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A Metaphor Analysis of Recovering Substance Abusers' Sensemaking of Medication-Assisted Treatment

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Abstract

In this study, we examined metaphors invoked by people recovering from opioid dependence as they described the challenges and successes of using medication-assisted treatment. Metaphors provide linguistic tools for expressing issues that are confusing, complex, hidden, and difficult to state analytically or literally. Using data from eight focus groups with 68 participants representing four ethnic minority groups, we conducted a grounded analysis to show how recovering substance users communicatively constructed addiction and recovery. The primary medication, methadone, was framed as "liquid handcuffs" that allowed those in recovery to quit "hustling," get "straight," and find "money in their pockets." Nonetheless, methadone also served as a "crutch," leaving them still feeling like "users" with "habits" who "came up dirty" to friends and family. In this analysis, we tease out implications of these metaphors, and how they shed light on sensemaking, agency, and related racial- and class-based structural challenges in substance abuse recovery.

Keywords

Approximately 22.1 million people—nearly 10% of the United States population—are addicted to drugs and/or alcohol (U.S. Department of Health and Human Services, 2010). Substance dependence is often framed as an individual problem or moral failing. Yet, the societal costs of substance abuse disorders are vast, exceeding $510 billion annually, including significant burdens to health care and justice systems (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011a). In fact, substance abuse is associated with considerable public health and safety issues, including the transmission of infectious diseases, traffic accidents, and crime (Kimberly & McLellan, 2006).

Addressing substance abuse requires focusing on a number of issues, including moral stigma about addiction in general (Room, 2005), the co-occurrence of substance abuse and criminality (Roman, Townsend, & Bhati, 2003), and risk factors that perpetuate drug use such as poverty, socioeconomics, and lack of education (SAMHSA, 2011b). Contributing to this complexity is the fact that, although promising pharmacological and behavioral therapies exist, the uptake and efficacy of those treatments remain low (Kimberly & McLellan, 2006), often resulting in relapse or recidivism (Hartwell, 1998). Furthermore, many who need treatment might not have access to it, especially those in socioeconomically disadvantaged populations and those living in rural communities. Examining the storied experience of substance abuse treatments can provide insight into the problems and possibilities of addressing addiction.

Medication-assisted treatment (MAT) for opioid (e.g., heroin) dependence offers an interesting context to study these issues. MAT involves the use of pharmacotherapies (medication) in combination with social support/counseling, behavioral therapies, and other services including primary medical care. With significant financial and research support from the federal government, MAT is recognized as an evidence-based practice in the health care community (Kresina, Litwin, Marion, Lubran, & Clark, 2009). MAT medications include methadone and buprenorphine, which licensed physicians prescribe and administer for acute or long-term treatment. When taken properly, these medications can improve the health and safety of those in treatment (Kimberly & McLellan, 2006). However, in the United States, MAT is only

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accessible to a fraction of those who would benefit from it (SAMHSA, 2011a).

To explore the experience of MAT and better understand challenges associated with maintaining a sustainable recovery, we conducted eight focus groups at outpatient treatment clinics across the country. Through a grounded discourse analysis of the data, we found that metaphors spontaneously invoked by participants richly illustrated their addiction challenges. Based on participants' descriptions of experiences with MAT in general and methadone specifically, in this article we trace through the journey of substance abuse, showing turning points in substance dependence and recovery. Moreover, we demonstrate how participants made sense of treatment and how their communicative framing had important consequences for recovery. To provide a platform for the analysis, we first review research related to methadone as MAT and metaphor analysis.

Background

Despite advances in new pharmacotherapies, methadone remains the predominant medication for treating opioid addiction. A synthetic opiate, methadone alleviates cravings for other opiates such as heroin or morphine, blocking the narcotic effects and "highs" associated with illicit usage (SAMHSA, 2011a). In circulation for more than four decades, methadone use and resulting research about its efficacy is prolific (Matto, 2004). That being said, we have few qualitative stories from patients who have used methadone, and even fewer from people of color (Ehrmin, 2002).

The literature about methadone reflects a treatment that offers significant risks and rewards embedded within societal narratives that malign illicit drug use, especially among people of low socioeconomic class (Valentine & Fraser, 2008). People using methadone describe social stigma, negative physical side effects, fears of "double" addiction (e.g., being addicted to heroin and methadone at the same time), as well as limitations on personal freedom (Gourlay, Ricciardelli, & Ridge, 2005; Peterson et al, 2010). The process of receiving methadone is restrictive, often requiring clients to travel to health care providers daily to receive medication in the form of a liquid or wafer. Only after patients reach specific benchmarks, namely sustained abstinence from illicit drugs and compliance with program rules, can they earn "take homes," or small stocks of medication that require fewer clinic visits.

Recognizing the physical motivations of substance abuse and treatment—specifically, seeking pleasure and avoiding pain—is pivotal to understanding the experience of substance-abuse treatment. Provocative research illuminates aspects of pleasure associated with substance use (Duff, 2008; Moore, 2008; Valentine & Fraser, 2008), suggesting that its hedonistic effects are a fundamental reason that abuse exists across all social classes, not just those of privilege. The gratification of an illicit high is juxtaposed with the terrible pain of withdrawal. For instance, a primary motivation for pursuing substance-abuse treatment (or engaging in opiate use during treatment interruptions) is avoiding withdrawal and associated illness at all costs (Hughes, 2007).

The concept of recovery from substance dependence is relatively new in the treatment of addiction, contrasting with the traditional "once an addict, always an addict" cliché. Fundamentally, recovery involves a process of identity reconstruction (Hughes, 2007); people reconstruct self-identity as they move from being substance-dependent to being substance-free. Moreover, methadone users who develop "nonaddict" or "functional" self-concepts respond to treatment better and depict having superior instrumental and relational resources compared to those who maintain "conflicted" identities related to addiction and treatment (Gourlay et al, 2005). Likewise, substance-dependent people who make "cultural transformations" from "addiction culture" to "recovery culture"—and shift associated behaviors, rituals, symbols, and language—might be able to better maintain sobriety (Matto, 2004, p. 10). As such, improved understanding about the cultural and identity implications of substance dependence and recovery is paramount for effective treatment.

Recently, scholars have investigated the social, embodied, and complicated experience of substance dependence and methadone treatment. For example, researchers have examined the gendered nature of methadone clinics that cater predominantly to male clients (Fraser, 1997), temporality in substance-abuse treatment (Klingemann, 2000), clients' ambivalent attitudes toward MAT (Fischer, Chin, Kuo, Kirst, & Vlahov, 2002), and spirituality in treatment (Wiklund, 2008). Some of this research implicitly suggests relational aspects of substance dependence; for example, by showing how rituals surrounding drug use are distinctively social, although physical compulsions are individual (Hughes, 2007).

We extend this inquiry by explicitly examining participants' talk about substance-abuse recovery. Specifically, we narrate the lifecycle of substance dependence and treatment, highlighting important transitions via metaphors invoked by MAT participants. Examining metaphors—words that compare one thing to another (Lakoff & Johnson, 1980)—provides insight into the ways people conceive and make sense of experience. Indeed, metaphors serve as linguistic steering devices, indicating where speakers' attention is directed and how individuals frame situations at hand (Kirby & Harter, 2003).

Metaphors also allow people to "express aspects both of themselves and of situations about which they might

not be consciously aware, nor be able to express analytically and/or literally" (Marshak, 1996, p. 156). Metaphors compactly convey the inexpressible: topics that are largely unacknowledged or unstudied, or are too emotionally shattering to articulate. Indeed, when people are in the midst of trauma—disease, death, divorce, abuse— metaphors offer a valuable route for understanding how people experience plights. Metaphor analysis has been successfully used to understand and offer solutions for such experiences as workplace bullying (Tracy, Lutgen-Sandvik, & Alberts, 2006), alcoholism (Shinebourne & Smith, 2009), and depression (Schoeneman, Schoeneman, & Stallings, 2004).

Methods

We generated data for this study from a large collaborative research project among federally funded[1] Addiction Technology Transfer Centers, which are regional educational and informational clearinghouses charged with improving the uptake of evidence-based interventions to treat substance-use disorders. The project was designed to understand cultural experiences of MAT across four racial/ethnic groups so as to develop public health campaign material and increase MAT usage. Data emerged from eight qualitative focus groups conducted at outpatient treatment facilities in six major metropolitan communities across the United States (Chicago, Honolulu, Los Angeles, New York, Oklahoma City, and Seattle) with participants of African American, Asian American/ Pacific Islander, Hispanic/Latino, and Native American descent. We chose outpatient treatment facilities that offered MAT and served one or more of the racial/ethnic groups of interest, from which we could recruit 10 to 12 people per focus group.

Participants

After receiving institutional review board approval from all affiliated academic institutions, representatives of local substance-abuse treatment centers recruited participants in person or via recruitment flyers. Criteria for participation included being a self-identified member of the respective racial/ethnic group who used MAT consistently for at least 4 months. We spoke with 68 people, ages 22 to 82 years, with the majority in their 40s and 50s. Education levels spanned from "some high school" to one person who had earned an associate degree; most were unemployed. Focus groups ranged in size from 5 to 13 people. Participants chose pseudonyms and received information emphasizing the confidential and voluntary nature of the study. As thanks for their involvement, participants received refreshments during meetings and $20 gift cards to local retailers or restaurants.

Data Collection Procedures

Focus groups were well suited to the goals of this study because they generate a "therapeutic effect" (Lederman, 2004) or "group effect" (Carey, 1994) that results in support and synergy among those sharing difficult or painful experiences. Furthermore, participants build off of each other's ideas. The talk demonstrates "a kind of 'chaining' or 'cascading' effect in which each person's turn of the conversation links to, or tumbles out of, the topics and expressions that came before it" (Lindlof & Taylor, 2010, p. 183). Also, by bringing together people with shared experiences or from similar communities, focus groups are particularly useful for understanding culturally specific language and vernacular (Tracy, 2013).

The focus groups were conducted by facilitators of the same ethnicity as the participants. In one instance, a White facilitator led the meeting, assisted by a cultural "ambassador" who helped liaise between the facilitator and group members. The first author attended every focus group, taking fieldnotes, beginning in-situ analysis, and performing administrative functions such as recording meetings and distributing gift cards.

Most focus groups took place at various outpatient clinics in client "group" rooms, staff conference rooms, or in one instance, the clinic's boardroom; one meeting took place in a university conference room. We used an interview guide[2] to frame the discussion, including questions such as the following: What is the best and worst thing about taking MAT? Who do you turn to for support in managing your health and recovery from substance abuse? What do your friends and family say about using medication to manage substance abuse? For the first question, we invited people to write down or draw their best and worst MAT experiences, and to elaborate on these verbally. Focus groups lasted approximately 90 minutes each, with one 10-minute break not included in the analysis. Digital audio recordings were professionally transcribed, resulting in 112 pages of single-spaced typewritten data; transcribed fieldnotes and preanalytic memos of the focus groups resulted in an additional 70 pages of data.

Data Analysis

We used a multistep, iterative coding process featuring elements of the constant comparative method (Glaser & Strauss, 1967) whereby we moved between our data and existing literature to examine emergent themes and existing salient issues about substance abuse, recovery, and MAT (Miles & Huberman, 1994). Data analysis therefore alternated between emergent grounded themes and our original research goals of understanding the lived experience of MAT and factors that contribute to substance-abuse recovery.

To begin, the first author read through all of the data twice, integrating her fieldnotes with the focus group transcripts, and uploaded the data into NVivo qualitative data analysis software (Bazeley, 2007). Using NVivo, the first author noted emergent concepts in each line of text, asking the general question, "What is going on here?" (Cresswell, 2007, p. 153). Codes included "motivation to use MAT," "benefits of MAT," "MAT as constraint," "negative judgments," and "fear of withdrawal from MAT."

A team of three researchers, including the first and second authors and a trained research assistant, coded the same subsection of data. The research team then met to compare coding, work out discrepancies, and further refine the codebook. We repeated this process until we came to consensus on the meaning and application of codes (Pope & Mays, 1995), and then split the data to code independently. We took an "examined stance" to data analysis practices (Charmaz, 2006, p. 69). In doing so, we ensured that codes reflected incidents as described by participants, that codes connected directly to the data, and that data were coded reliably and consistently.

Throughout coding and analysis, we found that participants often relied on metaphorical language to explain their recovery and associated challenges. Metaphors compare one thing to another, and in doing so, provide vibrant illustrations of how speakers interpret their experiences (Lakoff & Johnson, 1980). As noted by Tracy (2013, p. 212), "We use metaphors regularly, usually without even thinking about it. In consequence, they are abundant in almost all types of textual data like interviews, documents, and fieldnotes."

We combed the data a final time, specifically searching for metaphors used by participants to describe experiences with substance abuse and treatment. Then we analyzed the talk using a version of action-implicative discourse analysis (Tracy, 1995). This approach integrates information from field data to inform the particulars of talk:

> Action-implicative discourse analysis is not primarily making claims about what actually happened—what the speakers in particular instances intended and what recipients inferred. Instead, it seeks to describe meanings of conversational actions that are plausible given the situation type of interest. (Tracy, 1995, pp. 202-203)

Using action-implicative discourse analysis, along with grounded identification of metaphors, our aim was to reconstruct and explicate the ways that participants made sense of recovery.

In crafting our analysis, we focused on spoken excerpts that included "live metaphors," which are those that require "both a context and a certain creativity to interpret

adequately" (Fraser, 1993, p. 330). Certainly, "dead" metaphors also emerged in our data—things like "getting high." This metaphor for using drugs is spoken so often that it goes virtually unnoticed. It has a conventional meaning that can be understood without knowing its metaphorical connotation (e.g., that drugs are associated with an airy, lightheaded feeling). We focused on live metaphors within our larger coding framework because they are more associated with visualization, cognitive work, and creativity, and therefore are more revealing in terms of meaning. Interpreting the metaphor of MAT as a "crutch," for example, requires the listener to creatively ask questions such as: What is a crutch? When is a crutch used? What are the connotations of those using a crutch? What does a crutch symbolize in terms of power or self-efficacy? Ideographic live-metaphor interpretation (Grant & Oswick, 1996), coupled with action-implicative discourse analysis (Tracy, 1995), served as the basis for explaining the experiential challenges of substance-dependence treatment discussed below.

Results

In this analysis, we explore the rich metaphors participants used to narrate their individual journey from the throes of drug use to treatment to managing recovery and envisioning sobriety. Participants' language offers insight into the experience of substance abuse and recovery. Furthermore, it points to implications for addiction treatment at individual and organizational levels.

Metaphors of Drug and Street Culture

The initial goal of the research project was to illuminate cultural differences related to health care and substance-abuse treatment across four ethnic groups. Surprisingly, the participants spoke less about the salience of their cultural heritage or ethnicity and more about the culture of the street and its related activities of "scoring," "chasing," and "hustling" for drugs. We found that street culture resonated as a key part of participants' drug use despite racial, regional, and demographic differences.

Participants shared painful memories but also vivid nostalgia of drug use and associated culture. Diana, a 50-year-old Latina from the Bronx, admitted, "I like the hit and I like the high," even as she described losing her apartment, children, and livelihood as a result of her addiction. Galvan, a 49-year old Latina from East Los Angeles, spoke of "smoking rock, slamming rock" and chasing down a "fix," whereas Junior, a 28-year-old Latino also from Los Angeles (LA), mentioned "the ritual"—his process of procuring and consuming heroin. Danny, an African American man from LA, introduced himself as an ex-drug user who spent time in and out of

prison. Danny said he "shot dope like it was going out of style." When one participant invoked the reverie of drug use, others listened with affinity—nodding in agreement, smiling, or clapping. Clearly, drugs and street culture, full of exciting hits, highs, slams, and fixes, were not perceived as all bad.

Many participants described the sibling, cousin, friend, spouse, or parent who initially got them involved with drugs. Marita, a 23-year-old Pacific Islander, shared that she "grew up" in and out of methadone clinics because her mother was a heroin addict who eventually "got clean" in jail. For some, like Miguel, a 30-year-old Puerto Rican from the Bronx who was introduced to drugs by his cousin at age 14, "meeting" heroin was like love at first sight. Smiling, he said, "I tried it two or three times, and I did it, and had a whole bag, and that was a wrap." The colloquial use of "that's a wrap" signifies the close of filming a movie (or a scene in a movie), whereas Miguel used the phrase to imply that heroin ended other relationships. He described trying heroin as "the beginning of a beautiful friendship." By invoking the "wrapping" line of the classic film *Casablanca*—"Louis, I think this is the beginning of a beautiful friendship" (Curtiz, 1943)—Miguel linked drug abuse with classic glamour and performance. However, like *Casablanca's* Nick, Miguel was a man caught between love—in this case, heroin, and virtue—in this case, sobriety. Like *Casablanca's* Nick, Miguel framed his choice as difficult, ambiguous, and with no clear winners or losers.

Relationships with heroin and other drugs led most of the participants to commit crime. Smitty, an African American man in his 50s from Chicago, described the "hustle" necessary to get heroin: "I used to go out there and struggle with people." When questioned, he admitted this meant stealing to support his habit of drug use. Dee, a 54-year-old African American man from Chicago—the only participant with an associate degree—described himself as a "monster" on drugs. He said craving drugs makes people "do things that you don't want to do." When pressed, Dee explained: "Whatever it may take. That means everything . . . steal from your family, rob a person, sell yourself for prostitution."

As Dee recounted this monster-like behavior, others in the group nodded in agreement, including Bobby, an African American man in his 50s. Echoing the sentiment, Bobby said, "My addiction was not just getting high but the event of going and getting high. That was like the most exciting thing about my usage. It was going to get it [heroin], sticking somebody up [robbing someone], pickpocketing." Participants spoke nonchalantly about their criminal pasts, couching theft, prostitution, and drug trafficking in vague terms. Indeed, the metaphor of *monster* suggests that participants viewed their drug-using selves as largely external—separate and often uncontrollable—something that "came out" but was not an essential part of them.

Participants' terminology also conveyed a sense of frantic movement in street culture activity: searching, partying, shooting (injecting), and hustling to obtain drugs. Vicky, a Hawaiian woman in her 40s, said that, thanks to treatment, "I'm not running around to get drugs. I'm doing other things in my life which are positive." Although participants universally admitted enjoying drugs and getting high, most expressed extreme regret about the repercussions of their choices and actions. In fact, participants described a complex range of emotions when discussing drug use and subsequent treatment. As described in what follows, in addition to pride and relief, the emotions of sorrow, chagrin, shame, and defiance marked participants' comments about their decisions to enter treatment and the motivation to continue toward sobriety.

Metaphors of Transition and Motivation

Decisions to stop using drugs and seek treatment for substance dependence ranged from highly agentic personal choices, to court mandates, to "miracles" seemingly outside of participants' control. Rita, an African American woman in her early 40s, said she entered treatment after she got "tired of chasing them blows," referring to acts of prostitution to earn money to buy drugs. Miguel confided that appearance was a motivator. He admitted,

> I didn't like the way I was looking. . . . You cannot look nice and do drugs. . . . My family started looking at me different, they started pushing me aside. And I just woke up and got myself into methadone.

These comments framed treatment as personal choice and evidence of self-efficacy, meaning that participants felt in control and able to act in the interest of their own recovery.

In fact, several participants described recovery as a completely individual choice. Miguel said, "You have to fight for it. You can't, pardon the expression, you just can't sit on your ass. You have to go there and try and get it." Similarly, Diana relayed,

> There is help out there. It depends on you. You have to go get it. It's not going to go to your house. The same way you go get the drugs is the same way you go get the help.

Individual self-efficacy is an important part of achieving goals such as recovery from substance dependence (Bandura, 2001). However, focusing too much on individualism belies the complexity of treatment and the necessity for those pursuing sobriety to work cooperatively with

others. For instance, maintaining social support and accessing critical resources requires successful interaction with peers and important gatekeepers. Additionally, such a perspective perpetuates the notion that, like substance dependence, treatment can/should be an individual enterprise.

Many participants did eventually cite important others who prompted them to get into treatment. Teena, a 33-year-old woman of Native American descent, said, "I was getting worn out and going to the hospital. I have a disabled child. I needed to get clean. I had to for him and myself." Rhonda, a 42-year-old African American woman, also discussed pursuing sobriety for the sake of her child. Rhonda became dependent on oxycodone pills after having surgery. "My doctor was my drug dealer," she said. When Rhonda could not fill enough legitimate prescriptions to support her 25- to 30-pill-per-day habit, she turned to "dope" in the form of illegal opiates: "I felt like that was the bottom line. My counselor said, 'That was like the Titanic. Everybody on the boat drowned and you want to drown, too.'"

The Titanic metaphor suggests that progressing to illicit drugs is like knowingly boarding a ship that will inevitably sink and, in essence, choosing one's own death sentence. Furthermore, Rhonda shared that hiding her addiction was like being "in the closet" with her family: "I was an actress. I had a lot of roles to play," she said meekly, before describing how she wanted to overcome her addiction to be a better mother to her 18-year-old daughter. Metaphors of being in the closet (hiding behaviors) evoke feelings of inauthenticity and shame as drug users negotiate their recovery and roles with significant others.

Finally, a few participants described the decision to begin treatment as being wholly external to themselves. For example, Jay Jona, a 45-year-old African American man on his fifth treatment episode, felt forced to enter treatment because of court order. For others, like Craig, a 23-year-old man of Native American descent, dramatic circumstances and hitting "rock bottom" spurred treatment. Craig said, "The drugs slowly cover you up as a person. . . . It is like you are laying down in sand and eventually you are covered up." Craig equated his addiction to quicksand that nearly suffocated him; he conceptualized methadone, however, as a savior that allowed his loved ones to "get bits and pieces of me back."

With a similar tale of gratitude and salvation, Mikala, a 47-year-old native Hawaiian, attributed her decision to enter treatment to an "angel" at the clinic. When Mikala was originally turned away because of procedural requirements, the "angel"—the clinic director—intervened: "All of a sudden an angel appeared. 'I can help you,' the angel said. . . . I said, 'Thank you, Lord.' That was the first lady that gave me hope." By envisaging this gatekeeper as a heavenly being, someone magical and other-worldly,

Mikala likened the treatment process to submitting to the whims of providence. Although this metaphor provides comfort and hope, it also locates agency outside of the individual needing treatment. Furthermore, it makes the process of recovery seem capricious and unplanned. By focusing on the "angel" rather than her own persistence and choice, Mikala discounted her decision to take action and seek treatment in the first place, as well as the work it took to find community resources.

Once on the path to recovery, participants explained their motivations to continue treatment. Big Moe, an African American man from Los Angeles, described the best part of being in recovery as "keeping money in your pocket" and not feeling compelled to spend cash on heroin and other opiates. Moe explained, "It feels good to pay the rent every month. It feels good to know that if you pass a store and say, 'I like those shoes' . . . I know that I have money in my pocket [to buy them]." Catalina, a 50-year-old woman from Hawaii, similarly suggested that MAT treatment allowed her to "have my family back and money in my pocket that does not go to drugs." After confiding that her whole paycheck previously went to street drugs, she said proudly that "[now] I can even hold a dollar for a month."

Remarkably, the metaphor of "money in my pocket" was spontaneously articulated in all eight focus groups by multiple participants to describe why methadone was preferable to using illegal and expensive drugs like heroin. Although in many ways "money in my pocket" is a quite literal benefit of MAT, it also served as shorthand to a broader theme in our data of "the good life." Participants described components of the good life—housing, hygiene, freedom, transportation, family, relationships— as motivators for staying in recovery that outweighed the difficulties of taking MAT. Because MAT relieved people of the compulsion to pay for drugs, they had money available for these and other goods and services that most people take for granted. The "money in my pocket" refrain served to helpfully remind participants of MAT benefits.

Metaphors of Recovery and MAT

Although riddled with side effects such as constipation, weight gain, sweating, and insomnia, participants described living on MAT as relief and respite compared to active drug use. Bobby said, "You get a chance to stand still instead of moving all the time." Several participants noted the opportunities and chances that MAT afforded them compared to using heroin. Monica, a Native American woman in her 30s, said, "It saved my life. I know that if it wasn't for this medication, I would probably not be here." Similarly, Danny said, "It helped me get back on my feet." Trimble, an African American woman

from LA, described the sense of safety that methadone provided: "The good things are that I am calmer and it's kind of like a security blanket." Participants viewed MAT as lifesaving and providing a continuing safety net.

Despite feeling grateful for the medication, participants also seemed ambivalent about their dependence on it. Contrasting with the lively process of "chasing blows" and "scoring drugs," when discussing recovery, participants' language shifted dramatically from depicting agency to demonstrating dependence. Whereas "using" invoked fast-paced living through active language—choosing, acting, and seeking—"recovery" was couched in passive terms of constraint and powerlessness.

Participants portrayed treatment as "getting clean," "going straight," and "being detoxed" (detoxified) by parties and systems external to themselves. This passive verb tense demonstrates an absence of self-efficacy. Instead, such language locates power in the hands of treatment providers and systems outside of people in treatment. Rita described MAT matter-of-factly as happening to her instead of by her: "I've just been cleaned. . . . I don't use no more. I don't smoke crack and I don't use heroin anymore." Proud of her progress, Rita described wanting to get off of methadone, too, but feeling uncertain: "I'm trying to get detoxed off this methadone, too. I don't think I'm ready yet." Many participants articulated wanting to be independent of MAT, including Courtney, a Native American woman in her 20s: "The worst is that I hate having to depend on something every day. The best for me is that the program helps you wean off drugs until you are ready to get off." Unlike most participants, Courtney described actively "dosing down" on methadone and envisioned a life free from all substances; yet, she still invoked the imagery of a helpless newborn "weaning" from its mother when conceptualizing methadone.

Participants also struggled with negative judgments and stigma about methadone and substance dependence from others. Peggy, a Latina from LA, poignantly described the prejudice of her brother-in-law and how it impacted her recovery: "He feels that once you are on that stuff [methadone], you can never get off of it and you are always going to be trash." As a result of these negative judgments, the brother-in-law prevented Peggy from seeing her sister, whom Peggy relied on as a primary source of familial support.

Negativity toward MAT stemmed from viewpoints that framed substance dependence as a moral failing and MAT as a "crutch" or shortcut—something that crippled or injured people had to lean on when they could be independently strengthening themselves. Describing significant others in her Latino community, Pat said, "They just want you to do it [recovery] cold turkey," meaning to quit abruptly rather than transitioning gradually. Houston, a homeless African American woman in her 20s, described a family member's negative assessment of methadone: "He was like, 'Why can't you quit that [methadone], too?' He said he knows it helps, but it's just another drug. 'When you stop using everything and anything, then you can say you are clean.'" In the same focus group, Trimble relayed a troubling exchange with a judge:

> He said, "You are substituting with methadone?" I said, "Yes." He said, "You are still using. It is nothing but a substitute for Vicodin." He said, "You are still using opiates, so you are still using." Right there, the judge was mean. He said, "Methadone is a drug and you are not doing anything but substituting it for another drug. In my eyes, you are still using until you are totally off." I felt like shit when he said that. I said that if it wasn't for methadone, I would still be on Vicodin today, taking thirty, forty, fifty [pills] a day. Methadone saved my damn life.

As recounted by participants, negative stigma about methadone and MAT can impact how former drug users are viewed in court, interact with physicians to receive health care, and maintain support systems with family and friends. Participants struggled significantly with whether MAT should be considered a "medication" or "drug." They vacillated between perspectives of defensiveness—MAT is a "savior" and "life saver"—and distancing—MAT is stigmatized, a "crutch," something from which to "dose down." Feelings of ambivalence also permeated participants' talk about the future.

Metaphors of Maintaining Recovery

Although phases of addiction, transition to treatment, and recovery were clearly defined in participants' talk, visions of the future and what happens "after" MAT seemed amorphous. Clear, however, was the drive to avoid being "dope sick" (going through opiate withdrawals) and "slipping" back into addiction. Fear suffused participants' views of the future—fear of withdrawal, pain, and falling backward. Pedro spoke of "being detoxed" and the potential repercussions for recovery. In this context, being detoxed is the uninvited, mentally excruciating, and physically painful process of suddenly losing access to MAT—something that can happen if the person is thrown in jail or no longer can pay (or have insurance/government benefits that pay) for MAT. Pedro said, "If they detox you, you've got a problem, then you start getting high again." Joseph concurred: "If you lose your Medicaid card, they are going to detox you so fast that you gonna spin right out the door and start using drugs."

The idea of losing access to treatment sparked considerable anxiety. Discussing the prospect of state budget cuts that would affect MAT access, Lamont said,

This [forced MAT detoxification] could happen, and the fear, like you said, the fear of the unknown. I'm sure that I have enough armor to carry me if that does happen. I have support groups, I have a support network that I'm pretty sure would hold me if something like that happens. . . . It is a scary thought for me. It is real scary.

Lamont's notion of "armor" positions sobriety maintenance as a "battle" with unknown powerful adversaries. In recovery, when vulnerability might allow for helpful change, Lamont's conceptualization of MAT suggests he must keep himself guarded. Indeed, Lamont spoke of tools in his arsenal—support groups, social support—as ways to manage anxiety and survive the potential "war" on resources.

In response to fear, participants shared the "defenses" they employed to stay sober, including attending support group meetings and counseling sessions, talking with friends, going to church, and physically separating themselves from drugs. Afraid of relapse, Galvan said, "I get on the bus and I go straight home and work and I stay inside. You know what I mean? I haven't been back to prison in going on six years." Cynthia also related the importance of avoiding bad influences:

> I stay home all the time and I read. When it is seven o'clock—you can ask my niece—I am already in bed and locked my doors. When I do something it is during the day. I get it done and I go home.

Staying cloistered to avoid trouble and continue recovery contrasted starkly with the active and animated descriptions of using drugs and of former street life. The sacrifice, according to most participants, seemed worth the cost.

Fear of losing access to methadone contrasted with the perception that methadone was a long-term commitment. Cliff said, reluctantly, "It's on my menu now. Seven days a week. I don't like that." Pat described being "bound" to the clinic to get her medication and how that daily obligation impacted her schedule: "I'm not exactly free. I still have to plan around the hours of the clinic and it is not as easy to get 'take homes' here. You really, really have to earn [them]." Bobby resented the long-term daily commitment to MAT but admitted needing its structure to prevent "filling that void" in his life with heroin. Mikala offered a vivid metaphor of being "bound" to methadone:

> It is liquid handcuffs. Why? If you came along and said, "Mikala, we have opportunity for you to go to China and we have airfare, $5,000, and you get to go there and paid on top of it. You'll come back rich. . . . You are scheduled to get on the flight in two days, pack your things." I tell you, I cannot go. "What, are you crazy? What's going on?" I can't go because I will get sick without methadone. . . . I would have

to turn you down because it would take a lot of paperwork for them to set up the amount of methadone needed in China. . . . That is what I mean about "liquid handcuffs." I cannot do anything.

As illustrated in this poignant example, despite feeling grateful, participants discussed methadone with wistfulness, wishing they did not "have" to take medicine daily. Not only is methadone riddled with physical side effects, it constrains. When likened to handcuffs, methadone connotes the image of a prisoner, someone fettered to a punishment, unable to move freely. Referring to "liquid" handcuffs, Mikala suggested that MAT is fluid, portable, and enables positive outcomes; however, it only looks like freedom when, in fact, it feels like wearing shackles.

In total, participants used surprisingly little positive language about recovery and the future. Instead, they focused on the basics: staying "still," and not "slipping." This language suggests that they viewed recovery as largely related to deficiency and absence. Furthermore, it implies that participants viewed "getting clean" as not only omitting drugs, but removing excitement, thrill, and nighttime adventure from their lives. Only Lamont discussed MAT as a medication, without attaching stigma to it:

> I'm in recovery and I am clean. I see it as I have a disease of addiction. It is the same as me having high blood pressure. It [methadone] is prescribed to me from a doctor. The thing is that when I got on the program my usage was just a symptom of what was wrong with me.

A few people talked about going to college or getting a job. Most, however, seemed resigned to daily clinic visits, living on government aid, and achieving rudimentary aspects of "the good life," which included fulfilling basic needs such as food, shelter, and safety. All told, the image of recovery seemed bleak, lonely, difficult, and boring, which likely contributed to high rates of relapse and difficulty in maintaining sobriety. Changing how recovery is envisioned might have considerable implications for those in recovery.

Discussion & Implications

By identifying and conducting a close discourse analysis of the metaphors used by people recovering from substance-use disorders, we have constructed a picture of the turning points in substance dependence, treatment, and recovery. Through such investigation, we are not only able to portray rich and vivid experiences that complement existing literature, but also point out several important implications for treatment providers, clinicians, and those in recovery. Our interpretations prompt consideration of

how people managing substance-use disorders conceive of and demonstrate agency at various points in treatment, how goals are set in recovery, and the importance of creating narratives of success, healing, and hope.

Agency

Agency refers to the ability to act and influence the conditions of one's life (Bandura, 2001). Agency is directly connected to the motivation and ability to achieve goals, and can be observed in the language that people use every day (Ahearn, 2001). Ironically, focus group participants used the most active and agentic language when discussing the process of procuring and using drugs. Participants vividly discussed "hustling," "scoring," and "shooting" when in the throes of substance abuse. Fewer framed themselves as agents or used active language when discussing the process of entering treatment. Once in treatment, the power and control in participants' language again "shifted down" to be passive, and reflect an absence of agency.

During "using" phases, participants spoke of "taking" and "choosing." In recovery, by contrast, people depicted being acted on, saved by an "angel," "cleaned," "detoxed," and ensnared by "liquid handcuffs." This language implies that recovery is largely about relinquishing control and individual decision-making power. We suggest that this apparent lack of agency in language points to the critical importance of promoting self-efficacy—the perception that one is capable of acting and attaining a goal (Bandura, 1991)—particularly if that goal is successful sobriety and recovery. "Unless people believe they can produce desired results and forestall detrimental ones by their actions, they have little incentive to act or to persevere in the face of difficulties" (Bandura, 2001, p. 10).

Helping to foster agency within a context of significant financial and structural constraint is important, especially for people with minimal education and few socioeconomic means, like the participants in this study. This might mean helping people take ownership of recovery by developing active language even as they engage in "proxy agency" (Bandura, 2001, p. 13), or the process of enlisting others to help achieve goals in circumstances in which they have no access, ability, or expertise to achieve the goals directly. For example, clients might have to rely on the expertise of counselors and physicians to achieve and maintain recovery, but they can conceive of those relationships more equitably. Crafting active, affirmative language around proxy agency can help clients make sense of recovery in positive and motivating ways.

In recent years, evidence-supported treatments for substance-use disorders have included a focus on fostering agency. These treatments recognize the role of client motivation and treat it as a malleable characteristic.

Treatment strategies include specialized styles of counseling, including motivational interviewing, which emphasizes collaborative goal setting between clinicians and clients, and developing clients' intrinsic motivation to change (Miller & Rollnick, 2002). Additionally, the use of extrinsic rewards to incentivize client participation in treatment and reward treatment goal attainment has proven a successful recovery strategy primarily when clients are able to internalize and take ownership for the treatment process (Kellogg, Stitzer, Petry, & Kreek, 2007). These approaches to treatment specifically focus on agentic language and the promotion of self-efficacy.

Goal Setting

In the focus groups, participants described recovery as a monolithic, challenging, and almost unattainable goal. Although some invoked the 12-step mantra of "one day at a time," most talked about recovery as colossal and amorphous, and simultaneously as a process, a state of being, and a destination. Perhaps more significantly, participants framed their recovery in avoidance language (staying away from drugs, walking away from temptation, hiding from trouble) as opposed to engagement language (e.g., finding a job, maintaining a healthy lifestyle).

Research on goal setting indicates that goals are easier to attain when they are constructed in affirmative approach language (Lyubomirsky, 2010) and are broken up into small, measurable pieces (Locke & Latham, 2002; Weick, 1984). For instance, rather than setting an avoidance goal such as, "I will maintain my recovery by not taking drugs and staying away from my former drug partners for the rest of my life," an affirmative, approach-oriented goal would be, "I will maintain my recovery today by going for a walk and telephoning a supportive friend." Not surprisingly, evidence-supported approaches to treating substance-use disorders include treatment planning that emphasizes skill and behavior development (as opposed to behavioral suppression); "chaining" and "shaping" of client behavior by breaking treatment goals into smaller, more attainable objectives; and the use of extrinsic rewards to reinforce treatment progress (Higgins, Silverman, & Heil, 2008).

Likewise, recasting recovery into smaller, finite steps is crucial. For instance, instead of "I will take medication and attend support groups to maintain my recovery," a more specific and measurable goal would be, "I will take X milligrams of medication each day this week with the hope of decreasing it by X percent next week. Furthermore, I will attend three meetings per week to maintain my recovery." Breaking recovery into identifiable steps or phases can also help reduce anxiety, a significant theme in our data. Recovery as a monumental and vague concept might be intimidating, particularly

when thinking about maintaining the effort over a lifetime. In contrast, smaller goals such as attending support group meetings or taking medication every day are easier to deal with, especially when they are missed. For example, if clients miss a meeting or a dose, they can view that as stumbling on a specific element of the recovery process rather than failing at recovery overall. Likewise, framing sobriety in daily terms ("one day at a time") vs. a lifetime commitment can increase motivation and achievement (Bandura, 2001).

Conclusion

In drab outpatient treatment facilities across the country—places surrounded by barbed-wire fences, industrial complexes, and warehouses—we spoke with people recovering from drug dependence about their experiences using MAT. In doing so, we explored the journey of substance-dependence recovery among participants using methadone, beginning with their drug use, transitioning to treatment, using MAT, and maintaining recovery.

Participants' metaphorical language reflected the negative stigma attached to drug use, judgments that MAT is a crutch for the weak, and the bleak absence of hope or models of success. In the focus groups, the most colorful and "fun" talk was generated around stories of taking drugs. Although the participants wearily discussed the devastating consequences of addiction, they reminisced about using drugs with nostalgia and, in some cases, wistfulness. In contrast, participants related the lonely, boring, difficult, and tedious experiences of recovery. Largely missing from the data were stories of hope and success, and the message that individuals can still be good, powerful, and successful while in recovery. Metaphors not only exemplify the communicative representation of experience but fundamentally serve as shorthand to cognition. As such, our discourse analysis of metaphors is valuable for gaining understanding of the implicit and often unarticulated challenges associated with substance-abuse recovery.

Among other difficulties, participants' talk essentially maintained the notion that substance dependence is a moral failing and that users should suffer consequences in line with their actions (Matto, 2004). Crucially, negative viewpoints of methadone and substance dependence resonate throughout society and impact how people with substance-use disorders conceive of themselves and their recovery, as well as access to resources and treatment. This is unfortunate. Drug use is not just an individual moral failing; rather, it is tied to social issues such as intergenerational drug use (Gourlay et al., 2005); death of loved ones; rape; and child, sexual, and physical abuse (Ehrmin, 2002). A growing body of qualitative research transcends biopsychosocial and disease models of addiction. Instead, it illuminates a holistic perspective of substance abuse and treatment that incorporates identity, relationships, temporality, culture, gender, and pleasure (Duff, 2008; Fraser, 1997; Hughes, 2007; Klingemann, 2000). To understand addiction and creatively consider a range of treatment options, we must take seriously the social and communicative ways individuals narrate their recovery journey.

We live our life by the stories available to us (Goodall, 2000; Lakoff & Johnson, 1980). In the case of people recovering from substance dependence, if there are no stories or plot lines of success or hope, and no positive paths to follow or even dream of, the process of recovery then becomes that much more difficult, and frankly, undesirable. Constructing better narratives can help clients in recovery as their identities transition between "addiction culture" and "recovery culture" (Matto, 2004, p. 10).

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Notes

1. This project was supported in part by cooperative agreement #5UD1TI013592-10 from the Substance Abuse & Mental Health Services Administration. The opinions expressed herein are the views of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or Center for Substance Abuse Treatment. No official support or endorsement of DHHS, SAMHSA, or CSAT for the opinions described in this document is intended or should be inferred.

2. The interview guide is available on request from the corresponding author.

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