Narratives of Addiction[1]

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"The basic a truest meaning of the word *life* is not biological but biographical; and that is the meaning it has always had in the language of the people."

--José Ortega y Gasset

We are, undeniably, animals. And yet we are storied animals--embedded in and productive of history. Both in our individual and our collective lives we produce narrative patterns of meaning and in turn we live within those very narratives. It is possible and legitimate to consider a human problem such as addictions from either a biological or a biographical perspective. The objective of my presentation here is to illustrate how our understanding of common addictions can be illuminated from a narrative perspective.

Over the past 25 years, I have maintained a clinical practice with a primary concentration on individuals who were suffering various forms of addiction—mostly to alcohol and drugs such as cocaine and heroine, but also including tobacco, cannabis, gambling and sex. I have heard thousands of stories over the course of these years of clinical practice. At the same time, I have developed a theoretical approach with the objective of demonstrating how psychological understanding can be enhanced by employing the perspective of drama. (I consider drama to be an extension of narrative.)

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I will attempt here to relate some of the stories I have heard in these thousands of conversations in a way that illustrates central themes. In so doing, I hope to extend the argument about the utility of employing a dramaturgical approach to psychology.[2]

The biology-biography distinction to which Ortega referred is a genuine dichotomy. These are not the endpoints of a continuum, but rather are two disparate perspectives on human life—different angles of regard. When it comes to thinking of the common forms of human suffering, the biological perspective leads to the examination of chemical imbalances, the actions of neurotransmitters, anomalies in brain structure or function, genetic dispositions or allergic reactions to certain substances. A biographical perspective encourages us to examine relationships with others, successes and failures, aspirations and frustrations, opportunities and obligations, passions and antipathies, the mysteries of self-hood and the pathways taken in the development of identity. Sufferings that result from biological dysfunction are viewed as forms of disease or physical injury. Sufferings that result from troubled biographical progressions are seen as problems in living. Medicine is the discipline that is devoted to the relief of suffering through the application of medications, treatments, and curative programs. Psychiatry is as an extension of biological thinking about human suffering into the domains of biography. From this perspective, addictions are a form of illness requiring forms of medical treatment. Some psychologists, on the other hand, have regarded addictions not as illnesses but rather as problems in living that must be addressed by understanding how certain bad habits have come to have a part in a person's life. The elimination of bad

[2] See Scheibe, (1979, 1995, 2000)

habits does not require biological adjustments, but might be accomplished by education, maturation, or the development of a more satisfactory pattern of living.

The dichotomy I have sketched here has become the major point of contention for polemical debates—paralleling the more general debate about whether troubled mental states should properly be regarded as forms of illness.[3] Alcoholics Anonymous, in its origins and ideology, is thoroughly medicalized or biological in its perspective, even as it embraces as well the conception of a Higher Power as a way to achieve provisional redemption from permanent disease. People within AA are instructed to believe that they are alcoholics, and as such are powerless to control their disease. By attending meetings and by adhering to the progressive, twelve-step program, they might extend their sobriety and their recovery—though they are told never to expect complete recovery.

Critics of the ideology and functional effectiveness of Alcoholics Anonymous point out that many heavy consumers of alcohol quit their problem drinking spontaneously—either to become abstinent or to become light or moderate drinkers.[4] According to the doctrines of AA, this is not supposed to be possible. One means of dealing with this apparent contradiction has been the development of the concept of the "dry drunk"—that is, a person who truly no longer drinks alcohol, but who continues to manifest the underlying disease of alcoholism by engaging in other forms of obsessive, harmful and self-destructive patterns of behavior.

My own approach with respect to the ongoing dispute over biological and biographical conceptions of addiction has been thoroughly pragmatic. If a client of mine is an AA participant, I do nothing to challenge AA doctrinal positions, but do everything

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[3] See Sarbin (1967), Szasz (1961), Ellis (1967), Goffman (1961)
[4] See Sobell & Sobell (1993), Orford (1985), Peele (1985).

I can to help the person maintain their sobriety, including encouraging them to attend meetings. But if a client shows reluctance to join the AA program, I do nothing to urge them in that direction, but rather attempt to extend their sobriety through my own form of psychotherapy and counseling.

Early in my practice, I encountered a case that taught me the wisdom of this kind of pragmatic approach. I had a middle-aged, single woman as a client whose lifelong pattern of alcohol use had progressed to a troubling degree. She was reluctant to attend AA meetings because she did not like the quasi-religious tone of the few meetings she had attended. But at a medical consultation her doctor told here that she had a brain center that was uniquely responsive to alcohol, and that her particular configuration of brain structure was responsible for her addiction to alcohol. With this news, my client turned a decisive corner into sobriety. She told me, in effect, that she had come to think of herself as weak-willed and duplicitous and as a consequence felt guilty about her continued alcohol use. But with the announced discovery of her special brain center, she at one stroke lost all of her guilt and at same time gained the resolve she needed to refuse further exposure to alcohol. I did nothing at all to challenge the brain-center hypothesis, but rather supported her new and effective resolve to avoid alcohol. I followed her case for a year after she left therapy with me, and she reported continued full sobriety. I need here only add the observation that her discovery that a special brain center was responsible for her addiction changed the story of her self-understanding, and opened the way for a decisive and effective recovery from what appeared to be a long-term and stubborn alcohol dependency.

Much more recently, I encountered a case that illustrates in another way the futility of having fixed beliefs about the nature of addictions. In the course of taking a history for a 45-year-old female client who came to see me about current problems within her family, I discovered a pattern of reported poly-drug use in her early twenties. She was a regular cigarette smoker and a chronic marijuana user—3-4 occasions per week. She had tried cocaine on several occasions but discovered that she did not like it. She tried heroin—and found this much to her liking. She also drank wine, but avoided other alcoholic beverages. She continued to use heroin—on perhaps 30-40 occasions over the course of a year. But in the latter part of her period of heroin use, she began also to use LSD. She reports her LSD use as producing a transcendent experience—a true epiphany. She experienced a broadened and clarifying vision of herself and her place in the world. She immediately recognized that she could not continue to use heroin, for it was expensive, illegal, and potentially dangerous to her health. She recognized her habit of smoking cigarettes as repulsive. She came to see smoking pot as unnecessary and childish. She entered no course of therapy, no medical treatment, no twelve-step program. But she stopped all of her bad drug habits immediately, and soon thereafter felt no need for continued use of LSD. She never stopped drinking wine, and continues to drink it to a moderate degree to this day. I quote this case here to illustrate the point that it is well for the clinician to beware of fixed beliefs about the nature of addiction. According to the medical model of addiction, this sort of thing is not supposed to happen. She should have been physically addicted to heroin, and should have experienced physical withdrawal symptoms when she quit. Stopping cigarette smoking after ten years of daily use is supposed to be difficult as well. To be sure, we might want to resort to a

biological explanation of her preference for the sedative heroin (and of wine) over the stimulant cocaine. But the dramatic change in this case was attributed to short period of LSD use, which had the effect of bringing about a radical change in her understanding of herself and her place in the world. This might be counted as the unintended result of a biological agent, LSD, producing a profound change in her biographical progression. Needless to say, this is not a course of treatment to be recommended generally for heroin addicts.

I wish to cite now a less happy transformation in the story of an alcohol dependent man. Doug was a 45-year-old manager of a social services agency when he came to me for help with his alcohol dependency. He was a child of alcoholic parents and had an older brother as well who was an alcoholic. His own alcohol use was substantial throughout his college years. In his late 20's and early 30's his use increased progressively, even as his professional career blossomed. He became what is known as a 'high functioning alcoholic', of which the primary example is probably Winston Churchill. But his drinking did begin to interfere substantially with his professional work in his early 40's. He twice tried 28-day treatment programs to get his sobriety established. He came to see me as part of his aftercare plan on the completion of his second treatment program. For six months, I saw Doug with good results. His weekly sessions with me constituted his entire program—he had no taste for AA. During the course of his treatment with me, he more than once asserted that he predicted that if he ever should fall back into drinking alcohol, that he would certainly drink himself to death. I tried to counter this dire prediction by urging on him the "one-day-at-a-time" principle so strongly emphasized in AA. Alas, this proposition was put to the test. One week he

did not show up for his appointment. A call to his girlfriend revealed that he had begun to drink vodka, and would not stop. At my first opportunity, I went to their apartment, and there encountered him with a quart of vodka in one hand and a quart of Coca Cola in the other. He alternately swigged one and then the other. I managed to convince him to come with me immediately to an alcohol treatment center where I had an affiliation. He was reasonably docile and came with me. I had him admitted for detoxification. The next morning, I was informed that he had walked out of the place, AMA, and was missing. I never saw him again. About three weeks later, I received a telephone call from his lawyer, whom I had once met and who knew of his treatment with me. I was told that he had been found dead in a motel room in a nearby town. The room was strewn with vodka bottles. Doug's prediction about the consequences of his next relapse was entirely accurate. He was fatally trapped in his own story.

I wish to relate another story of the death of an alcoholic—this person not my client, but rather the husband of a client of mine—a kindly, middle-aged school teacher, who had struggled for 30 years with her husband's recurrent alcohol abuse. The husband ran a successful construction company so that the couple, without children, lived in comfortable circumstances. However, the husband had for the last 20 years had a cyclical pattern of excessive drinking, consisting of periods of sobriety lasting for a few months, followed by a progression to excessive drinking over several months. The husband in recent years had attended no fewer than 15 detox and rehabilitation programs,

including long-term programs run by the State of Connecticut for chronic alcoholics.[5] This made the life of the patient, adoring, and sober life of the wife a tortured nightmare. After tolerating years of this repeated cycle of drunkenness and sobriety, she finally, during a period of sobriety, gave him an ultimatum—to the effect the next period of drunkenness would result in a divorce. Sure enough, he soon was drunk again, and shortly into this period was served with papers and was asked to leave the house. The divorce was accomplished after the requisite time period. Shortly after the divorce was final, the schoolteacher arrived at home one afternoon to make a grim discovery. Her former husband had parked his pickup truck in their garage, closed the door, and sat in the cab of his truck, to be killed by carbon monoxide. He was dead when he was discovered. A brief note from the husband declared that he could not live without the marriage. But this series of events might also be read as a cruel visitation of revenge on the wife for having forced him out of his comfortable cycle of drunkenness and sobriety within his own home. Addictions are deadly serious, as I have too often discovered.

Just these few stories illustrate the variety of narrative forms taken by addiction to alcohol. Sometimes people recover, sometimes on their own, sometimes aided by a treatment program or participation in Alcoholics Anonymous. Sometimes people do not recover, but die early deaths. Observing cultural and national variability in chronic alcoholism reinforces the position that excessive drinking is strongly influenced by the cultural meanings attached to alcohol use. Few Jews are chronic alcoholics—for

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[5] Jefferson Singer (1997) has written a splendid description of the typical history of men who have received treatment in this facility. One must conclude, after reading these stories, that for some men at least being drunk is a state far preferable to being sober. For these men, enforced periods of sobriety must perforce be endured in order to have the pleasure of getting drunk again.

excessive drinking among Jews is seen as a sign of weakness—one risks being called a schlamozzel, a person with pathetic and weak character. On the other hand, Irish Catholics have a high incidence of chronic alcohol abuse. I once observed to an Irish Catholic client of mine that she seemed to drink when she was sad. "Yes," she said. "I drink when I am sad and I drink when I am happy. You see, I'm Irish." The incidence of chronic alcoholism is quite high in Russia, but lower in Mediterranean countries, and quite low in Arab nations and in the poorer nations of Asia. The curious history of Prohibition in the United States illustrates the radically different meanings that can be attached to alcohol use and abuse. Alcohol use was an accepted part of U.S. culture until the development of the Prohibition movement in the early 20th Century. The demonization of alcohol was strongly influenced by the anti-German sentiment around the time of World War I, and was encouraged as well by a growing feminist movement. The "noble experiment" to suppress alcohol use in the U.S. came to be regarded as a failure, and repeal was welcomed in 1933 to the general relief of all. However, it sometimes escapes notice that the moral force of the anti-alcohol movement did, in fact, reduce the level of alcohol consumption in the United States both during the time of Prohibition and for a long time thereafter.[6] To this day, the U.S. ranks in the middle of the distribution of nations in terms of the total per capita volume of alcohol consumed. In some sense, Prohibition did work to reduce the respectability of consuming alcohol.

One of the most successful antidrug campaigns in U.S. history has to do with tobacco use. The Surgeon General's report on cigarette smoking and health was issued in 1964. Over the past 52 years, per capita cigarette smoking in the U.S. has been

[6] See Okrent (2010) for a fascinating history of the rise and fall of Prohibition

drastically reduced--to approximately one-half of the 1964 level. Surveys of the means by which this reduction has been achieved suggest a large effect of education—discouraging many young people from ever starting to smoke. But among those who previously smoked, the majority of those who have quit have done so spontaneously—without a specific form of treatment or recovery program.[7]

From my own practice, I cite a few cases which illustrate the vagaries of smoking cessation attempts. One case is that of a surgeon in his 70's who was diagnosed with lung cancer and who had a major lobe of his cancerous lung surgically removed. As soon as this man was released from the hospital, he immediately began smoking again, though his smoking was surreptitious—concealed from his wife and family. Within two years after his lung surgery, he died of a heart attack. One might think of this as a case of slow suicide. At the very least, it illustrates the insufficiency of any rational calculus in bringing about smoking cessation.

Another case had a more positive outcome. I began work with a heroin addict in his early 30's. Despite one major relapse to heroin use, he became completely heroin abstinent and has been clean now for 10 years. However, despite repeated attempts to curb his cigarette smoking he continued to smoke until an incident that occurred four years ago. As a painting contractor, he had a severe fall at a construction site and suffered several broken bones in his legs and shoulder. As he was waiting for the ambulance to take him to the hospital, where he would remain for over a month, he asked for a cigarette from the attendant who was waiting with him. His request was refused.

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[7] See Wikipedia entry on "Smokng Cessation", wherein it is asserted that up to 75% of those who quit smoking do so cold turkey—that is, without a formal program, medication, or special cessation method such as hypnosis. This is consistent with other sources, such as Medline.

And so, he later testified, this must be the time for me to stop smoking. And stop he did. To this day, over four years later, he has not smoked a single cigarette—and is fully healed from his injuries.

I conclude with a third case of a person who devoutly wanted to quit smoking but was unable to do so. This man was a retired architect in his mid-seventies who had been smoking since age 15. He came to despise the habit—and tried on his own to quit. He came to see me to aid him in quitting, as well as to deal with other problems he was experiencing—depression and anxiety. After a few years of failed attempts to quit under my care, he asked if there were some recovery program to which he might be sent. I discovered an 8-day smoking cessation program at the Mayo Clinic—the cost of which was around $5000, plus air fare for travel to and from Minnesota. My client bought the program. He returned delighted with the result—and was completely tobacco free for six weeks—whereupon he borrowed a cigarette from a workman who was helping him with his boat. He quickly resumed his regular smoking pattern. But he was, to use the professional term, dissonant with his smoking behavior. So he went to Minnesota again, with the same cost of time and money. This time, his smoking abstinence lasted less than a week after his return home. Thus doubly discouraged, he never again tried to quit smoking. He died two years later of congestive heart failure.

I conclude with a final anecdote about a client who quit smoking, after a 40-year-period of light smoking, because an attractive woman he was dating told him it was an unattractive habit, and quite unnecessary. This decisive moment enabled the former smoker to quit for a period that now extends for over 10 years. He had attempted quitting

before, but somehow the disapproval of his temporary girlfriend provided the critical moment for changing his behavior.

In sum, I have observed that attempts to quit smoking are sometimes successful, sometimes not. It doesn't seem to depend on the strength of reasons to quit or the strength of desire to quit. Rather, it seems that the smoker will on occasion come to a point where the decision to quit smoking seems both easy and definitive. The Center for Disease Control asserts that the most effective program for quitting smoking consists of a 10-minute conversation with a physician about the need to quit.

Conclusions

I was told early on in my training as a psychologist to avoid counting anecdotes as scientific evidence, for the perfectly good reason that anecdotes are often falsifications—just stories. Also, the compilation of anecdotes or stories is often, as in the present case, adventitious or haphazard rather than systematic. Even so, with advancing maturity, I now question the universal correctness of the advice against collecting anecdotes. With respect to addictions, I am led to conclude—from the cases I have cited here—and countless others as well, that it makes no sense to think that here is some simple and sovereign explanation at the level of biology that will explain addictions and enable recovery from them. Rather, I am convinced that the set of bad habits that go under the name of addictions must be understood as part of a person's life story. In order to be of help to a person who is trying to gain relief from one or another of these bad habits, it is necessary first of all to listen sympathetically to that person's life story, and then to help construct a pathway out of addiction that is compatible with the assumptions and principles or organized understandings that are implicit in that story. One size will not fit

all. Let us not neglect what we know of the biological side of bad habits. But we must recognize that the path of recovery will entail a revision of biographical themes. The psychotherapist cannot control this kind of biographical reconstruction, but can certain help to move the story in the right direction.

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