for many addicts who relapse after years of sobriety. When the substance is removed, the feelings that have been medicated resurface.

When heroin use is terminated for whatever reason, saying goodbye to it seems to result in feelings of grief and loss. The heroin addict has difficulty in his ability to feel his emotions, so when he gives up the drug, he experiences difficulty to grieve the loss of the drug or “loved one”. Without grieving this loss, pain accumulates until it hurts so much that he looks for a way out. Normally his way out is killing the pain with heroin, as we have seen that heroin is a good painkiller – physically and psychologically (Dayton 2000:177).

If the addict does not go through this process of grieving, old emotions and problems begin to surface. Recovery goes further than just removing the self-medication; it is a painful process, and to relieve this pain users return to their addiction (Dayton 2000:181).

The stages of grief and loss as developed by Bowlby, in Dayton (2000:182) are:

- Numbness
- Yearning and searching
- Disorganisation, anger and despair
- Re-organisation

Even though the heroin addict seeks help voluntarily or involuntarily, the realisation is there that his drug is gone. Suddenly this situation seems unreal, and he does not really take it in for a while (Dayton 2000:182).

Slowly the truth seeps in, the person finds himself lost, wishing things to be the way they were. (In the early days of treatment, the person experiences ambivalence, and sometimes leaves treatment at this stage). When withdrawal starts, he tends to romanticise his heroin, forgetting the “bad times”. The stage of yearning and searching begins. The user deeply misses what he has lost. He strongly identifies with what he has lost (the relationship), and views this heroin

use as being an active part of his life and identity. He has no idea what to do with this void (Dayton 2000:183).

The addict feels angry at what is missing - life seems unfair to him. He despairs about his life that may never feel good again. He feels disorganised and asks many questions, until eventually he realises that it's over. Reorganisation usually begins here. Recovery begins by building step-by-step new relationships and skills for living. (Dayton, 2000:184).

Although these stages apply to the loss of a loved one, the same basic principles can be seen as pertaining to the loss of any object or experience, or relationship with the drug - a situation to which he has become attached.

Societal/cultural expectations tend to require from people to recover from losses in a matter of weeks or months. This impatience reflects a misunderstanding of how our primary relationships function. Relationships are essential - a part of the sense of the self and how life is organised. The addict has formed this kind of relationship with his heroin. The addict feels a loss of a part of himself, and his whole life needs reorganisation both inside and out (Dayton, 2000:185).

If one takes into account the above discussion and processes, one is left with the thought and question: is this what people don't understand? What is this mysterious connection with heroin?

## 2.8 THE MYSTERY OF THE HEROIN EXPERIENCE

Certain questions are being asked in an effort to understand heroin addiction. These questions are asked in the writings of Tyler (1995:275) and an unknown author in "Is it really that dope?" – Heroin experience 1. ([www.interdope.com](http://www.interdope.com)).

- Why this romance with heroin?



- Why do poets write about it, musicians sing about it?
- Why do people, when they talk about it, leave their shoes and talk in symbols and metaphors?

Tyler (1995:289) shares the idea that it could be that the link to this mystery lies in the experience of heroin use becoming anthropomorphised, that is, giving it human form or personality.

In “Is this really that dope?” – Heroin experience 1, the unknown author has taken heroin himself in order to understand why people dedicate their lives to a routine of searching for and using this drug. He is of the opinion that heroin takes on a mysterious life of its own; it literally lives. ([www.interdope.com](http://www.interdope.com)).

He has recorded certain experiences he has had while under the influence of heroin, and these offer an extra dimension of experiences that are not commonly described in the literature. These are:

- Moving in and out of consciousness;
- Not experiencing thought or contemplation;
- He simply could not think much at all;
- Experiences of missing time;
- When no time is experienced, no knowledge of reality is experienced;
- Heroin virtually destroys the act of higher contemplation; worry, fear, want, need are virtually non-existent;
- Heroin inhibits the brain’s ability to think in abstract terms;
- Contemplation of fear, worry, want, need, joy is the product of abstract thought, and the perception of these are the product of our ability to reflect upon our experiences;
- We acknowledge that we feel good, bad, or indifferent and this acknowledgement is the result of our ability to think abstractly. We are cognitively aware of our states of consciousness;

- When on heroin, abstract thinking is nearly completely impossible;
- The heroin user escapes into oblivion; the ability to think abstractly is devastated;
- The estimation is that, rather than enduring the pains and stresses of life, the user of heroin prefers a thoughtless existence;
- Where there is no thought, there is no psychological stress. No trauma, no pain. No fear, worry, want or need.

The author of Heroin experience 1. ([www.interdope.com](http://www.interdope.com)) describes the reason for using heroin is not because of physical ecstasy, but to escape the thought processes and psychological pain these thought processes produce.

He further describes the effect of heroin use as a temporary escape from the human condition as perceived by the heroin addict. This human condition is perceived by the addict as a sense of hopelessness, purposelessness, and the day to day struggles incurred simply by being a living, breathing person.

The attraction to heroin thus seems to be that there is nothing – nothing to worry about or fear, to need or want, as the brain's ability to produce these thoughts into existence has been destroyed.

Back in the “real world” the urge to return to cognitive non-being is preferred. By escaping all pain, we escape that which makes us human - the will, abstract thought, feelings, emotions, even the human idea of self, the I or ME. Ironically, the obliteration of pain by the eradication of abstract thought makes a human experience of life impossible. As the experiences of human life are taken away from the user, he ends up losing meaning or the ability to create meaning whilst under the influence of heroin.

When facing the “real world”, periods when heroin is not used, the user experiences this loss of meaning as painful. He attempts to create meaning in an empty world, and starts to anthropomorphise the heroin. Heroin now becomes the central part in the creation of new meaning.

Tyler (1995:289) acknowledges this process as well, and agrees that when not using, the heroin user finds himself in a life that is too scarily empty of meaning. A private sensory world is created.

This new “person” or personality becomes the romance, or the attraction.

### 2.8.1 Heroin, the person in my life.

When becoming anthropomorphised, the heroin is spoken of as a person; interacting and having a relationship with that person, and metaphors such as love affairs and marriages, are used. Heroin in this context is often called “Lady H.”

Various heroin users have written about their experiences with heroin:

**“I fell in love with heroin. The rush, the high, it erased everything and made me feel like something”**. (Heroine girl - <http://heroinegirl.blogspot.com>.)

**“I was hooked, but not in the addicted sense of the word. I guess it’s better said that I was in love”**, says Dr. H. ([www.heroinhelper.com](http://www.heroinhelper.com)).

**“Probably the closest I came to love at first kiss. I was overwhelmed with a new experience I had never felt before. It is not until much later it becomes a burden , and then the love turned into a relationship by choice, and soon became the sickness of habit”**. (<http://heroinegirl.blogspot.com/2005/01/all-i-want-is-you.html>).

Dr. H. ([www.heroinhelper.com](http://www.heroinhelper.com)) continues: **“Plus minus a year and a half later, I found myself surrounded by people who also had intimate relationships**

**with the Lady H. Many had solidified their love affair in engagements. Many more had been married years before with Lady H. being injected into them many times a day”.**

A heroin user describes his experience in Tyler (1995:276):

**“Like everything else, it has its price. It’s demanding and cruel, but sure is nice. So hello again my old friend, my companion and compatriot until the end”.**

Jason ([www.heroinhelper.com](http://www.heroinhelper.com)) said:

**“Heroin was the biggest lie of all!”**

### **2.8.2 The paradox**

The heroin user finds himself in a paradoxical situation. Heroin gives him the escape and nothingness that he requires to exist in a scary meaningless world. Heroin becomes the “person, the thing” that helps the user create new meaning. The very meaning this new romance promises, ends in pain.

Heroiner writes: **“[every]time I picked up the needle to find meaning, I got pain ...”.**

Heroin promises neutrality. It promises nothing. It takes away pain, and creates meaning that ends in pain. Richard Lingeman (in Tyler 1995:291) describes it as an antidote for a wretched existence, but leads to a wretched existence. Heroin has a dual action:

- It is a pain killer (where there is pain).
- It creates meaning (where there is none).

Tyler (1995:276) describes this addiction to heroin: that it holds the promise of escape, but those who return to it too often, find themselves entrapped. This

addiction can become like a terminally ill condition (terminal cancer) where people are never without pain or distress, unless cushioned with a painkiller.

## CHAPTER 3

### METHODOLOGY

#### INTRODUCTION

There are many quantitative studies done on heroin addiction, but few are available on lived experiences of the heroin addicts. Extensive literature exists regarding the writings of experiences of heroin addicts, but these are not presented in a formal research document, highlighting the themes and essences of these experiences.

This study does not focus on finding an explanation, cure or a new treatment approach for heroin addiction. Since the research question is based on people's perceptions and experiences, the meaning of heroin addiction is described from a phenomenological perspective, using a qualitative method. The usefulness and rationale for using this method, are discussed in this chapter.

#### 3.1 DESIGN

The researcher has selected a qualitative, descriptive design in order to answer the research question and achieve the aim and objectives of the study. The approach being used is that of phenomenology.

According to definitions of Denzin and Lincoln (in Cresswell 1998), qualitative research can be defined as:

- the research takes place in natural settings in which the problem is experienced;
- the researcher is the instrument of data collection, gathering words and pictures, and
- works inductively, attempting to make sense of the phenomena being studied by interpreting this phenomena in terms of the meanings people

bring to them. The focus is therefore on the meanings the respondents ascribe to their experience of the problem,

Qualitative research, according to Cresswell (1998), makes use of a variety of empirical materials - that is, personal experiences, life stories, interviews and visual texts that describe problematic moments and meanings in the individuals' lives.

Cresswell (1998) offers a further description of qualitative research – that of being an enquiry process of understanding, based on distinct methods/traditions of enquiry that explore a social or human problem. The researcher takes the reader into the multiple dimensions of a problem and displays it in all of its complexity.

The researcher acts as an active learner who can tell the story from the participant's view, and not as an expert who passes judgment on participants.

### 3.2 APPROACH

One tradition of enquiry, which also includes a specific methodology of qualitative research, is phenomenology.

The researcher decided on the phenomenological approach as she is examining the meanings of experiences that heroin addiction has for the individuals. The researcher goes into the study with the premise that human experience makes sense to those who live it, prior to all interpretations and theorising. Cresswell (1998) is of the opinion that human experience is an inherent structural property of the experience itself, not constructed by an outside observer.

Some keywords that are recognised and used in the phenomenological approach, and used in encoding the purpose statement, are:

- Phenomenological study
- Describe
- Experiences
- Meaning
- Essence.

This approach is therefore suitable as a method of enquiry, as it is appropriate to answer the research question. As there were few studies exploring the meanings of heroin addicts' experiences in the literature, a phenomenological study enables us to understand the addict's lived experiences. A phenomenological method best lends itself to examining this question.

There are many descriptions of the physical and psychological effects and the processes of becoming physically and psychologically addicted, yet it is often heard in practice by both professionals who are involved in the treatment of the addict ("we don't understand what it is about heroin addiction that is so intense") and the addicts themselves ("but you just don't understand").

The phenomenological approach, as described by Cresswell (1998), explores the central issues or essence of an experience. It draws on certain existential themes, such as empathy, openness and life as a mystery, rather than a problem to be solved.

Cresswell (1998) further identifies some basic features of a phenomenological study. This approach lends itself to enter the field of perception of the participants, seeing how they experience life and looking for and describing the meaning of the lived experiences of several individuals.

Phenomenology further suggests that there is an essential structure of experience of the individual, and searches for the essence/central underlying meaning of the experience.



The author studies a single phenomenon, this study being the lived experience of heroin addiction, from individual descriptions, derives general meanings from it and then describes the essence of the experiences.

The phenomenological approach provides specific methods of data collection, interpretation and presentation.

### 3.3 THE SELECTION OF RESPONDENTS

According to Cresswell (1998), when using the phenomenological approach it is important to make sure that the respondents are all individuals who have experienced the phenomenon that is being explored, in order to be able to articulate their conscious experiences.

#### 3.3.1 **Sampling plan**

Non-probability purposive sampling was selected, stating detailed criteria to identify respondents. Cresswell (1998) also calls this sample a criteria sample. According to De Vos (2002:334), non-probability sampling in qualitative research is used, and purposive, rather than random sampling is suggested. Purposive sampling offers the opportunity that all individuals chosen have experienced the phenomena being researched.

A particular case (or cases) are chosen that illustrate some process that is of interest to the particular study. The researcher must be clear on the population of study and then choose the sample accordingly. The criteria for selection of respondents are of utmost importance.

#### 3.3.2 **Selection Criteria**

The following criteria were identified according to which respondents were chosen:

- Four respondents. The researcher may choose from one to ten respondents, but due to the intensity of the in-depth interview, four respondents may be sufficient to provide a meaningful description of the experience.
- The respondents comprised two females and two males. They were chosen according to availability, and they had completed the duration of the treatment. The researcher is not examining any gender differences in the experience of heroin addiction, thus gender is not a significant factor, but the experience is.
- The respondents fall within the age bracket of twenty to thirty-five years of age. This is the average age span of the persons treated for heroin addiction at SANCA West Rand Clinic.
- All four respondents had used heroin for a minimum period of three years, and are of the opinion that they cannot recover; feel ambivalent, as they want to recover, and have made attempts to do so, but have failed. The researcher is of the opinion that this is a significant time for the essence of the experience to develop and manifest.
- All respondents have had at least two previous admissions to a clinic for treatment of their addiction. This can be an indication of the difficulty they are experiencing with their addiction.
- The respondents were admitted between October 2006 and May 2007. These time periods were chosen as it fits in with the time schedule that the researcher has set aside for the interviews and the research process.

### **3.3.3 How respondents were selected**

The researcher was advised by the admission officer of possible research subjects. The researcher checked their records in order to find those that fit the criteria as listed under 3.4.2. All respondents were admitted for a period of at least twenty-one days at SANCA West Rand clinic.

### 3.3.4 Description of the respondents

<u>Name*</u>	<u>Gender</u>	<u>Age</u>	<u>Number of admissions</u>	<u>Years of heroin use</u>
1) James	Male	27	3	5
2) Lewis	Male	25	4	7
3) Riza	Female	25	4	6
4) Lucy	Female	35	10	15

\* Pseudonyms.

## 3.4 RESEARCH INSTRUMENT AND METHOD OF DATA COLLECTION

### 3.4.1 The interview

The respondents were informed regarding the purpose of the research and their responses were very positive. They agreed that few people really understand their experience of heroin addiction.

The respondents were given the letter outlining the research (see Appendix A), as well as the consent forms allowing the researcher to tape the interviews (see Appendix B). Respondents were ensured of confidentiality, but they were prepared to have their real names identified. The researcher thanked them, but explained to them that she would rather maintain confidentiality for ethical and professional reasons.

All interviews were conducted in the researcher's office which provided a peaceful atmosphere. The office is situated away from the main clinic, in a garden next to a swimming pool. This atmosphere provided an environment conducive to sharing and feeling at ease during the interview. The researcher was also able to block the office telephone, in order to avoid disturbances from incoming calls.

The researcher has chosen the unstructured one-to-one interview, also referred to as the in-depth interview, for data collection. De Vos et al. (2002) states that this interview can be referred to as a conversation with a purpose. Open questions were asked in order to encourage respondents to express their attitudes, emotions, ideas and sentiments in their own words. The respondents were invited to tell their own stories (Collins 2000:179).

The purpose of this interview relates to the purpose of the research question, and that is to have an interest in the people's experience under investigation, and the meaning they make of that experience.

This interview allows the researcher to explore an issue. The interview can elicit information in order to achieve understanding of the respondents' point of view or situation.

Moustakas (1994) explains that the phenomenological interview involves an informal interactive process and uses open-ended comments and questions. The researcher may prepare some questions in advance which he/she wants to focus on, but they may be varied, altered, or not used at all when the respondent shares the full story of his experience of the topic. See Appendix C for the interview schedule with the prepared questions

The researcher asked for clarification and fuller descriptions of the experience during the interview. The researcher had also reflected and summarised, in order to focus on the topic, as some tended to drift away from the topic.

#### 3.4.2 Frequency and duration of interviews

<u>Name</u>	<u>Date</u>	<u>Frequency</u>	<u>Duration</u>
1) James	12.10.2006	1	85 minutes
2) Lewis	11.06.2007	1	55 minutes
3) Riza	07.05.2007	1	70 minutes

4) Lucy	07.05.2007	1	20 minutes*
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\*Lucy's interview was short but very significant. She was feeling extremely tired and was experiencing severe pain in her legs. The interview is transcribed in the following chapter. The information adds a significant dimension to the experience of being at the 'end of the road'.

All respondents were willing to offer further information, if needed by the researcher, and expressed their willingness to be contacted if necessary.

### 3.4.3 Method of data collection

The researcher used a tape-recorder for recording the interviews. One respondent, Lucy, has offered to supply some photographs of her infected legs, to use as visual information. Other visuals will be included, such as poems. These visuals were obtained with permission from the respondents.

## 3.5 DATA ANALYSIS AND PRESENTATION

Cresswell (1998) offers a useful framework outlining the steps to be taken (from a phenomenological perspective) in analysing and presenting the data. The researcher has chosen this model as the appropriate one to use in analysing the data obtained from the interviews. The combination of steps offered by Moustakas (1994) and Cresswell (1998) provide a meaningful guideline.

- The researcher begins with a full description of her own experience of the phenomenon, her views and perspectives. This will then be bracketed so as not to influence the outcome of the experiences of the respondents.
- All recorded interviews are listened to in their entirety.
- Significant statements are extracted from each description. Each statement is treated as having equal worth.

- The researcher then works toward a list of non-repetitive, non-overlapping statements.
- These statements are formulated into meanings, and grouped into meaning units. Descriptions of experiences are written down, including verbatim examples.
- The meanings are then clustered into themes.
- Themes are integrated into a narrative description, describing the essence of the experience.
- These steps are applied to all the respondents' stories, and thereafter the researcher will look for a single unifying meaning (essence) of the experience to help the reader understand the essence of the experience namely the meaning of heroin addiction.
- A discussion then follows, illustrating how the results reinforce the philosophical basis of the study.
- Implications of the findings for professionals, practice and research are then addressed.

This study attempts to understand the respondents' way of being in a situation as it was actually lived and experienced by the client. The essential structure of the experience of heroin addiction is allowed to show itself and speak for itself. It is not translated or defined by external criteria.

### 3.6 RELIABILITY AND VALIDITY

Stiles (1993:601) refers to reliability as demonstrating an element of trustworthiness of the observations or data. Validity refers to the trustworthiness of the interpretations or conclusions of the data.

### **3.6.1 Reliability of this study**

Stiles (1993) is of the opinion that in order to obtain reliability, the report should convey what another person who was observing would have seen (Wade 2001:67).

Verbatim evidence has been included in the report to assess the interpretation of the data. The interviews have been tape-recorded and the data is thus available and open for inspection.

### **3.6.2 Validity of this study**

The Earth and Fire Erowid website (2006:1) holds that statements which people make about their own experiences have an inherent validity. When people relate their experiences of a phenomenon, it is a subjective, first person point of view. One may disagree with their statements or have a conflicting experience, but at a fundamental level a first person description of an experience cannot be contested.

Validity emphasises understanding by people, including the readers of the study, rather than the facts (Wade 2001:68).

As the literature study was conducted before the data collection, it may lend itself to criticism. Phenomenological studies suggest that as the literature study was done prior to the data collection, it may lead to a biased interpretation of the data. It may not necessarily lead to bias - it can also enhance understanding and empathy and reveal existing preconceptions (Wade 2001:68).

Validity of qualitative research may be assessed by its impact on participants (Wade 2001:69). All participants have commented that they have gained perspective regarding their addiction and they truly hoped this would help other addicts.

The research should also enhance understanding of the phenomena in question (Wade 2001:69). This study confirmed many aspects of the literature review, but also offered insights obtained from entering the life world of the addicts themselves. Their accounts are presented in the next chapter.



## CHAPTER 4

RESEARCH FINDINGS AND DISCUSSION

## INTRODUCTION

Phenomenological research involves the researcher in an interpersonal situation, using empathy as a means of enquiry. The researcher's philosophy underpinning this enquiry is constructivism, and the relevant theory this enquiry is based on, is the person centred approach (PCA). This enables the researcher to record the data as the respondents experience it. It is helpful to bracket the researcher's own views and beliefs to ensure that the data obtained is not influenced by the researcher's perception of the problem.

A short summary of the researcher's views and orientation is presented; thereafter the research findings are presented in the following manner, and repeated for each respondent:

- A short description of the respondents' biographical data and background history
- A discussion of the process of the interview, including interactions between researcher and respondent.
- Constituent profile descriptions. Shantall (in Wade 2004:66) describes it as a condensed summary of the original data in the words of the researcher, containing the essence of what the subject expressed.
- Similar statements made by the respondents in their interviews were grouped together, which formed a meaning unit. These meaning units were clustered together and a theme identified. This was repeated for each respondent individually.

Once all constituent profiles have been presented, statements with similar - though not identical - meanings are gathered into categories which are arranged in hierarchical sequence, to describe the characteristics of heroin addiction.

The themes arising from this process are used to write an extended description from which the researcher can gain an overall view of the experience of heroin addiction, capturing the core qualities of the phenomenon (Wade 2004:66).

#### 4.1 THE RESEARCHER'S VIEWS AND BELIEFS REGARDING HEROIN ADDICTION

The researcher has consulted many theoretical explanations and perceptions of addiction, such as addiction being a progressive disease and the addictive personality theory. The addicted person has also been viewed as a person that lacks sufficient life- and coping skills and has an inability to make rational choices. Heroin addiction was also viewed as being a self-inflicted injury.

Initially the researcher experienced some confusion and frustration, as none of these theories, according to the researcher, could provide an adequate explanation for the addiction.

The researcher was of the opinion that heroin, being such an "end-of-the-road" drug, kills the users fairly quickly, and that it kills all feelings and (physical and emotional) pain.

The researcher further believed that if the users could find alternative coping styles and were able to make rational choices, they would win the battle. Therapy was conducted from this vantage point.

The researcher was unable to understand how the heroin addicts could not see how they were killing themselves, while having already lost many things, such as

work, possessions, friends and family relationships. The researcher became caught up in the stereotyped view that if the addict does not stop using, they would end up in jail, rehabilitation centre, or dead. The researcher also thought that if the heroin addicts were shocked sufficiently, they would be able to gain insight into their heroin use, and therefore stop.

The researcher used to adopt the positivistic philosophy - that is the linear causality, cause-effect approach. Thus, if the cause of addiction was found, the problem was easy to solve. As many users have realised what caused their addiction, the outcome was not as expected - many did not obtain or maintain sobriety.

Relapses were seen as not exercising the skills they had learned, and to prevent relapses, these skills had to be reinforced.

With these beliefs as a vantage point, the researcher often found herself feeling quite helpless in the treatment of the heroin addicts, viewing them as not trying hard enough and being manipulative.

In order to obtain a better understanding of the addiction, another approach was needed. As there seemed to be a clash of opinions between researcher and the heroin addicts as to what drives addiction and rehabilitation, it became necessary to develop a deeper understanding of the problem.

For the purpose of this research, the existing views that the researcher held had to be put aside, (or bracketed) in order to uncover the heroin addicts' experiences. By using the phenomenological approach, techniques obtained from the person centred approach, and a constructivist philosophy in mind, the researcher was able to enter the world of experience of heroin addicts and attempt to understand the meaning of their addiction.

The researcher was aware of the old views throughout the interviews, and did not allow these to affect the direction or content of the interviews.

The interviews were transcribed exactly as the respondents told their stories.

## 4.2 CONSTITUENT PROFILE DESCRIPTIONS OF RESPONDENTS

The geographical details, the process of the interviews and the interaction between researcher and respondents, are described, followed by the constituent profiles. The verbatim descriptions by the respondents are presented in italics, in order to distinguish between the researcher's and the respondents' descriptions.

### 4.2.1 JAMES

Name:	James
Age:	27 years
Gender:	Male
Marital status:	Single
Cultural Group:	White
In-patient treatment:	3
Occupation:	Unemployed

#### Process and interaction during interview

James had been an in-patient on three occasions, and his present admission was for a short period of time only, as he was due to receive an implant (an opiate antagonist) to aid him in his recovery. His system had to be completely opiate-free in order to receive this implant, as it might cause severe withdrawal symptoms and side effects.

James made it clear that he was using his last resort, the implant, as he did not want to be admitted to any rehabilitation centre any more. He had all the knowledge he needed to recover, and felt that there was nothing new to learn.

James was interested in this research project, and expressed his willingness to participate. He felt good that he could contribute towards helping other heroin addicts.

There was an instant rapport between the researcher and James, and he was very open and honest about his experiences with heroin. It was as if the researcher acted as a sounding board for him, to validate his experiences. When the researcher reflected back to him what she had heard, he usually confirmed that it was “just like that” or “exactly”. He related his story in a manner which made it easy for the researcher to listen to him. He was very articulate and clear about his experiences.

At no time was there any discomfort during the interview. James seemed to feel relieved to be able to share his experiences. He said that it helped him obtain perspective on his addiction.

### James' story

James was a gifted child and excelled at sport and academics at school. There were high expectations of him to become the doctor or lawyer in the family.

His life fell apart and it became unbearable, as his father was drinking alcohol excessively, was retrenched, and the family experienced financial problems. His dad started to have aggressive and violent outbursts. James' mother abused painkillers, and he viewed them both as addicts. James felt that he was not receiving love and support from his parents, but he continued to do well at school in order to please his parents. On the inside he was hurting. He could not foresee a future. He felt punished by God and could not understand why others were sailing through life while he was looking for happiness. He felt stigmatised and worthless and lost confidence in everything and the world around him.

At age 16 he started to rebel against everything and his school performance deteriorated. His matric grades were not good, and he became more disillusioned when he started employment. He felt life was all about money, therefore people did not matter. He questioned the meaning and purpose of life, and saw the world as greedy and evil. God to him did not seem to be the caring God as he was taught. He felt “slapped” by reality and wanted to get away from it all.

James experienced panic attacks but felt he should not show weakness, but show that he was strong. In this fight to stay in control and be strong, he lost control. At this point in his life he discovered heroin. He was 22 years old.

### **Heroin can't be bad – it answered all my prayers**

Despite having the knowledge of the dangers of heroin use, it did not deter him from using it.

*“I knew it was wrong, but the experience was so positive. It didn't blow me away, it levelled me off gently. I thought that this was not as dangerous as it was made out to be. On the logical level I was thinking: it works – so use it. On the spiritual level, I was aware that if I cross that line, if I open that door, I know I shouldn't have. I knew there would be consequences, but I did not think about it. I chose to ignore this”.*

James felt that heroin was the answer to all his problems and difficulties, and to all his prayers. It was as if his prayers were answered and he was experiencing the love of God again. He did not feel abandoned and out of control any more.

*“It allowed me to function, think clearly, gave me more energy. My anxiety, low self-esteem was taken away. It gave me confidence, relaxed me, calmed me. It was the ultimate cure to all my problems, a cure for every ailment. Heroin took on a God status, a deity status. My prayers were answered, I was experiencing God again.”*

Heroin replaced the people that he was depending on to give him acknowledgement, love and acceptance. It provided reassurance and feelings of safety. He experienced the beauty of life again.

*“It fulfilled the hole, it eased the pain of rejection and I did not have to seek the love and appreciation from others. I felt good about myself. I did not need others to tell me I was alright. IT told me I’m alright. IT told me it was a beautiful day. Even when 9/11 happened, it was still a beautiful day.”*

### **The seduction and disillusion**

Heroin became a personality with which he developed a personal relationship, feeling a sense of belonging and love.

*“This chemical to life force became a persona with characteristics. The substance became a personality. This is what started to happen.” This is when the relationship developed. It became my mentor, soul buddy, friend, lover. They were all reassuring me – don’t worry, I’m here.”*

James fell in love with this gentle, selfless persona. This is what he had been longing for, for a long time. It opened up his universal experience of love. It all happened very gently. He could experience the love for a person and the world with everything in it.

*“I have no girlfriend, no love. This friend became my lover. My need for love was fulfilled. I experienced the ultimate love – for self, peace and nature. It was so subtle, very seductive. It gives so much, but asks so little back. I turned into the nicest person. I was caring, and did not need love from the opposite sex. IT gave me all the love.”*

This seduction enabled James to experience the marriage of body and soul, experiencing complete integration of his whole being. He was now experiencing his core being, getting in touch with his soul. It was the force keeping him alive.

*“I got married – it was like being on honeymoon, it was perfect, being with the person you love. Heroin became the centre of my universe, everything I did, centered around heroin. I need it to function. Heroin eventually became my soul.”*

James started becoming aware that everything was not right. He became aware that there was a price attached to this wonderful relationship. Heroin wanted something in return.

*“The honeymoon was over. My lover started to demand things back, more life force. It was like experiencing sweetness and bitterness at the same time. My lover was demanding more.”*

Both James and his lover's demands on each other started to increase. James wanted to decrease this nagging awareness by having more of his lover. He wanted reassurance from his lover, that all was well.

*“I was like a co-dependent. I needed to function by demanding more of my lover. I had to have it. The ultimate feeling of love became less – I had to increase the dosage to experience this love again.”*

The uncomfortable awareness left James feeling robbed, disillusioned and sacrificing a lot, yet he still depended on the heroin for what it gave him initially. James realised that there was no easy way out of this slavery. James was losing himself.

*“I'm trapped in this relationship. I've given all to this personality. I've become a slave, as I depend on it for love, confidence, a friend; my perception started*



*changing. Spiritually it felt like I was losing my soul. I felt bankrupt, depleted. I was becoming empty. I'm being robbed of my core being, it is being mined away slowly".*

The ultimate love experience was gone, as if it had been devoured.

*"I have become desensitised to the things around me. I have no control, I feel like nothing, an empty void."*

### **Crossing the line to the evil side – new power**

With the emptiness inside him, James was now crossing the line, making space for this persona to enter his being. With the entrance of this persona, James experienced becoming powerful again. He did not experience the power of love, but the power of evil. The sense of uneasiness now became a truth for him. He experienced terror instead of love.

*"I became spiritually evil. I have developed a sixth sense, a foreboding that something is wrong. Something said to me – you're in trouble. I have crossed the line to a dark twilight state. I felt fearful and uneasy. It was like crossing into an evil spiritual world. I was deeply affected by the coldness of this being. I have experienced something that was more than just my three- dimensional outlook on life. It had opened spiritual doors, into one of the most evil realms."*

James had now obtained a new sense of power - the sense of evil being powerful. He was getting better results from evil than from love.

*"It was like evil was running through me. Even though it destroyed all my relationships, I felt superior. I would now ask this evil side to get me the drug; not ask God to help me get off it. I actually got what I needed, it was on my side."*

### **Losing power; lover, friend now the controller and abuser**

Having trusted the lover and having given himself to this lover, James felt that he had become like a puppet. He had no control of his own left, he became like a robot.

*“It reeled me in – it owns me now. Now it’s going to control me. I became like the walking dead. No life, no spirit. I was controlled by the thing, I did what it told me to do.”*

James realised that his friend, lover, master had seduced, used, abused and discarded him. He did not have any power left; neither love nor evil – he was powerless.

*“Its ultimate end is to destroy me, but first it takes as much as it can from me. When it doesn’t want me anymore, it dumps me. I was like a soldier of my emperor. It decided for me. I was trained, taught to kill, got ammunition, guns, sent out to fight the war. Now I’m not needed – it discarded me. I was used, abused, devoured, spat out.”*

### **Grief and loss**

James thinks back with nostalgia of how things used to be and how it had turned out. He is thinking about his losses and the disillusion and how this lover has become his enemy.

*“Once it was my best friend, lover, emperor, now it’s the ultimate enemy. I have no tools left to beat it. It is cunning, manipulative, took everything away. I feel used – first everything is given, then all is taken away. Something is replaced, which is horrible, now it’s leaving, you’re alone again. Now it’s not offering support or anything to take with me.”*

James feels hopeless about his situation, and he feels very vulnerable. He seems to be in the process of grief and loss.

*“It is like the loss of a loved one – my heart is broken into pieces. You know you’re on your own, with loneliness, despair, guilt. It’s terrifying to face this. It’s like going into a battlefield naked. I have nothing to protect myself, I need protection.”*

### **Separating, divorcing is painful, but heroin leaves you with a choice**

James sees a positive motive of heroin. It gave him choices and options. Unfortunately, these options were limited – to live or die. It did not give him tools to live, but one sure way to die.

*“You’ve got two choices at the end. Carry on with me (heroin) then you’re gonna die. If you want to live, you can take it, (the choice to live) but you’re sure gonna struggle. You’ll have to find your own way out. You’re on your own now. I’m not going to help you find a way out like I helped you find the way in.”*

James is still going to miss it. It is like giving up the comfort of the womb. When the baby is born, it hurts to be one; it hurts to be separated.

*“It does not mean I don’t want it anymore, but it’s not going to give me anything now. It’s like being born – not wanting to separate from the mother. We had molded into one unit. I have to separate and the birth is painful.”*

Heroin has left James with a subtle promise that he is still there. It highlights the good that is going to be missed. The good is remembered, the bad does not seem to matter anymore.

*“I feel pain and guilt breaking the relationship. I’ll never hug her again – hold her again. I’m losing a lover and will miss the good times.”*

James tries to bargain, but he knows it is wishful thinking. He feels hopeless.

*“I want just one more time. Logically I can’t! I know if I’m going for one more time it won’t even start with the seduction. It’ll take me where I am – vulnerable.”*

### **The path back**

Crossing back is like a new baby starting his life. He needs nurturance and guidance. The complication of this situation is that James feels like a grownup in a baby’s world, learning like a new baby, but having the programming of an adult. Learning a new life is complicated by old programming. The dilemma is how to teach a baby if he is already programmed. The memory of heroin use and the effects cannot be wiped out.

*“I am like a new baby learning to become human. I learn emotions, have to learn how to deal with all new experiences. The baby needs to be nurtured – I can’t do it on my own. I need to learn a new life. The complication is that I’m not like a new baby being programmed for the first time. I already have a programme – experience. I am like a baby though. I need to learn by experiencing. I need people to help me when I fall, make mistakes.”*

### **Holding on**

James is uncertain whether he will make it or not, but he’s holding onto all the hope he has. He is uncertain whether the hope is real, but it is all he has left. He wonders if all his efforts to recover will guarantee him life.

*“I’ve no hope. Unless I create and manufacture it, I still don’t have direction, hope to motivate me. It’s hard to find hope that’s real and hold onto it, but it’s difficult to hold onto hope. It seems fake, but it’s all I have; people climb Everest. This is my Everest. This is my mountain – I have to climb it, prepare and train, and maybe going to die. I may die for the cause, but I want to live.”*

James remains uncertain and ambivalent regarding the outcome of his efforts to come off heroin. He seems to be holding onto something he is not certain about. There is no guarantee that he will succeed.

#### 4.2.2 LEWIS

Name:	Lewis
Age:	25 years
Gender:	Male
Marital status:	Single (father of one daughter)
Cultural group:	White
In-patient treatments:	4
Occupation:	Unemployed

#### Process and interaction during interview

Having known Lewis from a previous admission, the researcher had asked his permission to be interviewed for the research project. He readily agreed and offered his participation.

Prior to the interview, the researcher had an informal discussion with him regarding the research, explaining the purpose of the research.

Lewis was known as a difficult patient to treat in the clinic, that he should be watched, as he exhibited aggressive and violent behaviour. He was, however, very excited to be able to contribute towards helping others. He had demonstrated altruistic feelings towards his fellow addicts. He commented that tsotsi's also had feelings and were not all bad. The researcher told him that it was strange to find a White tsotsi. Lewis laughed and said "you get them". This conversation enabled the researcher and Lewis to form a rapport before the interview commenced.

At no time did the researcher feel any threat, and felt comfortable in Lewis' presence. He was very open in sharing his experiences; he said he felt understood and accepted.

Most of Lewis' description of his life consisted of drug memories. It seemed easier for him to talk about drugs, dealers, gangs and jail.

### Lewis' story

Lewis lost his father when he was young. He grew up missing a father figure. He was very protective over his mother and cared for her very deeply. He said he would protect her with his life.

His life was characterised by violence and abuse which he did not want to talk about. The researcher accepted that.

Lewis left school after completing Grade 10 and joined a gang named the Untouchables. They started robbing the dealers of ecstasy and LSD. He ended up making friends with these dealers in order to sell drugs for them. Lewis was 16 years old when he went to prison for the first time. The charges were possession of drugs. On the day of his release, he and another accused went straight to Hillbrow, bought heroin and snorted it for the first time.

### **Heroin can't be that bad!**

The heroin experience was so positive for Lewis in the beginning, and he was amazed at what it did for him, making him feel alive, comforted and warm. It was like injecting him with life.

*“What a feeling! It's a downer, it gives me an instant hotness. My blood, chest, arms and whole body feels hot, hot. This heat is like warm water heating you up – like when you feel cold, you take a warm bath to warm up.”*

Lewis did not believe what others had told him about heroin. What others had told him, and what he experienced were very different. He believed in his own experience. This feeling was worth fighting for.

*“Warnings did not help. It did not happen as they warned me, so I did not believe them. Heroin came along and helped me – it’s my friend, not my enemy. I’ve put a lot of effort in it, setting my life on the line, breaking in, stabbing, all for heroin.”*

His friend, heroin, seemed to be taking over all responsibility for Lewis’ actions. Alternatively, Lewis was allowing it to take over that duty. Heroin was always there and he did not seem to mind. It satisfied all his needs.

*“I’ve explained to my mom – it’s like somebody else is controlling me. Like a remote control. When I stop, and start using again, it’s like it has never left me, like I’ve never stopped in the first place. I tell myself not to rob people or break into houses, but it tells me to do it – just for another spike. (Injecting with heroin). It gives me all I need – gets me where I want to be in my mind.”*

For Lewis, heroin was also a great medicine, a cure for all illness. All experiences were pleasurable.

*“I feel itchy, a bit sick, but nice. I vomit when I use (heroin), but it’s nice to vomit. When I felt sick like flu, diarrhea, stomach pains, I made sure I kept heroin for the sickness. It helped, I felt no pain, even if I cut myself.”*

### **The protective body-guard**

Lewis did not allow himself to be or feel vulnerable, as he saw it as being weak. He needed protection from feeling emotions as well as (potentially) dangerous situations he found himself in. He was often exposed to threatening situations in which he could be stabbed or shot. Heroin acted as a bodyguard to Lewis, and

protected him from many “weaknesses” that a powerful and respected man in his context should not have.

It protected him from exposing his crimes and possible arrest:

*“We were always in the danger of getting stabbed. I used it to deaden the pain. I couldn’t go to a hospital because I can’t tell them I robbed someone!”*

It protected him from the inability to act in a life-threatening situation. It kept him safe and fearless. Lewis could not afford to feel fear when in explosive, potentially dangerous situations. Fear unnerved him, he needed to be focused and calm.

*“Heroin is like my AK47 or R1. It doesn’t fail you. It helps me keep my head in an explosive situation. I keep my calm, like the eye of the storm. I am the eye. It feels good. You’re safe, you’re capable of protecting yourself and those you care for; I feel fearless – no fear. When I was scared of the police, I slaan ‘n spike (inject heroin) then I don’t worry. I’m not scared of nobody. I’m not scared of dying. It makes helps me think more calmly, I can shoot and rob with less worry. I am more focused, think more clearly, have good timing when shooting someone; heroin is my weapon – a crutch to survive in this world. Dog eats dog. Only the fittest survive. That’s what heroin was for me!”*

Heroin protected Lewis from feeling guilt and sadness; it helped him counteract feelings of vulnerability.

*“Heroin took away sadness – when a friend od’d (overdosed) and I went to his funeral, I did not get a fright. Oh, well, that’s how the cookie crumbles – life goes on. I must show that I don’t care about nobody – nothing will affect me. I’ve seen people die, shot and have taken other people’s lives. Heroin makes it easier. When you are sober and got blood on your hands, you worry; I feel so relaxed,*



*not worried about other people. I did not feel bad for the things I used to do. I know it was wrong, but heroin helped me cope – I know I'm wrong, but it's ok. When I feel bad, then I slaan 'n spike, then I don't feel bad anymore."*

### **Teaching others to protect themselves**

Lewis saw the heroin as an instrument to assist him in helping others to learn to protect themselves. It helps him teach others to survive this tough world they live in.

*"I grew up where nobody will protect you if you don't protect yourself. Only you yourself can do it. I have to protect people close to me, they are not like me. I inspire others to stand up for themselves. I robbed a guy, told him the day he stands up for himself, that is the day I'll leave him alone. He stood up for himself. I told him – nou is jy 'n man, nie meer 'n boy nie. I then left him alone."*

### **Strong leaders need to be respected and powerful**

Lewis viewed himself as a notorious leader in his community. In order for him to maintain this position, he needed to be respected and trusted. He did courageous things to achieve this status. Heroin gave him a helping hand.

*"I used to be the leader – they would fetch me when they had problems. They know I sort things out. I don't talk a lot. Go to Lewis – he'll show you. Heroin helped me become that; respect plays a big role in my life. I cannot tolerate disrespect – straight people want to walk over you – you're like a carpet. I cannot afford to be walked over. If you should stand on my toes, I'll break your neck, if you put your nose in my business, I'll break it. So, I'm a tsotsi, done everything – who are you to come and tell me; I walk in dangerous places – when I have that respect, I know I can walk down the street, no-one will touch me. It helps me show people who I am. I had petrol-bombed a brothel for someone once. People trust that I can do these things."*

### **The trusted friend**

Lewis saw heroin as a trusted friend whom he could rely on to do courageous things together. This friend was very supportive, giving him what he needed.

*“Heroin worked – like my friend, doing things together. We go hand in hand. He gives me braveness and courage when I don’t have it. He gives it to me to shoot somebody. All I then think of then, is to shoot this one raak, I’ll get my R5 000,00 then I can go get high.”*

### **Invincible, untouchable or not?**

Lewis survived numerous attempts at losing his life – by his own hand and that of others. His belief that he was invincible was reinforced by this survival.

*“Personally, I’ve tried to commit suicide – twice I tried to shoot myself, took an overdose of pills. I did not die. I just woke up three days later. I have cut my wrists, it did not work. I’m really untouchable – no pills, guns knives could get to me; heroin helps me. When I got stabbed when I was high, I still won the fight. People talk – daai man, moenie pla nie, daai man. I’m a dog of war – I don’t need doctors – I fix myself.”*

Lewis was experiencing some doubt though. He was wondering whether he’d be like this always. Some vulnerability was showing through this tough exterior.

*“The police made me realise I’m not really untouchable – just lucky.”*

### **It takes sacrifice to leave the heroin reality**

Switching from the heroin reality to a clean life, takes some sacrifice. Lewis is aware of his life on heroin and the power it has given him, but he also realises the loss of value in his life at the same time.

*“Crossing the line, (able to take someone else’s life) you don’t worry about your own life anymore. You’re spaced out, like a movie.”*

With the help of heroin, Lewis was able to cross this line, and he seems to be trapped there.

*“Heroin helped me cross this line, It became my reality. Even in rehab I still live that reality – I can still do the things I used to.”*

Lewis is tired of this life and longs to go back home to his loved ones. He wants to be valued by them for the person he is, not the heroin addict he has become.

*“I don’t want to be a tsotsi forever. I’m tired of getting stabbed, shot at. I’m tired of always having to prove myself.” I want to learn to be humble, learn to keep quiet. This lifestyle is not for human beings. I don’t want to bring shame to my mom and daughter. I don’t want my mom to get the message that I’m dead in the gutter or have overdosed.”*

Lewis is willing to sacrifice his life for his family and loved ones, to preserve his integrity. The integrity he has within the family.

*“But, if I die, not really scared they’ll kill me. I don’t mind, but my mother and daughter, I care about them. I don’t want them to know I made their lives a mess. I don’t want them to hurt because of me. I can give my life, not my family’s.”*

### **Saying goodbye – a bleak future**

Lewis seems fearful to face powerlessness and loneliness again. It is painful to face the losses he stands to lose when giving up heroin. He stands to lose meaningful things in his life ‘on the other side’.

*“It’s like losing someone close, my tjomma, my bra, protection, power.*

He relates the withdrawals and cravings to the emotional reactions and feelings he is anticipating should he give up heroin.

*“I’ll be sick, very sad, alone, depressed. The craving for heroin is like craving a friendship. I’m tired of being alone. I did not like being alone.”*

Lewis is uncertain and feels helpless about the future without heroin. He feels exposed and vulnerable. He is unsure of where to go from here.

*“It’s a struggle – what is going to replace heroin? What’s going to help me do what I must do? I don’t know what to expect from the future. People want to kill me – I don’t know what to do. I’m vulnerable. I have a kink in my armour. My heroin is gone.”*

This interview ended with questions and ambivalence.

#### 4.2.3 RIZA

Name:	Riza
Age:	26
Gender:	Female
Marital status:	Married (one child)
Cultural group:	Indian
Inpatient treatments:	3
Occupation:	Unemployed

#### Process and interaction during the interview

The researcher has known Riza since she was 15 years old, when she was admitted for her first rehabilitation treatment. The researcher has worked at three different in-patient rehabilitation centres, and it so happens that Riza was admitted to each of them.

Riza felt safe with the researcher and was happy to see her again, saying that she was glad to be with a person who knows her.

Riza trusted the researcher, as during the interview she did not withhold any information. She also cried at times and said that if she had this conversation elsewhere, she would probably go out and use heroin; it is so difficult for her to talk about it, as it makes her crave. She was getting so close to the heroin experience. Riza also said that she had given all the information she could think of, but she may have been able to give more, had she been on heroin at the time. She felt her words would even be more powerful if she was on heroin.

There was a very trusting and open relationship between the researcher and Riza. She seemed to feel relieved to share all of this information without being judged.

### Riza's story

Riza comes from an affluent Muslim family and is the older of two sisters. There has always been an abundance of material possessions showered on them, but she feels there was never enough emotional involvement from either parents.

Riza has memories of unhappiness at home, as her parents fought constantly. Riza feels very detached from her father as well as from her mother when she was alive. Riza's mother died of an overdose of painkillers. During this addiction, Riza was acting as care-giver to her mother. She was twelve years old. She found her mother when she was dying and tried to help. Her mother died in her arms.

Riza has harboured anger and sadness at the loss of her mother and she feels she has missed out on experiencing a mother figure.

Riza has had a stormy relationship with her father and step-mother. She started using dagga and LSD at fourteen, and used mandrax at fifteen. She met her first husband when she was twenty-two, and he introduced her to heroin. They were both users of heroin.

Riza and her husband moved to Australia to live with her new parents-in-law, who were trying hard to help them to stop using heroin. They were unsuccessful. Riza fell pregnant and had a son. She divorced her husband and returned to South Africa without her baby. The baby is in the care of her in-laws. In 2006 she met another man, a heroin addict, and married him. While she was in treatment, he continued to use. He is not prepared to give up his drugs. She is unsure whether she could live without it.

#### **Premonition of being a heroin addict**

While using other drugs, Riza has been listening to others, especially those using heroin. Since the age of fourteen, she had been receiving information about heroin, the “good stuff”. Those ideas stayed with her and found a place in her world. She was prepared for it when she used it for the first time. She was not disappointed.

*“From that day I knew I was addicted. Nothing compared to heroin. Since fourteen, I knew I was going to be addicted to heroin. I’ve been listening to all the heroin junkies – the thoughts stayed in my mind for years to come. I wanted heroin!”*

#### **The magic of finding exactly what I need**

It was as if Riza was experiencing a spiritual awakening, as if her search for belonging had ended. She had reached a sense of belonging.

*“When I found heroin – it was not an escape, it was just normal. This fitted exactly with my life, the feeling I was looking for all my life. It was like*

*homecoming, instead of escape. This is where I belong, the ultimate high I was looking for.”*

Heroin took her to a place that she described as heaven, a spiritual experience that non-users don't seem to understand.

*“No-one understands the feeling it gives you, the bond you make with it. The first shot – it felt like walking in a garden of lavender flowers. It was magical, like a man making sweet love to me. I even told my husband he can never replace this feeling heroin gives me. I never felt like this before – It made me feel like I was in heaven.”*

This feeling was so good that it replaced all other feelings she has had. It was an awakened sense that nothing really matters - a sense of indifference.

*“You have the feeling of no pain (physical and emotional). Nothing and nobody matters – yet you do care. I was at my gran's funeral. I was on heroin. I did not cry – it did not matter.”*

### **Bringing out the best in me – the new me**

Riza felt like a truly happy and secure person whose needs were fulfilled. She could handle her emotions and be her true self whom she believes she was or should be.

*“Heroin gave me the love, attention, confidence, mainly the attention. I felt secure, like I did not need anybody. I did not have to confess my feelings to anybody. It was placed into my shot. That was it – no need to explode. I could control my emotions very well. It gave me acceptance. They did not know I was on it.”*

Everything was falling into place. A bonding had taken place, as if body and soul became synchronised. Riza had discovered the “new me”.

*“You become one. It feels like ‘wow’, this is really me. I got a sense of being truly me. This is me – this is what life is all about. Heroin brings out the ultimate best. I can deal with things, I have better coping skills, I am the best I can be. I have power, I am truly me.”*

This “new me” was able to live up to expectations of society and her family. Heroin gave her the opportunity to be a good mother and wife. It made her family happy too.

*“When I have a shot, I clean, and cook. I got energy and confidence. I feel like a human being. I felt normal, and fitted into society.”*

Heroin also gave Riza the ability to be whom she wanted to be - almost as if she was living herself into a role, like an actress.

*“I looked beautiful when I’m on it. No-one knew. Dad couldn’t believe I was on needles. I’m the great performer – I stood out in the lime-light. I acted very well; I acted the part I wanted to be.”*

### **The struggle between who I really am**

Riza shows insight into whom she is when not on heroin. She expresses ambivalence regarding herself as a person. As she believes the person on heroin is the real “her”, so she also sees a side of herself, off heroin, as also being the real “her”.

Riza views herself as a monster, ‘not a nice person’ without heroin. She sees herself as two different people, depending on whether she uses heroin or not. The heroin Riza seems now to be a fake.



*"I wear a big mask when I have a shot. When I don't have a shot, I am two different people. When I don't have a shot, I'm like a monster. Very aggressive, distressed and sick. When I'm clean, I was not really a nice person. With heroin, I was not the MAD Riza."*

Having taken feedback from others to heart, Riza has confirmed her view of herself when she is not on heroin. To go back to the one she likes, to change and become nice, relapse seems to be the solution, being reinforced by other people's feedback towards her.

*"People tell me I'm not a nice person, that's why I go back and relapse. My dad tells me I'm bitchy when I don't have a shot. I don't want to be this nasty person. My husband also reacts like a monster towards me; he looks at me as a dirty person."*

#### **Heroin assists with the bonding experience of motherhood**

It would appear that Riza was only able to bond with her baby when she had used heroin. She was aware of the baby in the womb but was not able to develop a bond with him.

*"When I fell pregnant I used heroin four to five times. I did not really care, even though I knew the baby was inside of me. I could feel the baby go to sleep. Scary. It would kick while I'm not using, when I shot up, he'd go to sleep, like I did."*

Riza felt no exhilaration at birth; she could not get in touch with the feeling of giving birth.

*"I couldn't deal with the fact that I did something good. Having a baby. There was no bonding. Only with heroin in me, could I do it. I did not even worry that he was ok, until after the shot, did I ask questions."*

Heroin helped her get in touch with her motherly instincts. Riza experienced guilt and confusion at her inability to enjoy the start of motherhood without heroin. She questions herself, but has the answer.

*“Not even giving birth made me feel like when on heroin. This is cold and nasty to say it. I feel pathetic when I say it – when I gave birth, I asked for a shot. How come I wasn’t satisfied with this little baby? Wasn’t this enough happiness for me? It wasn’t – I needed a shot to feel happy, otherwise I feel like a brick wall, the shot helps me to feel everyday feelings.”*

### **An aid to feel empathy and understanding**

Riza had a traumatic experience when her mother died of an overdose of painkillers. Heroin aids her to deal with this loss, giving her insight and understanding regarding her mom, whereas without heroin, she harbours a lot of anger and abandonment.

Riza feels very distant from the memories of her mother and finds it difficult to get in touch with her mother’s overdose, but heroin brings her closer to these feelings.

*“I can think of my mom in a good way. When I’m sober, I think of my mom in a pathetic way. It’s almost as if I understand her pain, when I’m on heroin. It’s almost as if I understand people better, when I’m on heroin. When I’m sober, I don’t understand people – I’m lost. When I’m sober I’m in a world that I don’t know; I can now care about my mother – she was looking for something the same – it’s like walking in her shoes. Heroin made me understand more. It gave me a lot of insight.”*

### **Heroin – my lover, my abuser**

Riza experiences the relationship with heroin as falling in love, being conned into this relationship gradually, and then being abused. Riza recognises this process of the cycle of abuse.

*“Putting it into words, like a man making sweet passionate love to you. It really then f\*\*\*\*s you up. He is abusing me, but I need him all the time.”*

They have a special bond. To have him, all she has to do is think of him, making a connection in her mind. Yet, this bond entraps her.

*“When I talk about him, I draw him closer and closer. I’m tired, have had enough but yet my love for him is so great, I tolerate the abuse. I’m stuck in the middle of love and abuse.”*

Riza experiences ambivalence in this relationship. It is bitter/sweet, love/hate at the same time. There is always the promise of good after the bad. Her lover is a giver and taker at the same time.

*“He’s very domineering – he controls me, making me do everything he wants me to do – but I like him. He’s making me ugly, but inside he’s making me feel good, better, as if inside he’s healing me. It feels like the devil’s taken over, can’t get enough of him. He gives me paradise and torture. (Riza’s hair was standing up on her arms) – he cons me, gives me paradise, but takes it away. I get sicker and sicker.”*

### **Divorcing heroin is painful**

Riza feels sadness and despair, as if she has lost her soul. She feels that she goes back to square one, and no needs are fulfilled anymore. She experiences fear and feels that she is sacrificing a lot by giving up heroin.

*“I’ll die if heroin disappears. I can’t face him leaving me. I’ll be very angry when he leaves. I’m scared of not having him. I feel abandoned, unworthy, unaccepted. I give up a lot, when I give him up. Like giving up love, comfort, life.”*

Riza is experiencing intense emotions at the thought of giving up her lover, heroin. She cries when she gets in touch with this loss.

*“I’m very sad, knowing I can’t have him now. It’s painful not to have him. I love him, but then he hurts me. Sometimes I think how I am going to live the rest of my life without having it.*

Riza feels robbed of her soul and questions whether she’ll ever get it back.

*“Have I given myself completely to him? He took my soul. I want my soul back – the big question is will I ever get it back?”*

### **The reassurance and the doubt**

Riza seems relieved that heroin is still around. He is also predictable and dependable. There’s hope; the future does not have to look so bleak without heroin. She can go back, knowing he’ll be there.

*“One shot, and I’m back with him. He’ll make me feel better. Nothing makes me feel better. I want THIS. This is what I need; this works for me. He is calling me – it’s for real. Talking to him is so exciting, like saying wedding vows. I love him, I could always depend on him to make me feel better, no matter what circumstance. I know he’ll never leave me, he’ll be around.”*

Riza is experiencing confusing thoughts – certainty that heroin is there as a back-up when she needs it, and uncertainty about the consequences of which she has an indication. She is also shocked and disillusioned at the thought that she has been fooled by the heroin.

*"I have lived a lie – conned myself. The idea was enticing, but I hate what I've put myself through. Am I making the right choice – stopping? But then again, do I want to die?; before, I was a monster without it, now I am a monster with it. Now I think, my God, what have I done? But yet I miss it."*

### **In the end it was worth it**

It seems that the heroin experience has won. She has made her final choice. Death does not scare her – does not mean anything to her. She realises that she is slowly committing suicide, but the experience has been worth all the good feelings heroin have given her. It is like dying for the cause - a hero's end.

*"I'm slowly committing suicide. Every time – this may be the last shot. I couldn't care. I'm not scared of death. I've seen it many times, when my mom overdosed on pills. She looked very peaceful to me. In my religion, I'm supposed to be scared of death, when you go to your grave, your punishment starts. For me, if I'm gonna get punished, I'm gonna get punished; I have only got one life. So, have a shot, at least I have felt good. Tomorrow doesn't matter. Only today matters. Paradise today, I don't care about tomorrow".*

#### **4.2.4 LUCY**

Name:	Lucy
Age:	35
Gender:	Female
Marital Status:	Married (two daughters)
Cultural group:	White
Number of in-patient treatments:	10
Occupation:	Unemployed

### Process of interview and interaction with Lucy

Lucy has been known to the researcher for four years. She has been a well known patient at the clinic where she is being treated. Lucy has a close relationship with the staff members, and feels very safe and at home with the staff.

Lucy appears lost and confused most of the time. The researcher experienced a deep feeling of empathy for her, and wonders whether this emanated from the feeling that Lucy is viewed at this time by the clinic as a terminally ill patient. She has earned respect from the staff for having survived this addiction for so long.

The researcher and Lucy have an open relationship. At no time did the researcher feel uncomfortable during the interview. Lucy was very tired and feeling sick. She was also in excruciating pain due to the infection in her legs that will not heal. She was still willing to give as much information as she could at the time. The researcher realised that the information Lucy was giving was relevant to her context of the moment.

### Lucy's story

Lucy has experienced her childhood as very difficult, having always felt like the odd one out. She has two brothers one of whom has been physically and emotionally abusive towards her since childhood. She ran away from home at age fifteen, fighting for her independence. She experienced disillusionment early on in her life.

Lucy is married and has two daughters, aged sixteen and twelve. Her husband is also abusing heroin, and they are both equally ill, being at an advanced stage of their heroin addiction; yet they keep holding on.

Lucy has been using heroin for about fifteen years, with many attempts at recovery. Lucy's legs are severely infected, and these wounds have not healed for eight years. Her legs had been bandaged up for eight years. She lives in constant pain, as the muscles of her legs are being eaten away as a result of the infection. Her hands and feet are always swollen and red, due to bad circulation. She has her wounds cleaned weekly at the local hospital; as the damage is so severe, she is not able to do it herself.

At this stage the only medical treatment indicated by the doctor is morphine to control the pain. Living without pain gives Lucy some quality of life. She finds it hard to survive from day to day if she does not have any morphine.

The experience of heroin addiction for Lucy is one of struggle from killing pain to killing pain.

### **The end of the road**

Lucy feels she is nearing the end of this process of addiction and fighting to survive. Looking back, she is unable to see any accomplishments in the past.

*"I have accomplished nothing – I've been on a big downhill the past two years. I've sold everything, we have only two beds left. No food – I eat bread so that the kids can eat."*

Lucy is at a point where she wants to quit life - not just the addiction any more. She wants to get out of her body and give up the battle.

*"This is the end of the road. I can't go on any more. I want to get out of this body, this pain. I cannot tackle the battle anymore – it's not cool"*

Although she is trying to preserve the last bit of strength she has left to survive, this strength is being depleted. She feels that she is holding on for dear life.

*“I’m holding on for dear life. I’m hanging from a cliff, holding on between life and death. I’m sliding.”*

### **Ambivalence – wish for new life, fear of failing**

Lucy does not have much physical and emotional strength left, but there is still a glimpse of a wish for a new beginning. She fears failing at making a new beginning.

*“I’m so tired, tired of living, tired of pain. I still sometimes wish for a better life but I’m tired. I feel despondent and sick. I’m so scared of failure and pain, big time! Failure is going back to drugs. Heroin causes pain and failure is to relapse.”*

### **Loss of sense of self and direction**

Lucy is experiencing a sense of loss of connection with her spirit, soul and environment. It is as if her life force has diminished. She feels as if she is on the brink of death, about to give up.

*“I’m exhausted, not being me anymore. I don’t want to be me anymore. I’m lost, I’m nowhere to see if I can make it. What’s the use?; with my painful body, I cannot connect spiritually. My body is failing me. I don’t want to be in this body anymore, it’s almost like my soul is leaving me. My soul -- is not wanting to be around anymore. When people are going to commit suicide, their soul leaves before the body dies. I feel my soul is going; I’m depleted. My soul is taken.”*

### **Heroin becomes irrelevant – the pain is more powerful**

For Lucy, heroin has become irrelevant. It seems as if it has lost its power. Her focus now is on killing physical pain. Initially it was the killing of emotional pain, now it has become the killing of physical pain. If she can obtain relief from morphine, she does not need heroin anymore.



*“Things are so hectic at the moment. I have hectic pain. I have this PAIN in my legs. I was very sick, now the pain is out of hand. My legs are very infected, my flesh is being eaten away. I don’t think I’ll have any legs left in two years; the doctor put me on morphine – it does not put me on a high anymore. It takes the pain away; it’s a relief! I’m using morphine and pethidine to ease the struggle. The struggle is so hectic, it does not matter whether I use heroin or not.”*

Lucy’s perception regarding heroin has shifted. She now views heroin and the addiction to it as bad, causing pain. Reframing this addiction to a terminal disease, morphine is good, it brings some relief and quality to her life. She experiences different outcomes, but both drugs are from the same group of opiates.

*“I feel the desperation of having been diagnosed with a terminal disease.. Heroin causes pain. Morphine is the good one – my life saver – it helps me cope with the pain in my legs. It’s good.”*

#### **Holding on for dear life – a small safety net is still there**

Although she feels she is hanging between life and death, Lucy still has something to keep her holding on. She feels she still has not lost all connection; she is still important to someone. Moments of happiness still appear in her life, which act as her safety net at the moment.

*“The kids are suffering too – they’re holding onto us. I try to make them laugh. I’m holding onto happy moments. I’ve realised I was looking for happiness in so many different places, I realise that happiness is momentarily. It comes in bits and pieces. Like my kids and little dog. I’m holding onto happy moments – they keep me going.”*

Lucy seems to connect more with sad moments, and she questions normality.

*“Sad moments are the realistic part of life. I don’t know what normal is – is it out there?”*

### **Life or death – but no struggle**

After experiencing ambivalence regarding holding on, or letting go, her thoughts swing between “making it” or dying. Certainty has now set in. She has made her decision. Lucy seems determined and relieved that she has made the decision that death is the only outcome, should she fail - if not life, then death, but no struggle any more.

*“If I don’t make it this time, then I’ll end my life. When I decide, I’ll do it. The kids will be better off. I’m not looking for attention – it means that I can’t make it on this earth. When I commit suicide, I want to die. God must judge me and put me in hell. That’s where I’m gonna go.”*

Lucy has resigned herself to the knowledge that life will go on, with or without her.

*“I’m not gonna carry on – people will carry on – they’ll cry for me for a while, but I know the family will look after my daughters”.*

### **A moment of clarity**

*“I have conned myself – I’ve lived a lie.”*

## **4.3 CATEGORIES DISCLOSING THE CHARACTERISTICS OF HEROIN ADDICTION**

The themes arising from each participant’s interview, as identified in section 4.2, were clustered together and formed into specific categories. These categories are presented in hierarchical sequence which may be an indication of the circular process of the experience of heroin addiction.

### **Heroin helps create new meaning**

The heroin addicts experience heroin as creating meaning in their lives where they felt that all meaning has been lost. Heroin seems to fulfill the users' specific needs. Even though these needs seem to vary, it is viewed in the context of the particular user.

The heroin addicts who participated in this research all seem to have reached a point of nihilism - that is, going through the despair over the apparent meaninglessness of life (Frankl 1988:166). They lack the awareness of a meaning worth living for. They seem to be caught in an existential vacuum - that is, being haunted by a void within themselves (Frankl 2004:111).

A respondent felt forsaken by God, and heroin helped him feel God's love again. The addicts feel that they are able to experience the beauty of life again, seeing the beauty and pleasure in everything. Unfortunately this pleasure borders on a feeling of blissful indifference where nothing matters anymore. They feel that they are functioning optimally while on heroin and that all their needs are met. They experience a positive self-esteem, feeling good about themselves. They feel loved and accepted, reassured. They feel safe, fearless, focused and calm. They feel assisted to survive any circumstance. Some heroin addicts call it the injection of life. It gives them understanding and empathy and improves their relationships. The users also experience a spiritual awakening, as if it is the end of the search for meaning. For them it is like finding the ultimate meaning, exactly what life is about. It is as if they experience a complete synchronisation of body and soul.

### **Trapped in a paradox**

Karl Menninger (1966:141) describes this paradox as using a substance which gives relief, analgesia, opportunity to heal without pain or enhance the quality of life (as with morphine used medically and heroin being a derivative of morphine)

to the person, but for some people it becomes an instrument of self-destruction, resulting in tragedy and suffering.

The substance, heroin, becomes personalised. It becomes the users' friend, lover, companion and care-giver. The users experience being supported and cared for. A personal relationship with the heroin develops. Initially this relationship is experienced as a subtle seduction by a selfless, loving being. It gives so much, and asks so little in return. Disillusion slowly sets in. There is a realisation that there is a price attached to this relationship, as if the honeymoon is over. Heroin is demanding more life-force and users feel the need to increase the use to feel the initial love again. They start feeling worse again, and take more to feel better. They are experiencing the start of a never-ending cycle.

The heroin addicts now start to experience being abused. Their lover gives them everything and then abuses them. They feel that they are conned into this relationship gradually, and then abused. Even though they feel abused, they still need him.

The addicts now experience the lover as a giver and a taker simultaneously. He gives paradise and torture at the same time. It gives them all the meaning they are looking for, then takes it away. They are left with nothing. They are now left with the uncomfortable feeling of being robbed, disillusioned, having sacrificed a lot. They are left with a feeling of having lost the self. They feel desensitised, empty, meaningless. It gives the meaning and takes it all away. They now feel like a puppet, with no control over themselves, like a robot. They feel controlled from the outside, have no life, no spirit. They believe that the goal of the heroin is to destroy them. It takes everything and then dumps them. They feel trapped and powerless.

### **Heroin takes over your life**

Heroin takes over their life by allowing them to cross a boundary to another, darker reality. These feelings of emptiness and powerlessness seem to pave the

way for the persona to enter their being, giving them new power. This power is experienced as one of evil, not of love. It does, however give them “better results”, makes them feel superior. One respondent reveals that it helps him “cross the line” and enables him to take someone’s life. He feels so powerful that he is able to overcome death, after surviving numerous suicide attempts.

Good feelings are replaced by fear and terror, and a sense of being in trouble starts to surface. Being on the other side, and experiencing the destruction of the self and others becomes a critical situation, feeling out of control. There is a longing for the life before heroin. In these moments of despair to end this struggle, having had enough, they feel that heroin gives them a choice and they feel forced to make a choice. Making a choice seems to bring clarity and relief, as if the cycle is broken. This choice is limited though. They have two options - to live or die.

Living means facing the struggle again, without any tools to do it with. Living means going through the divorce, grief and loss.

### **Divorce is painful, with a bleak future of grief and loss**

In spite of the consequences, which they never believed initially because their experience was so positive, the addicts find it distressing to divorce this persona. They experience it as if they are the one leaving, and cannot face it. They feel angry and abandoned, as they are sacrificing love and comfort. It feels as if they are giving up the comfort of the womb. It hurts to be separated. They are fearful to face the powerlessness and the loneliness. The future looks bleak and feels uncertain and without direction. They cannot imagine living without heroin for the rest of their lives.

The addicts feel hopeless and vulnerable, as if they had lost a loved one; they are heartbroken, and scared to face loneliness and despair. Furthermore, they

experience a loss of connection with their soul, a detachment from everything, as if their soul has been taken. They feel sick, sad, depressed and alone.

### **Choosing the path back is complicated; holds no guarantees**

The course of heroin addiction is uncertain, and a profound fear of the future exists for the addicts. It would appear that, according to them, heroin is the one thing that reassures them, and guarantees availability and effect.

The path back is complicated by the “old programming”, memories and experience of the heroin, and some report that it is like learning a new life like a baby, but with the “old programming” of an adult. They question how to de-programme themselves. While on the path back to sobriety, doubt and fear set in. The addicts feel that they have no protection, no safety net. Their effort at recovery may be hampered by the fear of making a new beginning. They often don't like the person they are when not on heroin, thus, returning to the sober life as an un-likeable person does not seem an option to them. They miss the nice person that they were on heroin.

Relapse seems to be the solution. Heroin leaves a subtle promise that he's still there. The addicts remember the good that will be missed and the bad times seem to fade. They find relief in the knowledge that heroin will always be around, is predictable and dependable. The future looks much brighter, knowing they can always go back and heroin will be there. This seems to be the most trusted safety net available. The addicts seem to resign themselves to this process and death loses its meaning. The experience is worthwhile after all. If they die, it will be like a hero's end, dying for the cause. The moments of paradise are all that matters at this stage.

In spite of seemingly giving up, the addicts still have the instinct to hang onto the little bit of meaning they have left. Some feel there is always hope, some hold onto the bit of happiness left in their lives.

### **Heroin loses its power**

Some addicts reach the feeling of being at the end of the road, and feel they don't have the energy any more to attempt the path back to recovery. Their addiction has become a way of life; no other life makes sense to them. There is no place to return to. They once wanted to quit their addiction; now they want to quit life. One respondent wants to leave her painful body by giving up the battle. Heroin used to be the power in her life; now the pain is the most powerful, controlling her life. Her struggle is now how to kill the pain caused by the heroin, and heroin cannot kill this pain anymore.

Her perspective has changed as she sees herself as a terminally ill person, not a heroin addict. Heroin is now the bad thing that is killing her, and morphine (a similar drug) is now the good one, the life saver giving her quality of life - that is, being pain-free. Living without pain is her goal now.

Heroin has therefore changed from the wonder drug that gave them meaning and fulfilling all their needs, to losing all the power, only causing pain. The majority of the addicts realise they have been living a lie.

#### **4.4 EXTENDED DESCRIPTION**

Heroin addiction can be viewed as a circular, paradoxical process in which addicts become entrapped. The addicts tend to disbelieve the people when the consequences of heroin abuse are spelled out to them, as their initial experience with the heroin was very positive to begin with and they have not yet experienced the negative effects. Only in retrospect can they verify the negative consequences.

The heroin addicts seemingly start using heroin at a point where they experience a loss of meaning in his life. Heroin gives them the feeling that all their needs are met, each one in his specific context. This feeling can be described as the

marriage of body and soul, a complete synchronisation of the self. They are then able to see the beauty in everything, having a spiritual awakening. The effect hereof may lead to an indifference where nothing matters, only the feeling heroin gives them.

The heroin becomes personalised, and is called a friend, lover, companion, protector. The addicts feel loved, safe and protected. Disillusion slowly sets in when the realisation appears that the heroin is not the selfless giver any more. It is taking more and more from them. They experience the effects of abuse, feeling very ambivalent as they are now experiencing love/hate, paradise/torture at the same time. They feel robbed and empty, but yet they want the heroin. They feel trapped and powerless.

During this feeling of entrapment and emptiness, heroin offers them another sense of power, experienced as evil, yet more powerful than the initial feelings. In spite of this new sense of power, their feelings are now marked by fear and terror, feeling controlled by an outside being. At this point of despair they make a choice about living or dying. Continue using, and possibly dying. Continue living, they face a big challenge, with no guarantees. If they choose life, they have to go through a divorce process, facing sadness and loss.

Facing a great fear of a new beginning, they need a safety net. This safety net may be any meaningful aspect in their lives, but often the reassurance of the heroin is always in the background. Heroin being dependable and predictable seems to be their strongest safety net. Relapse seems to be the solution as they remember the good times which were worth it after all. If they die, it would be for "the cause". Should this process continue for some heroin addicts, the decision to die brings certainty and clarity. The heroin has lost its power and is recognised as the destroyer. The meaning left for this person is only to have a pain-free life (from emotional to physical pain), going back to the beginning.



It would appear that this addiction is marked by many beginnings, and no end (Hamilton 2002:4). When the heroin addict says it is the end, would it mean the end of their addiction or the end of their life? Where do they begin?

“Everything was a lie.

What parents and the government told me was a lie.

Heroin was the biggest lie of all.

I think if I had been told the truth –

told to me straight – I would have made better, informed choices” writes Jason (Dr. H. 2002).

## CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

## 5.1 CONCLUSIONS

**5.1.1 The value of phenomenology in understanding the experience of heroin addiction**

The primary focus of this research was to provide a description of the experience of heroin addiction from the perspective of the addicts themselves.

This perspective has been poorly understood by families of addicts, therapists and doctors involved in the field of heroin addiction - hence the statement “we don’t understand” and “what makes this addiction so intense and different?”

Using the phenomenological approach, it was possible to access the addict's perspective and experience of living with heroin addiction. The process that was highlighted in this research is able to add to the mysticism of heroin addiction and to complement existing research on heroin addiction.

Heroin addiction is experienced as being trapped in an endless cycle of wanting to live or facing possible death: the paradox of “I am dying, but fighting to live”. Making choices either way initiates complications. The addict's life world is disrupted by this experience and may result in many attempts to recover, but no end (recovery or death). Phenomenology allows access to the lived experience of this phenomenon.

Treating heroin-addicted patients in a clinic from a multi-disciplinary approach, may lead to a tendency of misunderstanding between heroin addicts and those professionals who treat them. Many of the staff follow the disease approach to

addiction, which has value in treating the physical symptoms as well as teaching the addicts new coping skills. The addicts bring their own reality and context to the treatment, which is often not understood, resulting in them being viewed as manipulative and unmotivated. The different realities are distinct, and then a source of misunderstanding between addicts and those who treat them develops. Phenomenological studies such as this one provide the basis according to which the source of such confusion can be clarified (Wade 2001:102).

This research provides an added dimension to heroin addiction by complementing the existing views on addiction, that is, signs of physical and psychological addiction and the treatment thereof. Treatment includes medical, educational and skills training. This added dimension depicts the addict's context in which the addiction is experienced, and the meaning they ascribe to their experiences. Phenomenology discloses how this experience impacts on the addict's life and the themes which emerge reveal the struggles that addicts go through while on or attempting to get off the heroin. This study also highlights the "mysticism" of heroin addiction that many find difficult to understand. Phenomenology and qualitative methods allow access to this dimension, deepening our knowledge and understanding.

### **5.1.2 Implications for the professional working with heroin addiction**

#### Therapists/counsellors

This study highlights the importance of working with the client's context, thus entering the world of experience, as well as understanding the meaning they ascribe to the heroin addiction. The themes that are highlighted can assist the therapist in adapting the focus of therapy and possibly making the therapeutic experience meaningful for both addict and therapist. Therapists can also identify specific themes relating to the clients they are working with, and plan interventions accordingly.

The therapist appears to play an important part in the relationship with the heroin addict. All four subjects were relieved to be able to talk openly and honestly about their experiences. They felt understood and accepted. It would appear that the therapist acts as a mirror or another pair of eyes to help the addicts validate their humanity and struggle. They need to be seen as people, not needles. (See appendix D, "Give me your eyes")

The therapist can also use this information to inform the family of the heroin addict's struggle and help them gain empathy and understanding regarding this addiction. This can be done by providing family counselling, as the addiction does affect the family as well. It is not an isolated phenomenon.

#### Medical personnel

Medical treatment is important to help ease the physical symptoms of withdrawal as untreated withdrawal may leave the person with extreme physical and emotional discomfort. When the cycle of addiction repeats itself, tension can develop between doctor and patient due to the clash of perspectives.

It can be valuable to educate doctors regarding this process, and promote empathy and understanding regarding the patient. Some addicts reach "the end of the road" and experience being terminally ill. Viewing this phase of the addiction as such may bring relief to both patient and doctor, where they can focus on pain relief instead of continuing the struggle to give up heroin. As in the case of Lucy, the doctor assists her by controlling pain with an alternative to heroin, as heroin has become irrelevant to Lucy. The results show a rise in quality of life for Lucy.

#### **5.1.3 Strengths of the present study**

- The persons that were interviewed had themselves gained perspective on their addiction and were able to provide valuable insights into their life

worlds. This in turn offers another perspective on heroin addiction which can enhance the understanding of this addiction and develop more empathy towards those involved in any way.

- This research can provide a basis on which misunderstandings can receive attention and be overcome.
- Both males and females were included in this study, which can indicate that the experiences are similar for both sexes, taking their contexts into account.

#### **5.1.4 Limitations of the present study**

- This research only focused on those heroin addicts who have been admitted for in-patient treatment on numerous occasions, and who are seemingly unable to overcome their addiction.
- Not all heroin addicts end up in this process, or end in death. Although there are many similarities in the process they all go through, this research does not examine those addicts who have stopped using successfully.
- This study focused on heroin addiction only, and it is not clear whether these findings are applicable to other drugs such as cocaine, ecstasy or crystal meth.
- The participants are all from the same race – white - and one is a Muslim person. This is due to the availability of subjects being interviewed at that time. The results may not be applicable to other cultures/race groups. However, the aim was not to produce statistical generalisations regarding heroin addiction.

## **5.2 RECOMMENDATIONS FOR FURTHER RESEARCH**

Further studies can be conducted to address some of the limitations of this study.

- As this study focused on those addicts who don't seem able to overcome their addiction, a study can be conducted on those heroin addicts who have successfully overcome their addiction. Their perspectives, coping skills, reaction to treatment and how the process was successfully interrupted, can be studied.
- Another study can focus on those heroin addicts who recover spontaneously, without ever having received specialised treatment (Hanson 1985:5).
- A study investigating the lived experiences of addicts using other drugs, such as stimulants or hallucinogenics, could be conducted in order to detect differences (if any) and similarities of these experiences and meanings.
- A combined qualitative/quantitative study can be conducted to include different cultural groups, which can provide statistically generalisable results.
- The impact of heroin addiction on the parents, spouses, loved ones and children of heroin addicts warrants further investigation.

### 5.3 CLOSING REFLECTIONS ON THE STUDY

Helping professionals are faced with a complex process in which both client and professional sometimes feel trapped and experience great frustration. Adding another perspective to the experience of this addiction brings a deeper level of empathy and understanding. While struggling with their addiction, feeling helpless, the addicts also display a very strong survival mechanism.

The process of addiction to heroin, as experienced by the subjects under investigation, seems to be that of a paradox. Heroin was chosen as a coping mechanism which fulfilled all their needs, making them feel whole again. Yet, at the same time, they were robbed of exactly that. The use of heroin produces contradictory feelings, of reward and empowerment on the one hand, and

distress, enslavement and threat on the other (Hanson 1985:11). While heroin meant the world to them, helping them create meaning, they ended up reflecting that it was all a lie - that heroin was the biggest lie of all. Recognising the lie does not end the process of addiction for them. For them, heroin addiction seems to be a never-ending story.

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APPENDIX A

**Letter outlining the purpose of the research**

Dear

I am currently completing my Masters degree in Social Science (Mental Health) and would appreciate it if you would participate in my research. The topic of my dissertation is the meaning of heroin addiction. I wish to provide the description of the experience of heroin addiction from the point of view of the people who have this problem. I wish to tape record one or more interviews with several people, which would then be transcribed and analysed. Results would be used for research purposes only. When the results are published, all names will be changed to ensure confidentiality. Participants will also have the opportunity to view the results.

If you are willing to participate in the study, I would appreciate your written consent.

Thank you for your kind assistance.

J.I. VAN ZYL

Registered Social Worker

Registration number: 10-19378

APPENDIX B

**Letter of consent signed by research subjects**

I, .....agree to participate in the research on heroin addiction, conducted by Mrs. J.I. van Zyl.

I give consent for the review of my medical/therapeutic records if necessary, and for the tape recording of interviews and the publication of research findings.

Signed .....

Date .....

(Adapted from examples as they appear in the dissertation of Wade, 2001).

## APPENDIX C

### **Interview schedule with possible questions to ask during interview**

1. Please give me a short sketch/brief history of the significant aspects of your life.
2. Please give me in as much detail as possible, your experience of living with heroin addiction.
3. What is it, in your experience, that people don't understand about your addiction?
4. When did heroin become a problem?
5. Describe your experience of the relationship with heroin.
6. What are your experiences trying to give up heroin?
7. What about the future, living without heroin?
8. Is there anything more you feel you could share/or have left out?

The first three questions were normally sufficient to obtain all the details, as the participants were very open and honest.

The other questions were there for possible clarification of some details, but not used throughout every interview.

## APPENDIX D

## GIVE ME YOUR EYES

Oh boy, look at yourself  
 What have you done?  
 What have you become?  
 Well, I couldn't say  
 Slow down and think of your heart  
 Where do you go?  
 Now how am I supposed to know  
 I'm always looking away?

Give me your eyes  
 So I can see me straight  
 Give me your eyes  
 I can't tell night from day  
 Give me your eyes  
 So I can see me straight  
 Give me your eyes  
 And watch me walk away

I took a look at myself  
 Nothing inside  
 Except cigarettes and thai  
 Where there should be a life  
 You've been watching me for a while  
 And do you like what you see  
 It's in the eye of the beholder  
 Now give them to me.

Give me your eyes  
 They seem to like my face

Give me your eyes  
 So I can see me straight  
 Mirror, mirror on the wall  
 Who is the fairest of them all  
 Mirror mirror made no reply  
 Mirror went black and cracked  
 From side to side

Oh boy, look at yourself  
What have you done?  
What have you become?  
You know the camera won't lie

Give me your eyes  
So I can see me straight  
Give me your eyes  
I can't tell night from day  
Give me your eyes  
So I can see me straight  
Give me your eyes  
And watch me walk away

Permission given by:  
*Ettienne*  
*Sanca 13-15 Feb 2007-10-20*

(Thai is the street name : "Thai White" is a brand name for heroin).