

7-1-2015

# Understanding Heroin Addiction from the Life Course Perspective

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## Recommended Citation

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**Understanding Heroin Addiction from the  
Life Course Perspective**

By

Kayli Fisher

An Honors Thesis Submitted in Partial Fulfillment  
of the Requirements for Graduation from the  
Western Oregon University Honors Program

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July 2015

### **Abstract**

Heroin and other opiate dependence is a disease that affects the user, interpersonal relationships, and the surrounding community. Due to societal stigmatization of heroin addiction, it can be difficult to help the wider community see the need for more effective intervention and prevention efforts. The purpose of this study was to better understand risk factors of dependency by examining the life courses of individuals who have been through addiction, treatment, and are currently in recovery. Early childhood experiences, specifically parental abuse and social rejection, combined with substance abuse as a model for coping, were found to be influential in the development of addiction. Social support and self-awareness during and post-treatment were effective components of sustaining recovery.

From an outsider's perspective, heroin addiction is an evil that harms not only the user, but society as a whole. Generally speaking, individuals have an impact on their community. Each person's ability to find and maintain employment, buy goods and services, and obey the laws of one's community dictate whether or not that individual is helping or harming the local economy and community as a whole (Mark, Woody, Juday, & Kleber, 2001). When an individual's choices harm the community overall, there are resources in place that deal directly with the outcomes of behaviors. Law enforcement, treatment services, and DHS (Department of Human Services) are typically reactive programs that interact with the individual once the negative behavior has already occurred. Others in that person's community may not see specific behaviors as symptoms of a disease—which is, in this case, addiction—but rather as a series of choices that are completely within the individual's control. As a result of this, addicts are stigmatized as junkies or dopers and are spurned by their communities more often than they are helped. The goal of this study is to illuminate the disease of addiction by highlighting the personal stories of those who have been completely immersed in heroin or other opiate dependence, and are now in recovery. It will mainly examine the risk factors identified in early childhood that influenced later addiction, as well as common factors in successfully completing treatment and maintaining recovery.

Within the medical community, heroin addiction is viewed as a disease. Taking a mind-altering substance changes the individual's metabolic state, which after multiple uses will require continued and increased dosage to avoid withdrawal (Van Zyl, 2009). Once a drug user has reached the addiction stage, control over one's use is lost. This leads to increased spending and drug-seeking behavior that can have negative personal and interpersonal consequences (Cheng, Lu, Han, Gonzalez-Vallejo, & Sui, 2012; Higgs, Jordens, Maher, & Dunlop, 2009; Simmons &

Singer, 2006). Heroin is especially dangerous, due to its addictive potential and destructive nature (Cheng et al., 2012; Vaillant, 1988; Van Zyl, 2007)

Although heroin and other opiates are certainly not the most commonly used substances, their individual and overall impact are what makes them of concern. In a 2011 assessment of national drug use, the National Survey of Drug Use and Health (NSDUH) determined that the rate of individuals who had used heroin in their lifetime over the age of twelve was 1.6%, and individuals aged twelve and older who had used in the past month was just over 0.1%. It is estimated that the total number of heroin users per year in the United States is 560,000 and the number of frequent users is about 338,000. A major limitation in heroin statistical data is that estimates are based on self-reporting by the surveyed populace, as well as heroin-related hospital and treatment facility admittances. Therefore, it is difficult to determine how accurate these estimates are, and many researchers agree that the number is likely higher than professional estimates (Mark, Woody, Juday, & Kleber, 2001). Finding longitudinal data for long-term success of opiate and heroin recovery is difficult. However, one study from Australia suggested that, depending on the form of addiction intervention, long-term success rates can range from 52-63% (Ross et al., 2004).

The life course perspective provides a framework for understanding the development of the individual, family unit, and their community over time. It is a comprehensive theory that takes into account the historical, cultural, and societal context in which the unit changes, and lends insight into the unique changes in relation to those contexts (Connidis, 2011). Specifically, the life course perspective focuses on pathways through the life-span, and age-related roles, transitions, and trajectories over time (Hser, Longshore, & Anglin, 2007). Certain life events, in general, relate directly to age (i.e. education, marriage, work, etc.). Adaptation to particularly

stressful life events dictates an individual's trajectory (Hser, Longshore, & Anglin, 2007). Additionally, the life course perspective provides an understanding of how the individual, family unit, and community changes interact and influence one another. Van Gundy and Rebellon (2010) used a life course approach to the "gateway hypothesis," regarding the role marijuana plays in adolescent drug use and subsequent drug abuse in young adulthood. The authors proposed that certain components such as age-linked stressors and social roles are potential factors in adolescent marijuana use, and the prolonged exacerbation of these factors may influence an escalation to the use of other drugs and subsequent addiction in later life (Van Gundy & Rebellon, 2010). For example, exposure to trauma such as emotional or physical abuse may condition an adolescent to use substances as a means of coping, which in turn teaches the individual to use the same strategies in response to stress later. Therefore, "teens embedded in high stress environments may be particularly susceptible to 'gateway' risks" (Van Gundy & Rebellon, 2010, p. 245). Their study tested whether there was a causal link between marijuana use in high school and other drug abuse in later adolescence or whether the link can be explained by life course events and circumstances such as education, work, and youth stressors. They found that the "gateway effect" of marijuana use is more complex than simply getting hooked on one drug and progressing to another. Early marijuana use was not the dominant factor in later-life substance abuse. Instead, other variables, specifically age-linked experiences like teen stress, mediate their propensity for escalation into abusing more potentially dangerous drugs as they develop.

For this study, the life course perspective provided the theoretical lens for understanding heroin addiction. Investigators theorize that many turn to drug use as a result of a variety of stresses and anxieties of their everyday lives (Hawkins, Catalano, & Miller, 2007). Individuals

whose parents modeled substance use may be more likely to repeat that behavior, having learned that coping method instead of healthier alternatives (Hser, Longshore, & Anglin, 2007). These individuals then in turn may be more likely to develop a dependency because of genetic factors that make them more susceptible to addiction (Hawkins, Catalano, & Miller, 2007). The life course perspective explains why someone with a genetic vulnerability for substance dependence, combined with use modeled in the home and traumatic or stressful events during dependency, might be more likely than someone with a healthier track of development to become substance-dependent. The use of qualitative methods will help in understanding the heroin user's perspective of addiction and psychosocial outcomes. This study will attempt to address two research questions: How do earlier life and current experiences shape addiction and recovery for adults with heroin addiction? And how do adults with heroin addiction describe and evaluate their family, peer, and community relationships over time?

### **Method**

This exploratory qualitative study included individual interviews conducted with post-treatment, long-term recovery individuals (N = 5) with a history of heroin and other opioid addiction. Recruitment was conducted after the proposed study design was approved by the Institutional Review Board at Western Oregon University. The criteria for participation in the study included participants who: a) were 18 years of age or older; b) experienced a history of heroin or other opioid addiction and c) completed at least one year of ongoing recovery time. A treatment agency in Oregon was contacted and agreed to assist in identifying participants who met the study's criteria. This convenience sample strategy resulted in participant affiliations with the targeted treatment agency.

All agency identified participants were contacted by the researcher. The study was explained by phone and interest in the study was confirmed. Participants completed informed consent prior to the interview. Participants consented to voice recorded interviews of approximately one hour with the understanding that they would be asked to discuss their childhood and personal history, addiction history, and story of recovery and continued abstinence. Interviews were conducted in various offices of the participating treatment agency. These interviews were semi-structured with probing, open-ended questions such as, "How was your relationship with your parents growing up?" and "Please tell me the story of your addiction." Interviews ranged approximately from 45 minutes to an hour, and participants were free to discuss the elements of their addiction story that they found to be most relevant, although certain elements such as family history and peer relationships were actively probed as per the interview protocol (see Appendix).



All recorded interviews were transcribed verbatim and read repeatedly. A coding system (Berg, 2001) was developed for analysis in consultation with the major professor. Nineteen major codes (i.e. SH = school history, PIA = parental influence on addiction) and 49 subcodes (i.e. SHP = performance in school, PIAM = influences involving mother) were used to analyze the transcribed interviews. While the main concern during analysis was to identify major themes that directly addressed the original research questions, there were minor themes present in the data that were noted and given secondary attention in the analysis.

### **Participants**

Five individuals were interviewed for this study. Four males and 1 female were recruited, with ages ranging from 33-55 ( $M = 39.4$ ,  $SD = 7.91$ ). Four participants identified as Caucasian and one identified as Hispanic/Latino. Time of sobriety between participants ranged from 2-10 years ( $M = 7.2$ ,  $SD = 3.90$ ). Only one participant in this study completed high school on time. However, as a part of treatment, incarceration or otherwise, all other participants obtained a GED and attended college-level classes. The minimum amount of secondary schooling for all participants was two years.

## **Results**

Participants described in detail their childhood experiences, addiction history, and the story of their treatment and recovery. Early experiences that were shared were generally perceived as having some level of influence on their initial time of substance use and later addiction. Similar experiences occurred amidst addiction across interviews, and each participant shared his or her motivation for the final entry in treatment. More themes emerged regarding recovery, specifically the external and internal factors that contributed to maintaining recovery.

### **Early Childhood Shaping Later Experiences**

There were several themes that emerged across all five interviews. The most noteworthy in what appeared to contribute to addiction later in life consisted mainly of childhood experiences, specifically those relating to experiences with the individual's family of origin. One common theme across all five interviews was the presence of parental substance abuse in the participant's home during childhood. Each participant had at least one parental figure in the home that they described as having a substance abuse problem, and 3 participants noted substance use in more than one parental figure in the home. Alcoholism was the most common expression of parental addiction and was present in at least one parent or step-parent across all interviews. Three participants also indicated an understanding of the biological nature of addiction as contributive to their disease. Samuel attributed his father's alcoholism as a genetic factor in the development of his addiction, "So I'm pretty sure I was born an alcoholic. At least the mindset, the disease of alcoholism."

Another significant similarity across interviews and likely one of the most influential factors in the participant's development of their addictions was the presence of parental abuse

during childhood. Between interviews, abuse ranged from verbal and emotional in one case, to physical in the other four, with additional elements of emotional and sexual abuse for one participant. This participant, Jessica, described the abuse she received from her stepfather, in addition to the sexual abuse at the hands of her biological father when she was sent to live with him later in her teenage years.

It was with my stepfather, it was emotional, physical, sexual [clears throat]. It was, I mean, any of the abuses. Financial, like I had, at 13 years old, I had to work in the bean fields. And babysit for my own school money to buy school clothes. He wouldn't let my mom buy me anything...He separated us from our family, especially me.

While 3 participants acknowledged the genetic nature of their disease of addiction, everyone attributed their later dependence to the abuse they had witnessed in their childhood homes.

None of the participants of this study began the development of their dependency with heroin or other opiates. The numbing nature of heroin and other opiates was mentioned as something that participants often felt the need to chase in order to escape the emotional pain they experienced at the time. Gary was particularly eloquent in the analysis of his addiction as a disease and its relationship to his emotional state prior to treatment and recovery.

[Addiction] has everything to do with your behavior, and your thought processes, and the way that you perceive the world around you, and your inability to reconcile your emotional condition with your outside environment. And it creates a condition that you cannot stand how you feel. So your condition is that you develop this dependence on changing how you feel.

Marco described the emotional component of his relationship with drugs at the beginning of the

development of his dependence. His initial drug use, which consisted of alcohol and marijuana, occurred at age eleven. Prior to this experience, he grew up with his parents who were separated and witnessed drug abuse, criminal activity, and physical violence in the home directed toward himself and others.

And drugs was not my problem. Drugs was my solution. My problem was life. I was always filled with fear. I always felt insecure. I was scared all the time. I had anxiety going on, 'cause I never knew what was going to happen next. But when I drank, and I smoked that weed, and I had that girl that night, I felt I could accomplish anything in the world. It was like I was Superman.

### **Psychosocial Factors in Early Childhood**

While childhood experiences in the home were found to be influential in the development of later dependence, social rejection during childhood and early adolescence was another common element. This included experiences as the target of bullying and/or feelings of social anxiety and not fitting in. These experiences often led to performing poorly in school, which tended to further exacerbate the desire to not be there. Every participant described eventually assimilating into a peer group where they found acceptance and friendship. Jessica described her first use beyond marijuana and alcohol with her peer group:

I was sixteen years old and I did my first line and I fell in love with it. And that's all I wanted to do. I loved how it made me feel. I didn't care, I was invincible No one could hurt me anymore. And these people did that. And they liked me, and I wanted to be part of that.

Unfortunately, these groups tended to encourage and reinforce substance use and other

delinquent behavior such as fighting and stealing. Each participant was asked to discuss their first experience of inebriation under the influence of illicit substances. All participants described their first use as a part of their social environment, whether a friend offered them drugs or alcohol or the group set out to consume them together. Samuel discussed how he found that his initial experiences with alcohol finally allowed him the social confidence he felt had been missing. He stated, after freshmen year, “I started drinking more and more and it just, it made me more sociable. I could get over the internal fear of talking with other people and I seemed to fit in and I had fun.”

### **Common Elements of Dependence-Related Experiences**

Alcohol was the most common substance of first use, as well as one that most participants developed a dependency to either in addition or prior to their addiction to heroin. Marijuana and hallucinogenics also were common first use substances. Each participant’s addiction to substances progressed until he or she began habitually using heroin, or in one case, prescription opiates. Most participants also continued their dependence on alcohol or other drugs in addition to their heroin use.

A number of strategies were employed to obtain heroin and other opiates across participants. Gary, who mainly used prescription opiates, had learned to cleverly con doctors and hospitals into giving him morphine and prescribing him medication. He described his elaborate understanding of the nature of communication between hospitals in the area; which doctors would contact doctors in other areas about his attempts to obtain medication, which ones were suspicious, and which ones still believed his claims of unendurable pain:

If I was on vacation in Central Oregon, and I could get away from the campsite

for a little bit, I'd drop in to the emergency room at the hospital ... You know, I knew which hospitals gave what, and I knew that the urgent care at [Hospital A] and [Hospital B] did not communicate. And I knew which days, which doctors were on rotation, and I just knew how it worked. And they had a very poor system. I capitalized on it, and by design it was for people to be honest, and I was not.

He also stole bottles of unused medication from friends and family, preferring that to stealing from strangers or contacting drug dealers.

The others who mainly used heroin did what it took to have enough money to pay drug dealers. These strategies included prostitution, bank robbery, burglaries, drug dealing, and "boosting" large appliances from department stores to sell later. Marco discussed taxing other drug dealers as one of the major distributors in the area. He shared,

In California, you have to pay taxes to local gangs. You can't—not anyone can sell drugs. So, sometimes I would just tell people, "Hey, if you're going to sell, if you don't want me to rob you, then you gotta give me this much every single week."

Four participants had interactions with law enforcement because of the criminal activity they engaged in to obtain drugs. Two participants were in and out of the penal system until their final stint in treatment.

The nature of participants' relationships with their family, peers, and communities immediately prior to treatment were similar across interviews. The only participant who still had a close relationship with a parent was engaging in drug use alongside his mother and wife. The others described their relationships with siblings, parents, and extended family members as

similar to “nonexistent.” One participant lost his job and marriage due to a relapse after a ten-year period of sobriety. Three participants had their children taken by DHS before entering rehabilitation. Three participants were living in poverty, while the other 2 participants were supporting themselves with drug-dealing. Participants also had difficulty obtaining and maintaining employment. There was a sense that participants knew they were capable of more, but because of incarceration, pre-employment drug-testing, or having previously been fired for drug-related reasons, they were often simply unable to find work that could stimulate or challenge them. Marco described his frustration with the kind of employment that was available to him:

I had no work history and I had a whole bunch of criminal history. So, the jobs that I could get were all general labor jobs that left me unfulfilled emotionally and spiritually and mentally. Just, it wasn't a challenge for me. It was completely grunt work.

### **Steps to Recovery**

There was another common similarity across interviews regarding motivation to enter treatment. Although there were experiences of poverty, loss of relationships, and a sense of alienation from one's community, each participant was motivated by an external force, whether that was family members, friends, or a community resource, such as DHS or a parole officer. As Gary put it:

In some way or another, somebody made you go. Because, nobody ever wakes up one day in their addiction and raises their hand and volunteers to go to treatment. You go to treatment for a variety of reasons. One is, you got nowhere else to go,

or some external force has applied motivation to you, whether it be your family, or the legal system, or your doctor, or whatever. Nobody wakes up one day and says, 'I want to go to treatment.' They do not.

It is important to note the similarities between participants in their recovery stories, as well as what each individual found to be influential during their treatment that helped contribute to their sobriety. Although external support was found to be substantial in the accounts of treatment experiences, there was a general consensus that ultimately the success of treatment was up to the individual in treatment. Dave is now a treatment counselor after going through his own journey of addiction and treatment. His work allowed him to provide significant insight into the likelihood of successful treatment and recovery:

But really, it's on the guy coming through the door, ultimately. If that person's hit a point where, they've hit their bottom, they surrender. They don't wanna fight anymore, and they're really coming genuinely from that place. Anybody can be successful at that.

### **Contributing Factors to Treatment Success**

The most notable similarity with this cohort was the presence and impact of the support they received from peers in treatment and support groups. Each participant mentioned the importance of the bonds formed with people they met in treatment who understood where they had been and what they were currently experiencing. Participants discussed how treatment peers were always willing to help, whether that was lending a supportive ear, providing childcare, or helping the participant move. When asked to describe their current peer support, it was clear that participants' post-treatment peer relationships provided more meaning than their peer groups



during addiction. Jessica met her best friend in treatment, and like the other participants, continues her friendships with her treatment peers. She discussed the significance of her current friendships on her treatment and continued recovery:

If it wasn't for them, I would not be here. They are the ones that hold me up to this day. They're the ones that are there for me; hold me when I'm crying. And it's the bonds that I have with them and the sisterhood... I have great friends that want nothing more from me than just me.

A slightly less critical, but still important, factor in recovery was family support, both during and after treatment. As stated previously, family relationships were generally described as at an all-time low just prior to entering treatment. Healthy family members had for the most part written off their substance-dependent child or sibling prior to the participant seeking treatment. However, participants reported that at least one family member was supportive throughout the treatment process, and that family relationships overall have vastly improved since their recovery. Although participants generally discussed their peer relationships as the main source of support during treatment, repairing relationships with family members was mentioned as a significant part of continued sobriety. Families of participants, especially their parents, tended to provide childcare as the main expression of support. In one case, the participant's family now seeks support from him, and views him as one of the more stable members of his family. Although most participants are not especially close with their parents post-treatment, all of them reported having made amends to the point of civility at minimum. Dave, whose relationship with his father was volatile as a child and adolescent, described the nature of their connection today:

My father's still on the East Coast. We don't talk a great deal. But I think we've gotten to a place where we've moved past our resentments and at least

communicate... We communicate openly. There's no animosity. [chuckles] Sort of the antagonistic nature of that relationship has disappeared.

Participants also indicated a new level of awareness of themselves and the nature of their substance use and addiction. One of the key parts of treatment is working with counselors and support groups to begin talking about the emotions and traumas that are covered up or forgotten. Because of this, participants were able to articulate low feelings of self-worth and esteem prior to and during addiction, as well as their relationship to heroin and the other drugs they had used. They were able to reflect on the destructive nature of their dependence, and how their poor emotional well-being had both contributed to and been harmed by their addiction. Marco described the emotional effects of using heroin:

Drugs make you feel more of whatever it is you're in the mood for feeling. So if you're feeling like, that person's cute. Or that person's really nice. It's like, 'Oh my god, I've never seen anyone so gorgeous in my life.'...But if you're feeling sad, or you're feeling like someone let you down, you're like manic-depressive, crying. Or you're full of rage and anger and you're putting your hands on people. 'Cause you're just so frustrated...So, it left whatever relationships I had there at the end—is hurt relationships, untrusting relationships, unhealthy relationships.

They knew that their individual histories had set them on a path to addiction, and at the same time had taken responsibility for their actions, including those that led them to treatment and sustained recovery.

### **Relationship to community after treatment**

Participants in this study were sampled from staff working at a treatment agency, so the

nature of their employment would indicate that these participants might feel more positively connected to their communities. That is, in fact, what the interviews suggested. Participants reported feeling more connected to their communities, as well as an increased sense of meaning in “giving back.” Participants tended to balance their perceptions about how the community treated them prior to treatment with an awareness of their state and behaviors amidst their addiction. However, there was a sense of the desire to use their experiences to work to improve a system that they felt had both failed them and saved their lives. Marco, who began the development of his addiction in early adolescence, has extensive experience with both negative and positive feelings toward his interactions with community resources throughout his lifetime. He now uses his past experiences with addiction to make a difference in various community domains in addition to his work with the treatment agency. His perspective was particularly insightful:

It was in-home robbery, but they knocked it down to burglary. I was 11 years old.

And from that time, I had kept on getting in trouble. I was never offered alcohol and drug treatment until I was 24 years old. That’s my experience with ‘em...

When I work with the kids—there’s kids that are 16, 17, no foster homes or group homes would take them, and they’re homeless. And when they say, ‘I don’t know where I’m going to get my next meal,’ I say, ‘I remember that. That sucks.’ And they say, ‘You don’t—you never did that.’ And I said, ‘Oh, really? So, you never had to do this, this, and this?’ And they’re like, ‘Oh shit, you do know.’ Right? So now it’s a strength. It’s a gift.

### **Discussion**

The goal of this study was to better understand how early life experiences and development influence later addiction and recovery, and how those two elements shape the individual's relationships with family, peers, and community over time. The life course perspective helps underscore the significance of early-life experiences and trauma in the choices and behaviors of the individual later in life (Hser, Longshore, & Anglin, 2007). It can be argued that when an individual has a family history of substance abuse, there is a likelihood of biological susceptibility to addiction. A few of the individuals in this study's sample suggested the possibility that they were born with the "disease of addiction," and that viewing their situation in that way has allowed them to understand and control their behavior better.

Regardless of the biological context of the individual, children who experience family substance abuse as a model for coping strategies is already more likely to abuse drugs than those who do not (Hawkins, Catalano, & Miller, 1992). As demonstrated in this study, familiarity with this coping method, combined with traumatic early-childhood experiences at the hands of a caregiver, increases the individual's susceptibility to substance dependence later in life (Hawkins, Catalano, & Miller, 1992; Hser, Longshore, & Anglin, 2007).

Those who lack healthy support and coping methods in the home typically need resources in their social environment. When one is instead met with bullying and/or perceptions of social rejection, this can exacerbate any feelings of loneliness and rejection felt at home. Participants in this study had the common characteristic of eventually assimilating into peer groups that introduced and encouraged drug use. The combined effect of finally finding the emotional support of a peer group as well as the introduction of a coping method with which the individual is familiar begins the descent into addiction (Dishion, McCord, & Poulin, 1999).

Another common element between interviews was the phenomenon of “liking it instantly,” during the initial use of heroin or their first experience with drugs in general. With a childhood and adolescence filled with rejection, stress, and trauma, these individuals had finally found something that instantly and consistently brought feelings of happiness and freedom from worry. Because of the immediate and euphoric high that heroin presented to the user, those who participated in this study who demonstrated common risk factors may have been more predisposed to developing a dependence upon their first uses (Hawkins, Catalano, & Miller, 1992; Hser, Longshore, & Anglin, 2007).

The nature of addiction is such that, at some point, depending on the drug, being “high” becomes a normal and comfortable state for the user. It requires increased doses to achieve any high feeling at all, and a base dose will simply allow them to achieve their new state of “normal.” Because of the extreme addictiveness of heroin, this phenomenon may become the case after just a handful of consistent uses. Once the user has reached that point, too much time spent without getting high introduces his or her first experiences with withdrawal. Withdrawal symptoms of heroin are so extreme that the user is forced to choose between enduring 3-7 days of nausea, muscle and bone aches, sweating, insomnia, etc., and simply getting another fix (National Drug Strategy, 2013). Once the user has a full-blown dependency, their goal becomes finding more heroin. For this study, the interpersonal consequences were that any family and friend relationships not related to drug use were no longer pursued. Marco’s previous comments about the nature of his relationships during addiction lend important insight into this phenomenon. For this study’s sample, any emotional energy invested in existing relationships tended to be volatile, while any new peer connections were mainly formed in the drug community, further reinforcing the lifestyle of the user. As their dependence progressed, the user became increasingly violent

and emotionally distant.

The consequence heroin dependency has on the community is impactful on a greater scale. Poverty, crime, arrests, and time spent in prison are all consequences that this study's sample experienced, and it is these elements that cause experts to estimate the economic cost of heroin addiction to be over \$21.9 billion annually (Mark, Woody, Juday, & Kleber, 2001).

Successful treatment leads to the required changes in the individual's lifestyle that improve his or her relationships with peers, family, and the community (Prochaska et al., 1994). Although the friendships he or she has at the beginning of treatment ultimately are abandoned, those are typically the friendships that developed within one's drug community, and were therefore deemed detrimental to one's treatment success and continued recovery. Instead, new friendships are formed in treatment and support groups like Alcoholics Anonymous with those who can relate to what the individual is going through and are themselves working on the same changes. For this sample, the ability to support one another in this endeavor and continue that support after treatment helps strengthen the friendship and reinforce sobriety.

Family relationships in this sample began with overall volatility, decreasing over time as the individual continues in his or her dependency, and improving upon treatment and recovery. However, the issues surrounding family relationships are not easily overcome, even with successful treatment and improvements in one's health and lifestyle afterward. Often, these relationships, especially those with parents, are what contribute to the development of one's addiction. Support groups like AA often require that individuals make amends with family members, which helped this sample create a new sense of civility in the parent-child relationship (Step 9, 2014).

Substance-dependent individuals who can find a way to contribute to their communities

upon completion of treatment, like those in this study's sample, are able to gain a different sense of meaning, purpose, and worth through these helping activities. Participants were all using their past to help those in the community struggling with drug addiction, there are various ways that one with a history of drug dependence and new life in recovery can contribute. It may also be significant in the continuation of one's sobriety. The disease of addiction is one that the individual must fight every day. As indicated in these participant's narratives, keeping up one's sense of self-worth and self-esteem through activities that give back to the community may be instrumental in continued recovery.

Future research should consider the need for prevention efforts during childhood and adolescence. This study presented various early risk factors for later-life development of substance dependence: parental substance abuse, physical, emotional, or sexual abuse, and isolation and/or rejection from peers. With school programs in place used to identify these factors in children, better support can be offered outside of the home. Future research should also consider comprehensive support for the family unit of children identified with these risk factors. It is likely that parents of these at-risk children have similar backgrounds of the participants presented in this study. If they are receptive to learning new coping techniques and seeking their own treatment for any substance abuse, a family treatment plan may be effective in improving the health of the entire family unit. Lastly, future research should examine the individual differences of those in treatment who successfully complete treatment and sustain recovery, and those who fail treatment, or complete treatment and soon relapse. It is important to better understand the characteristics and motivations that separate successful individuals in treatment and those who quit or relapse soon after.

A major limitation of this study was how the sample was drawn. These participants were

staff members at the treatment agency in question. It might have been more revealing to get a more diverse sample of participants—specifically some who are not currently employed at a recovery agency—in order to better understand community relationships after treatment. Another limitation was the inexperience in qualitative interviewing techniques of the main investigator, which mostly affected the first interview. The first interview was the shortest and contained the least amount of content for investigators to pull analytical data from.

The goal of this study was to understand heroin addiction by examining the personal narratives of those who had lived through it and are now well into their recovery. It is important to understand that, at least for this sample, the experience of significant trauma combined with substance abuse as a model for coping, was influential in the development of later-life addiction. The trajectories of their relationships with friends, family, and communities, were tied directly to their stage of addiction, meaning that the deeper they went into dependence, the more relationships suffered. Conversely, the longer they sustain recovery, the better their own well-being and relationships were. Social support and self-awareness were found to be the most influential factors in achieving treatment and maintaining recovery.



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**Appendix**

**Protocol**

**Interviewer** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Project Title:** Heroin Addiction: A Qualitative Analysis from the Life Course Perspective

**Principal Investigator:** Kayli Fisher, Psychology Division, Western Oregon University

**Faculty Advisor:** Dr. Margaret Manoogian, Psychology Division, Western Oregon University

I want to thank you for agreeing to be interviewed. I am interested in hearing about your experiences regarding your past addiction to heroin or other opiates. I want to remind you that this interview is voluntary. You do not have to answer every question and at any time, you may stop this interview. All information that you give us will be kept confidential. Let's begin. [Start tape recorder.]

**Part A: Demographic Questions**

1. When were you born? \_\_\_\_\_

2. Where were you born? \_\_\_\_\_

3. How long have you lived in this area? \_\_\_\_\_

4. How would you identify your race/ethnicity? \_\_\_\_\_

5. How many years did you go to school? \_\_\_\_\_

6. What is your current marital status? \_\_\_\_\_

7. If you are married, how long have you been married? \_\_\_\_\_ years.

8. Is this your first marriage? \_\_\_\_\_. If not, please describe your marital history.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Do you have any children? \_\_\_\_\_ If so, tell me about your children and their ages:

\_\_\_\_\_

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10. What is your current occupation? \_\_\_\_\_

11. What letter most closely represents your 2013 income?

- |                         |                          |
|-------------------------|--------------------------|
| A. Less than \$10,000   | E. \$40,000 to \$49,999  |
| B. \$10,000 to \$19,999 | F. \$50,000 to \$75,000  |
| C. \$20,000 to \$29,999 | G. \$75,000 to \$100,000 |
| D. \$30,000 to \$39,999 | H. Over \$100,000        |

### **Part B: Life Course and Addiction Questions**

I am now going to start asking you questions about your history and life before drug use. The first questions I am going to ask have to do with your childhood and your family of origin.

1. Please tell me about your family of origin
  - a. Who was in your immediate family growing up?
  - b. How was your relationship with your parents, siblings, etc.
  - c. How would you describe your relationships with extended family members? (i.e. grandparents)
2. When you think about your family experiences from your childhood, how would you characterize your family? [Probe: Function/dysfunction, substance and other abuse, parenting, marital, or parental relationship stability, etc.]

Outside of spending time with the family, children typically spend a lot of time at school. Naturally, our school experiences have a lot of influence over us as we develop.

1. How would you describe your school experiences for k-12?
  - a. How would you describe your performance in school during that time?
    2. Describe your peer group growing up.
3. How would you describe your neighborhood(s) when you were a child?

As you know, I am also interested in your experiences with drugs and alcohol leading up to your addiction and later recovery.

1. When were you first exposed to drugs or alcohol?
  - a. Can you describe that initial experience for me?
2. Could you tell me your story of addiction?
  - a. How did it start?
  - b. How long did it continue?

- c. How old were you during initial drug use?
  - d. Was there any experimentation with Rx opiates before you used heroin?
    - e. What strategies did you employ to obtain the drugs?
  - f. Did you have any interactions with the law because of your addiction?
    - g. How did addiction affect family/peer relationships?
    - h. How did it affect gaining/maintaining employment?
3. As you think back on your childhood, are there experiences that you feel contributed to your addiction? If so, please elaborate.
4. Please tell me the story of your recovery process
  - a. What sparked quitting and receiving treatment?
  - b. How did your family and peers respond to you seeking treatment?
    - c. What was it like physically, mentally, and emotionally?
    - d. How open to treatment were you initially?
  - e. How would you describe the effectiveness of your treatment at this time?
  - f. Where did you find the most support in your recovery? (i.e. friends, family)
5. In your opinion, what has been the most influential factor in your recovery process?
  6. How would you describe your relationship with your family now?
  7. How would you describe your peer relationships now?
8. Have you currently been able to obtain/maintain employment? If so, what are you currently doing? (if actively seeking/working)
  9. How do you foresee your future?
    - a. Employment
    - b. Peer relationships
    - c. Family relationships
10. Do you have any questions for me?

Thank you for your time in talking about these experiences with me. I understand that some of this material is very sensitive, and I appreciate your candor on this matter. I would like to assure you that all your information will be kept confidential. I hope to be concluding this project by this spring, when I will be presenting my findings to the Honors Program at my school. If it goes well, I hope to be looking into submitting it to the academic journal at my school. If you would like a copy of my project once it is complete, send me an email and I will be happy to send you a copy.