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The Consciousness of Addiction: Toward a General Theory of Compulsive Consumption

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This article reviews and integrates recent theories of addiction drawn from a diverse set of disciplines—consumer behavior, medicine, sociology, psychiatry, and psychology—to provide a comprehensive framework for understanding the etiology of addiction and other compulsive consumer behaviors. Interpretive material from personal interviews with addicted and nonaddicted drug users is then used to illustrate the consciousness of addictive consumption. Two a priori themes—serial/simultaneous addictions and personal crises/role transitions—and five emergent themes—relapse, deception, dysfunctional families, suicide, and boundaries—are discussed.

> When I was using drugs they were the focal point of my whole life. They were all I thought about. Every two hours I would think, 'How can I do my drugs?' . . . They were what I allocated my time to *first,* my money to *first.* [JULIE, 23, recovering addict]

Since the mid-1980s consumer researchers have explored several manifestations of compulsive and impulsive consumption. In perhaps the earliest effort of this type, Rook and Hoch (1985) identified five characteristics differentiating impulsive from nonimpulsive buying patterns: (1) a sudden, spontaneous desire to act that departs from prior behavior patterns, (2) psychological disequilibrium that causes the consumer to feel temporarily out of control, (3) psychological conflict between obtaining current gratification and resisting giving in to what are perceived as irrational or wrong urges, (4) a lowering of utility-maximizing criteria for product evaluation, and (5) a disregard for negative consequences that may be associated with the consumption act. Rook and Hoch (1985) further noted that impulsive consumers often sought to enact special rules or behavioral devices to help them control their behavior. In a subsequent article, Rook (1987) linked impulse buying to other "impulse control disorders . . . [such as] chemical substance abuse, binge-purge eating behavior, spending sprees and sexual compulsiveness" (p. 195).

A related line of inquiry was initiated by Faber and O'Guinn. In an article on compulsive consumption (Faber, O'Guinn, and Krych 1987), these authors associated this phenomenon with others characterized by compulsive behavior, including addiction: "The behaviors of the compulsive consumer seem fairly similar to the common manifestations of addictive behavior" (p. 132). They identified several characteristics that appeared common across addictive and compulsive phenomena: (1) the presence of a *drive, impulse,* or *urge* to engage in the behavior, (2) *denial* of the harmful consequences of engaging in the behavior, and (3) repeated *failure* in attempts to control or modify the behavior.

Most recently these authors presented a detailed theoretical framework accompanied by supporting data from phenomenological interviews and surveys conducted with compulsive buyers (O'Guinn and Faber 1989). They argued that compulsive buying is conceptually connected to the larger category of compulsive consumer behaviors that include, for example, alcoholism, drug abuse, eating disorders, and compulsive gambling. They found strong support for this proposition and also that compulsive buyers were characterized by lower self-esteem, higher scores on general measures of compulsivity, and a higher propensity for fantasy than the general population.

In the most recent contribution to this research stream, Hoch and Loewenstein (1991) presented a detailed discussion of compulsive and impulsive forms of consumer behavior. Their conceptualization focused on the interplay of willpower, desire for gratification, and self-control in regulating consumption. As with the

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other research discussed, they drew parallels between their model of "time-inconsistent preferences" and other manifestations of compulsive and impulsive consumer behavior such as cigarette smoking, alcoholism, impulse buying, and overeating.

My present purpose is to bring together these related conceptualizations and focus them on interpreting an as-yet-unexplored aspect of compulsive consumer behavior—the phenomenon of drug addiction. Drug addiction differs from the consumption phenomena studied thus far in several respects; for example, it is more socially stigmatized and viewed as deviant than impulse purchasing or credit-card abuse, and it involves physical dependency and withdrawal processes. However, it will be argued that drug addiction bears much in common with other forms of compulsive consumption in both its etiology and consciousness. Unlike impulse buying and compulsive purchasing, the investigation of which was originated by consumer-behavior researchers, drug addiction has spawned a long history of theorization and research in fields such as psychology, sociology, and medicine, and it is to a brief review of these literatures that we now turn.

ADDICTION METAPHORS AND MODELS

The metaphors with which a society conceptualizes phenomena inevitably influence the social responses to them. During the eighteenth and nineteenth centuries, drug use (e.g., opiates, cocaine, cannabis) was not widely viewed as a social problem (Berridge and Edwards 1981), while alcohol consumption was seen as a sign of moral turpitude (Musto 1973). However, during the early part of the twentieth century, narcotics and alcohol both came to be seen as sinful and morally debasing. Society demanded protection from "dope fiends" and drunkards; this culminated in the Harrison Act of 1914 and Prohibition in 1920 (Walker 1981).

Disease Theories. However, by the 1930s a revisionist view was gaining strength that envisioned alcohol and narcotics users as victims of a disease (Isbell 1958). Addiction became incorporated within a larger societal shift that secularized and medicalized what had been previously regarded as moral or spiritual problems (Szasz 1961). Drug addicts and alcoholics were now seen as powerless over their actions and in need of treatment rather than ostracism (Peele 1985). The disease model is now the dominant metaphor used to conceptualize both drug addiction and alcoholism in American treatment programs, as well as in recovery groups such as Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) (Mendelson and Mello 1986). Within this model, the focus of research attention is on the development of physical dependence (Tabakoff and Rothstein 1983), the identification of genetic predispositions (see, e.g., Crabbe, McSwigan, and Belknap 1985; Petrakis 1985), and the assumption that the disease is progressive, that is, will worsen if left untreated.

Among the most heavily investigated aspects of the disease model is the presence of genetic abnormalities or tendencies that predispose some persons to be susceptible to the effects of alcohol and/or certain narcotics (Davison and Neale 1986). For example, Goodwin et al. (1973) examined alcoholism in adopted children and found a higher rate of this behavior in male children whose natural parents were alcoholic. In a later study, Bohman, Sigvardsson, and Cloninger (1981) found adopted daughters were also susceptible to alcoholism, if their biological mother was alcoholic. Thus, there is evidence that a predisposition toward alcoholism can be inherited.

Social Theories. Several socially based theories have also been put forward to account for drug addiction and alcoholism. Sociocultural theory proposes that ethnic groups such as Jews, Italian-Americans, and Chinese-Americans, who specify appropriate ceremonial, nutritional, or festive uses of alcohol but who negatively sanction overindulgence and drunkenness, have lower rates of alcoholism. Conversely, other nationality groups such as Irish-Americans and English-Americans appear to more positively sanction alcohol consumption as a social activity and sign of manhood and also experience higher rates of alcoholism (Davison and Neale 1986).

Somewhat related to these perspectives are the social learning proposals of Becker (1969, 1953) that state that novice drug users must learn from their more experienced peers how to detect and respond to the pharmacological properties of marijuana, LSD, and opiates. Similarly, Ray (1961) views the relapse of recovering drug addicts as attributable to their social uncomfortableness with nonaddicts. In this social labeling view, addicts have come to label themselves *as* addicts (and have been so labeled by society); thus their recovery from addiction is stymied by their continuing identification with the addict subculture.

Personality Theories. Another significant area for addiction theorization lies in the area of personality. For example, in drug addiction, as well as in many other forms of compulsive behavior, there has been found a strong tendency for persons to exhibit anxiety, depression, and low self-esteem as adolescents (Mendelson and Mello 1986). In other studies using the Minnesota Multiphase Personality Inventory (MMPI), persons who later became alcoholics were found to be more nonconformist, independent, undercontrolled, and impulsive than their peers (Mendelson and Mello 1986). These "prealcoholics" "tend to do things on the spur of the moment and are frustrated when they cannot immediately get what they want. Upon making mistakes, they are often unable to change their behavior to avoid repeating the mistake" (p. 61).

Mendelson and Mello (1986) further note that prealcoholics and alcoholics have trouble establishing and maintaining emotional intimacy with others and often feel alone and isolated. They note that these same traits are characteristic of persons addicted to narcotics, amphetamines, barbiturates, and LSD, as well as of people who are heavy marijuana smokers, gamblers, and those with eating disorders.

Other personality scales also have shown correlations with compulsive behaviors, including drug addiction and alcoholism. Among these is the Machiavellian Scale; persons who score highly are "bold and aggressive reward seekers . . . [who] seek out and enjoy the pleasures of life. They thrive on excitement" (Mendelson and Mello 1986). Closely related to this is the Sensation Seeking Scale (Zuckerman 1979), which measures tendencies to seek excitement and novel sources of stimulation. Persons who score highly prefer unusual, stimulating experiences and are easily bored with routine. High scores on the Sensation Seeking Scale are associated with heavy and multiple drug use and also with cigarette smoking, a preference for spicy foods, and social drinking. Mendelson and Mello (1986) also report on several studies that indicate that alcoholics and drug addicts have an external locus of control: "they are easily influenced by environmental factors and do not perceive that they are capable of controlling their drug use. These feelings of helplessness spill over into all aspects of their experience, leaving abusers feeling buffeted by events and emotions that they are powerless to change or even manage" (p. 68).

Personality Subtypes. Integrating the findings from these diverse studies has led researchers to the identification of two personality subtypes among alcoholics and drug addicts. The *distressed* subtype uses drugs and alcohol as a form of self-medication to help cope with feelings of depression, anxiety, and dysphoria. In contrast, members of the *sociopathic* subtype incorporate drugs and alcohol into a generalized impulsive search for immediate gratification (Mendelson and Mello 1986).

Recent clinical evidence (Leon 1984) suggests that both these patterns may be present for persons suffering from eating disorders, as well. For example, bulimics often exhibit significant anxiety, depression, and feelings of alienation from other persons. These feelings are commonly superimposed on a more general pattern of impulsive behavior, followed by feelings of guilt and anxiety. As with addicts and alcoholics who exhibit the distressed subtype, bulimic binge episodes are usually preceded by feelings of worthlessness and lack of control. Bulimia is often associated with past or current excessive alcohol or drug use and with family histories of substance abuse (Leon et al. 1984). Anorexia, another compulsive eating disorder, is also characterized by feelings of anxiety and being out of control. Anorectics attempt to attain mastery over themselves and their environment by controlling their body weight. Clinically, anorectics "tend to be conscientious, overachieving, obsessive-compulsive, perfectionistic, and shy" (Leon 1984, p. 189).

These clinical findings may be meaningfully interpreted in light of the impulsive and compulsive consumption studies conducted by Rook and Hoch (1985) and Faber et al. (1987). One case of compulsive consumption reported by Rook and Hoch (1985) was similar to the phenomenology of bulimia: "I passed by a case containing brownies. I am depressed to begin with, so I bought four and ate them right there. I was glad I did it—it made me feel better" (p. 25). This consumer's impulse to consume was driven by dysphoria; however, unlike a "true" bulimic, the consumer felt more positive about herself afterward, instead of suffering guilt and anxiety over her momentary loss of control. It is likely that this individual still maintains a sufficient set of internal controls to prevent her impulsivity from deteriorating into self-destructiveness. As Rook and Hoch (1985, p. 24) note, "Most people develop an elaborate repertoire of devices to control their impulses," for example, by establishing rules about food consumption or credit-card use. However, in their sample of "normal" consumers, Rook and Hoch (1985) also encountered instances of uncontrollable impulses, which closely resembled the phenomenological state of drug addicts: consumers described these as "a hunger," "seems almost physical," "a tingling" (p. 27), which suggests that some members of their sample may be at risk to move into compulsive consumption.

Faber et al.'s (1987) investigation of compulsive buying drew its sample from consumers self-identified as out-of-control spenders. These people usually purchased in response to impulses but had lost the ability to establish and maintain rules to constrain their buying. As a result, their behavior often led to negative consequences such as hiding of their purchases, bankruptcy, and even criminal behavior, such as theft and embezzlement. Further, many of these compulsive buyers were found to experience negative emotional states both before and after their buying sprees, making them largely analogous experientially to distressed-subtype alcoholics, drug addicts, and bulimics. A group of these consumers also displayed sociopathic-subtype compulsivity. Some, for example, reported speeding their cars and parachute jumping, suggesting the sensation-seeking aspect of sociopathic impulsivity (Mendelson and Mello 1986; Zuckerman 1979). Compulsive buyers were also found to engage in denial patterns, which are common among drug addicts and alcoholics. Further, one of the major self-help groups to which these consumers turned was Debtors Anonymous, a 12-step group modeled after A.A.[1]

[1]Alcoholics Anonymous was founded by recovering alcoholics in 1935. Since that time over 10 national organizations for compulsive-

In Rook's (1987) study of impulsive consumption, he reports that 31 percent of his sample felt compelled to purchase something once they experienced the buying impulse: "It becomes almost an obsession. I start looking for ways to get it. Somehow I feel I can't wait," reported one 19-year-old man. A 68-year-old man said, "For me it was a total mind-filling experience. I could only think of one thing," and a 55-year-old woman reported, "Once I see it in my mind, it won't go away until I buy it" (p. 193). As Rook noted, for persons such as these, the experience was one of "feeling compelled, obsessed, and desperate" and "being out of control" (p. 194).

These experiential descriptions can be instructively compared to those of Julie, 23, the recovering drug addict cited at the outset of this article: "When I was using drugs they were the focal point of my whole life. They were all I thought about." As we shall explore in greater detail below, there is much in common between drug addiction and other extreme forms of compulsive consumption. As Mendelson and Mello (1986, p. 29) state: "When drug use or any other compulsive behavior becomes the center of one's existence . . . , we can then say that such a person is to all intents and purposes *addicted*" (my italics).

COMPULSIVE CONSUMER BEHAVIORS

We are now equipped to establish a connection across a broad range of consumption behaviors that have in common a compulsive quality. Behaviors such as these go beyond the bounds of normalcy and also exceed the consumer's ability to control them through reason and willpower. These behaviors—unless restrained by the consumer or some external intervention—will lead to negative consequences, perhaps even death. In this sense, addictive behaviors are analogous to extreme compulsive behaviors.

For example, O'Guinn and Faber (1989, p. 147) define compulsive consumption as "a response to an uncontrollable drive or desire to obtain, use, or experience a feeling, substance, or activity that leads an individual to repetitively engage in a behavior that will ultimately cause harm to the individual and/or others." As examples they cite alcoholism, drug abuse, eating disorders, compulsive gambling, compulsive buying, compulsive sexuality, kleptomania, compulsive working, and compulsive exercising. In harmony with this, Mendelson and Mello (1986, p. 21) define addictive behavior as "behavior [that] is excessive, compulsive, beyond the control of the person who engages in it, and destructive psychologically or physically." As examples, they cite drug abuse, alcoholism, anorexia, bulimia, excessive gambling, exercising, and television watching.

Compulsive consumer behaviors, such as drug addiction, bulimia, and compulsive buying, are extreme forms of normal consumer activities. Consumers must eat and make purchases. Further, many experiment with drugs and alcohol and engage in exercise. Some even occasionally gamble, act promiscuously, or have a set of television programs they watch regularly. The vast majority of consumers do these things and do not become addicted to them. But some do. What goes wrong?

As already discussed, there are genetic, social, and personality theories concerning the etiology of addiction, all of which contribute valuable insights to our understanding of this phenomenon. These theories are not mutually exclusive and each has empirical evidence to support it. It is highly likely, therefore, that there are genetic, social, and personality aspects that contribute to addiction.[2] Yet by themselves they do not tell us why some consumers who are in high-risk groups become addicts while others do not. For example, a consumer may have inherited genetic tendencies to have dramatic responses to alcohol or narcotics, belong to an ethnic subculture in which alcohol and/or drugs are widely consumed, and have some personality traits (e.g., sensation seeking) that are associated with addiction yet still not become addicted to drugs or other forms of compulsive consumption (see, e.g., Peele 1985).

Other consumers may have some or all of this same set of characteristics and become drug addicts, alcoholics, or bulimics. Why? The answer, we propose, lies in another area of theorization regarding addictive-compulsive behavior—that of learning theory.

THE ROLE OF SELF-ESTEEM, SELF-CONTROL, DESIRE, AND WILLPOWER

Hoch and Loewenstein (1991) present a detailed account of the interplay among self-control, desire, and willpower in regulating consumers' behavior. They orient their discussion toward explaining the etiology of compulsive preferences, such as impulse buying. Their argument is constructed from learning-theory views of addiction, which propose that compulsive behaviors are "learned responses that are acquired and maintained because they reduce distress" (Davison and Neale 1986, p. 258). This approach is appropriate for understanding both the distressed and sociopathic subtypes of addic-

addictive consumer behaviors have been modeled after it. Among these are Narcotics Anonymous, Cocaine Anonymous, Debtors Anonymous, Gamblers Anonymous, Smokers Anonymous, and Overeaters Anonymous.

[2]One reviewer objected to the intermingling of information collected from positivist/empiricist studies with that obtained from phenomenological inquiry. While the reviewer's stress on methodological "purity" can be appreciated, it would seem overly restrictive and myopic to narrow the knowledge base of *any* inquiry only to information generated by the same mode as the inquiry itself. Cannot interpretivists and positivists/empiricists fruitfully learn from each other?

tive-compulsive behaviors. Let us consider first the distressed subtype.

Distressed Compulsive Consumers

Consumers who exhibit the distressed subtype of addictive-compulsive behavior are plagued by feelings of self-doubt, incompetence, and personal inadequacy (Brister and Brister 1987). Despite external signals to the contrary (e.g., praise, promotions), they suffer from performance anxiety, depression, isolation, and feelings that their inadequacies will inevitably be discovered (Brister and Brister 1987; Johnson 1980). Feeling unable to manage their emotions through internal means, they turn to an external substance or behavior to (1) help them escape their anxiety and (2) make them feel more in control of themselves. This external "prop" may be shopping, undereating, overeating, exercising, or sexual, as well as chemical, in nature. If the substance or behavior succeeds in reducing their anxiety and enhancing their sense of self-control, it is positively reinforcing and the consumer learns to turn to it in times of distress.

It is significant to note that even seemingly innocuous products can serve the functions of alleviating anxiety and enhancing perceived self-control. For example, Julie, the recovering addict mentioned earlier, began her pattern of drug abuse by compulsively taking Bufferin when she was 10 years old. She reported "carrying my Bufferin bottle to school every day just in case there was a test." She later moved on to more potent substances as they became available and ultimately placed herself in a drug treatment program after her concurrent use of marijuana, alcohol, and valium had become "completely unmanageable."

Consumers with this addictive-compulsive personality subtype typically originate in dysfunctional families (see Leon 1984). Such families are characterized by patterns of alcohol/drug abuse, physical violence, and/or emotional conflict (e.g., divorce, separation). Children growing up in these environments commonly feel anxious, emotionally detached, and unable to deal with feelings of anger and fear (Leon 1984). These children are at risk for compulsive consumption, if they later discover some substance or activity that alleviates their dysphoric feelings. In addition, for children growing up in families in which substance dependence (e.g., alcoholism, heavy cigarette smoking) or some other compulsive behavior is present, social modeling may suggest to them that such behaviors are appropriate responses to feelings of depression or alienation. In the phenomenological data collected from drug addicts for the present study, dysfunctional family structure was found to play a major role in the etiology of later drug dependence.

In the Hoch and Loewenstein (1991) framework, addictive behavior is depicted to occur as a conflict between willpower and desire. Within the present framework, desire is not conceived as the seeking of hedonic pleasure but rather the reduction of dysphoria or emotional distress. Thus, from the consumer's perspective it is important to realize that engaging in the addictive-compulsive activity may be viewed as a rational act. In essence, the consumer is engaging in what is phenomenologically experienced as an effective treatment (i.e., medicine) for unhappiness. Child-actress Drew Barrymore, for example, was hospitalized for alcohol, cocaine, and marijuana dependencies at age 12. As she describes her drug use, "Instead of dealing with whatever pain or troubles you have, you medicate them. The problems are still there, you just don't feel them until the drug or alcohol wears off. Then you medicate again. . . . When I felt [emotional] pain, I medicated it" (Barrymore 1990, p. 124).

As Hoch and Loewenstein (1991) note, typically the compulsive consumer will attempt to establish boundaries around the use of this self-medication. And these rules may work for an extended period of time (or even indefinitely [Peele 1985]). However, two processes may cause these boundaries to be exceeded and the self-medication to become uncontrollable. First, the consumer's emotional state may worsen as a result of events *not* connected to his/her compulsive behavior (e.g., a death in the family). This may cause the compulsive consumer to turn to his/her "medicine" more and more frequently, until an out-of-control (i.e., boundaryless) level is reached.

A more common process, however, is that the compulsive consumption activity itself leads to emotional distress, resulting in heavier and heavier self-medication until an unbounded level of use is reached. For example, drinking, gambling, overeating, or drug use in response to emotional upset can lead to poor work performance and familial conflict, both of which contribute to heightened anxiety and depression (Brister and Brister 1987). Caught in a vicious cycle, the compulsive consumer continues to self-medicate until s/he is institutionalized, seeks rehabilitation, or dies (*Narcotics Anonymous Handbook* 1988). This pattern will be illustrated through personal interview data gathered from drug addicts.

Sociopathic Compulsive Consumers

The second type of compulsive consumer—sociopathic—adheres more closely to the model presented by Hoch and Loewenstein (1991). These compulsive consumers are characterized by strong impulsive drives that are experienced as irresistible (Mendelson and Mello 1986). They are likely to be above average in sensation-seeking tendencies (Zuckerman 1979) and to exhibit a relatively low level of remorse and guilt over their actions (Mendelson and Mello 1986). Sociopathic compulsive consumers are likely to seek out stimulating activities and/or substances in their search for immediate sensory gratification. Upon discovering something that provides the sought-after pleasure, they may be

more sensitive to being deprived of it than other consumers. Their impulsivity, therefore, will lead to a compulsive pattern of gratification seeking that is not easily terminated because of their lower level of secondary-process thinking (i.e., rationality).

Both the sociopathic and the depressed subtypes of compulsive consumers are vulnerable to the effects of acclimatization to the external (e.g., narcotics) or internal (e.g., natural endorphins) chemicals that their addictions provide (Brister and Brister 1987). The dysphoria of the depressed compulsive consumer is intensified by withdrawal, and the sensory pleasure of the sociopathic compulsive consumer is reduced by withdrawal. Hence, increasing amounts of the activity or substance are required to produce the same effect (Brister and Brister 1987).

This theoretical framework, however, can take us only so far in understanding compulsive consumer behavior. To understand addiction from the consumers' point of view, we must enter the world in which they dwell. To this end, I will now present an account of addiction. As will be detailed in the Method section, phenomenological aspects are reported both from the researcher's vantage point as a recovering addict and from my communications and friendship with addicts (both active and recovering) over a three-year period. The account developed puts forward a rarely glimpsed view of the life-world of addiction, as lived by those who have been or are still dwelling there. In this account, I attempt to show how the consciousness of addiction is linked to other compulsive forms of consumer behavior, and I describe the meaning structures that characterize the thought-worlds of addicted consumers.

METHOD

Phenomenological inquiry is intended to represent the lived experience of consumers. Unlike some qualitative methods that assume the existence of an objective reality independent of the consumer (see, e.g., Miles and Huberman 1984), phenomenology brackets the external world to include only those aspects that are present in the consumer's consciousness (Eagleton 1983; Husserl 1960). In applying this method, the researcher seeks to obtain testimony (McCracken 1988) from consumers that is structured from their own worldviews and represents, in as complete and comprehensive a manner as possible, their experiences and beliefs regarding the consumption phenomenon of interest (see, e.g., Bergadaà 1990; Thompson, Locander, and Pollio 1989, 1990).

The present research included personal interviews conducted with 35 consumers who labeled themselves as drug addicts and/or alcoholics and six consumers who did not label themselves as drug addicts or alcoholics but who had used drugs and/or alcohol frequently over an extended period of time. In addition to these formal interviews, the researcher participated in informal interactions (in the form of group discussions) with consumers labeling themselves as drug addicts and/or alcoholics, which included altogether approximately 70 people. This informant base is large by phenomenological inquiry standards (e.g., Bergadaà 1990; McCracken 1988; Schouten 1991; Thompson et al. 1990) and was selected to provide a breadth of personal experience across age, race, gender, and socioeconomic status. It was reasoned that the common themes that emerged from such a diverse set of interviews would be more representative of the lived experiences of addicts generally than those emanating from a more restricted set of informants.

The emergent themes were further developed against the template of the researcher's personal experiences. As McCracken (1988, p. 12) observes, "It is by drawing on their understanding of how they themselves see and experience the world that [researchers] can supplement and interpret the data they generate" in phenomenological interviews. This was especially apt in the present instance, because the researcher is a recovering addict (see Hirschman 1990, 1991). Thus, I am able to provide direct experiential testimony regarding the consciousness of addiction (see, e.g., Holbrook 1988).

Informants

In seeking informants for the study, I developed four initial avenues of contact: a state-supported in-patient and out-patient clinic for young addicts, a private rehabilitation facility for persons suffering not only from addiction but also from mental disorders, and two chapters of Narcotics Anonymous. I observed and talked with patients (termed "clients") at both the clinic and the institution over a five-month period beginning in November 1989 and continuing through March 1990. I attended group discussion sessions and talked extensively with counselors and administrators. I identified myself as a recovering addict as well as a researcher investigating addictive and compulsive forms of consumption.

In March 1990 I joined two chapters of Narcotics Anonymous as a member and active participant. One chapter meets weekly in the basement of a church in a college town. On average 20–25 people attend the meeting, about 12 of whom are regular attendees. The age range is from 17 to 55; the mean age is around 28. About 10–15 percent of the attendees are minority group members; two-thirds are male. The socioeconomic status of the attendees ranges from skilled labor to professional. The second chapter meets weekly in a multiuse facility at a shopping center. The building houses several other 12-Step groups as well: Alcoholics Anonymous, Smokers Anonymous, Al-Anon, and Alateen. The site is near a large, industrial city with a large minority population. The attendees are predominantly male, about one-third are minority group members, and the majority are blue-collar or professional class. The

age range for this meeting is usually from 18 to 50; the majority are in their late twenties to early forties.

Data Gathering and Confidentiality

As a participant-observer at both the clinic and rehabilitation institution, as well as at Narcotics Anonymous meetings, I had access to addicted consumers in both the recovery and active stages of their addictions. Obviously, there is an extraordinary responsibility placed on the researcher under these conditions to maintain complete confidentiality of the informants with whom I was (and am) in contact. The stigmatic nature of the consumption activities I was investigating proscribed the use of audio and video recording devices for most interactions. Audiotape recordings were made *only* of interviews with treatment personnel (i.e., counselors and administrators) and only with their direct permission (see Hill and Stamey 1990; Schouten 1991). Only handwritten notes were taken in group discussions or interviews with addicted consumers. No photographs were taken, and all interviews were conducted on a first-name-only basis.

Interviews were conducted in a nondirective, nonevaluative format (see Jorgensen 1989; McCracken 1988). They were initiated by inviting the informant to simply "begin at the beginning" and relate his/her story of drug and/or alcohol consumption. Once the interview was underway, I let it flow in as unrestricted a way as possible (Jorgensen 1989). Most informants chose to follow a roughly chronological order of their lives, beginning in early or mid-childhood and working their way up to the present time. A few organized their narratives on a drug-by-drug basis (e.g., marijuana, cocaine, LSD), describing their experiences in using each. After the interviews were conducted, I wrote up my notes into a narrative and later gave it to the informant for correction and/or amplification. On average, the interviews lasted 45 minutes to one and a half hours. Upon completing the interview with each informant, I often shared my own experiences as a way of reciprocating their willingness to share theirs with me.

Supplementing the interviews conducted at the two institutions and Narcotics Anonymous meetings were six interviews conducted with persons who did not label themselves as addicts despite their long-term use of drugs and/or alcohol. I felt that this was a necessary group of consumers to include in that they may possess insights and strategies regarding drug consumption that would differ from persons self-labeled as addicts. I first attempted to recruit informants in this category through referrals from institutionalized and recovering addicts. This approach proved naive and fruitless, as recovering or institutionalized drug users seek to *avoid* contact with active drug users.

Thus, I turned to personal contacts to generate these informants. I called or talked directly to seven persons whom I believed might fall into the active drug user–nonaddict category. Remarkably, six of the seven agreed immediately to an interview. I believe their willingness to serve as informants was based largely on their knowledge of my own addictive history, their personal trust in my promises to maintain strict confidentiality of our conversations, and their desire to help with what they viewed as a useful research project. As with the other informants, I took down written notes during the interview, wrote these into narrative form, and returned them to the informant for correction and/or amplification.

Hermeneutic Interpretation

The 35 interviews with addicted consumers served as the primary data source. As interviews accumulated, I began to detect events and beliefs that were common across informants. These were documented in my field notes as well as in marginal comments alongside each interview (McCracken 1988; Miles and Huberman 1984). Some examples of "early" marginal comments made are as follows: estranged from father and conditional love; child of alcoholic mother, beaten by father; weak father-son linkage; mother is critical and physically abusive. (These and similar others were later grouped into a larger, emergent theme termed "Dysfunctional Family.") However, I did not use them to guide or restructure interviews with later informants because to do so would have betrayed the essence of the phenomenological approach, which, at its base, requires letting each informant tell his/her *own* story. What I did attempt to do, however, was to diversify as much as possible the types of informants I talked to, in order to see whether the themes and concepts common to one sort of informant (e.g., young, blue-collar males) were also found in the experiential narratives of other types of informants (e.g., middle-aged, professional women). The emergent themes that are described in the present study were common across the majority of addicted consumers to whom I spoke, regardless of gender, age, or social class. For this reason, I view them as representative of the consciousness of addiction.

The identification of phenomenological constructs across informants is essentially a hermeneutic activity (Bleicher 1980; Ricoeur 1976) in which the interpreter iterates between specific details in individual interviews and more general themes or concepts that are present in his/her own mind (Jorgensen 1989; McCracken 1988). In the present instance, the concepts and experiential structures present in the stories of informant-addicts were being compared to the general conceptual template of a researcher-addict. As Jorgensen (1989, p. 93) states, such "personal experience derived from direct participation in the insiders' world is an extremely valuable source of information, especially if the researcher has . . . experienced life as an insider."

As will be described in more detail later, my insider status led me to two a priori themes as I approached

informants. These were the belief that most addicted consumers would display a pattern of serial and/or simultaneous addictions and also that dependence on the addiction would intensify during periods of role transition and increased stress in the consumers' lives. Although I did not push or guide my informants into discussing these two themes, I was alert to them when or if they were mentioned during the course of an interview and would note them accordingly.

As the interviews progressed, I also found myself becoming aware of repeated themes that were consistent with my own experience during addiction but that I had not yet explicitly recognized and labeled for myself. Among these were the linkage of dysfunctional family life to the origin of an individual's addiction, the attempt to establish boundaries around one's addiction in order to separate it from one's family and/or work; the tendency to resort to crime or deception to support the addiction; fantasies, plans, or actual attempts to commit suicide in order to escape the unmanageable state of one's life due to addiction; and the marked tendency to relapse into active addiction even after periods of successful abstinence. As these themes surfaced in the interviews, I would find them simultaneously mapping onto my own experience. The seeming specificity of one informant's story (for example, of crashing his car into a telephone pole) would resonate with a plan reported by another informant (e.g., flying an airplane into a mountain) and would connect with my personal fantasy during addiction of running a red light and being struck by a large truck. In an instant of recognition, I would see these as all reflecting the absolute desperation addicts sometimes feel to escape their uncontrollable lives by any means possible, including death. Once I recognized a theme such as this both in myself and across several informants, I would note its presence and become "alert" to it in later interviews. I would also go back and mark earlier interviews that contained references to this theme.

I was aware, however, that I might still be overlooking some themes. Thus, when all the original interviews were completed, I reread each of them 8–10 times. I did not detect any new themes; however, I did gain a much better sense of the subtleties of several of the themes and the different modes in which they could be expressed in the lives of addicted consumers. To reflect this, I have chosen excerpts in the analysis section that are intended to illustrate the various contexts in which a particular theme may express itself. Thus, the hermeneutic process in the present inquiry may be described as relating an informant-specific detail to another informant-specific detail to a researcher-specific detail leading to researcher recognition of an overarching emergent theme.

The insider status of the researcher permitting the detection of emically based themes, however, may prove a stumbling block to achieving an appropriately distanced analysis (Jorgensen 1989). To overcome my own possible tendency toward denial and self-deception, three avenues for cross-checking the robustness and credibility of the analysis were used. First, as mentioned earlier, I conducted interviews with drug/alcohol consumers who were not self-labeled as addicts to see how their self-concepts and drug/alcohol consumption experiences compared with those of addicts and my own experience. This analysis was conducted *after* the themes had already been identified for the addicted consumer group to enhance comparison and contrast.

Second, my analysis of the interviews with addicted consumers was given to two consumer researchers for examination and comment. These two researchers were selected because they possessed special knowledge regarding addiction: (1) Both have family members who were/are addicts and (2) both have conducted interpretive research that has brought them into contact with addicts. Thus, from both a personal and professional standpoint, they are familiar with the phenomenology of addiction. Their comments are incorporated into the present analysis. Third, two types of member checks (Bergadaà 1990; Hirschman 1986) were employed. First, the emergent themes, once identified, were presented to members of the Narcotics Anonymous chapters to which I belong and subjected to group discussion. This check proved both valuable and enlightening; insights from these feedback sessions are included in the present article. Second, the entire manuscript was submitted to another consumer researcher familiar with interpretive methods who has frequently consumed a variety of drugs over a 25-year period but does not label himself as an addict. The insights of this person are also incorporated in the present version.

SOME A PRIORI CONJECTURES

What does it *feel like* to be an addict? How does one *become* an addict? How do addicts *differ* from nonaddicted consumers of drugs and alcohol? Although a theoretical explanation for addiction has been presented, questions such as these are best answered through examining the contents of the consciousness of addicts. My own self-exploration of these questions began just over three years ago when a medical emergency attributable to drug consumption put me in the intensive care unit of the local hospital. Once there, the physical pain experienced from being without the substances I had grown physically dependent upon, coupled with severe reprimands from several attending physicians, brought (forced) me to the realization that I was, indeed, a drug addict. Once this recognition arose in my consciousness, I found myself searching through my prior history for the sources and manifestations of my addiction.

After "rummaging" (McCracken 1988) through these recollections, I became aware of a distinct pattern of compulsive behaviors that could be traced back to early adolescence. Among these were an inordinate fear of

obesity, which manifested itself in a life-long pattern of obsessive weight control, a tendency to avoid unpleasant realities by escaping into fantasy (as a child) and work (as an adult), and a striving for complete control over my environment, coupled with a corresponding fear of losing control and spinning into chaos, which I dealt with by assuming ever-increasing amounts of responsibility, which were met by taking ever-increasing quantities of stimulants.[3]

Serial and Simultaneous Addictions

Examining this mental state of affairs, I came to two a priori conjectures regarding drug addiction. The first was that drug addiction was part of a larger pattern of compulsive behavior that was manifested in multiple ways in the consumer's life. For example, I did not *just* take stimulants consistently. I also drank alcohol almost daily, exercised ritualistically, worked in binges, ate certain foods repeatedly, and would go on shopping "splurges" during which I would buy large quantities of one item. Further, I had a long-term pattern of doing these things. My behaviors, therefore, were very much in keeping with the research described earlier indicating a close linkage between drug addiction and compulsive consumer behaviors generally (see, e.g., Hoch and Loewenstein 1991; Mendelson and Mello 1986; O'Guinn and Faber 1989; Orford 1985; Peele 1985).

Addiction and Role Transition

My second a priori expectation was that drug addiction—and other compulsive consumption acts—would be intensified during periods of role transition and personal crisis. As with the research cited, I believed that addicts commonly retreat to their addictions in an effort to escape stressful events. One's addiction serves as a place of refuge and a form of solace in a troubled, anxiety-filled environment. Further, because the addict can control the content of his/her experience within the addiction, it can provide a feeling of security and control when other aspects of one's life seem unmanageable.

Reflecting on my own experience, I noted that two serious bouts with anorexia occurred when I left home for college and then left college for a job. On both occasions, I was departing a safe, known haven for an unknown and potentially fearful place. By ritualistically controlling my body, I was attempting to maintain control over my threatened and exposed sense of self. Similarly, it was during my freshman year of college that I engaged most frequently in weekend drinking "to get drunk." I did not want to be me, and drinking alcohol was a reliable way of removing me from myself. Thus, I anticipated that other addicts would engage in similar acts of chemical escapism during stressful periods in their own lives. This reasoning was consistent not only with empirical studies on addictive and compulsive behavior, but also with recent research on the effects of stressful role transition on consumer behavior (e.g., McAlexander 1991; Roberts 1991). In fact, in one of these studies (Roberts 1991) the traumatic impact of unexpected job loss led one informant to begin using and dealing marijuana.

[3]I therefore closely matched the classic pattern for anorexia (see p. 7).

THREE LIVES

To provide the reader with exemplars of the types of information provided by personal interviews with addicted consumers, as well as illustrating some of the emergent themes resulting from the study, partial case histories are presented below of three informants. The first two appear to be largely consistent with the pattern of the distressed subtype; the third was chosen to represent the sociopathic subtype.[4]

Edward (w, m, 43). Edward describes himself as "an addict." He believes he has always been an addict and that he has an "addictive personality." His father drank heavily on weekends but was a successful businessman during the week. His mother never drank and had negative attitudes toward alcohol. When Edward was a little boy his mother would give him whiskey mixed with lemon juice and honey "for medicinal purposes" if he had a cold or sore throat. Edward began to like the feeling this remedy gave him and soon began developing more frequent sore throats. By early adolescence, he was sneaking liquor from his father's supply and by midadolescence was regularly drinking cheap wine he bought with a friend: "It helped kill the emotional pain" both were feeling. Both boys felt estranged from their families.

When Edward got to college he began to drink hard liquor regularly. By his senior year, he had developed severe stomach problems, which culminated in bleeding ulcers: "I was always coughing up blood." The severity of his stomach disorders caused him to "submerge his addiction" for 10 years. He got married, fathered a son, and returned to graduate school. He earned a Ph.D. in criminal justice and found that his services and expertise were much in demand for developing behavioral modification programs for prisoners. His "new addiction became money." He would repackage the same program

[4]These are my personal, *nonclinical* assessments. It should also be noted that the majority of persons interviewed (70–80 percent) I believed to be of the *distressed subtype.* When queried about this relative imbalance by one of the reviewers, I checked with a friend of mine who is a longtime member of N.A. and who counsels addicts in prison and in mental institutions. In his view, many of the sociopathic subtype addicts are imprisoned or classified as criminals. They often are prone to violent actions (as a result of weak impulse control), which can lead to imprisonment or death. Since my interviews were conducted in noncriminal rehabilitation institutions and among N.A. chapters serving nonincarcerated addicts, I encountered relatively fewer of this subtype.

for governmental clients at the local, state, and federal level, earning three consulting fees for the same work. Eventually, his double-billing scheme was uncovered and his clients dropped him, although "none of them pressed charges" against him.

With the large amounts of money he was making, Edward became attracted to gambling. He first gambled at the racetracks and then at the casinos. Soon his gambling debts were running $1,000 a month, and he was frequently gone from home the entire weekend. He introduced his childhood drinking buddy to gambling. His friend became so addicted that "he lost his wife, his children, home, car, and job." After seeing how much gambling had cost him and how destructive it was to his friend, Edward quit.

Edward's next addiction became sexual promiscuity. He began having affairs with several women at once. He also began "dabbling" in drugs, particularly marijuana and cocaine. His drug and sex dependencies began to become uncontrollable. He owned several apartment buildings and would take women there for drug and sex binges on weekends. His work performance began deteriorating.

Edward bought drugs in such large quantities to supply his own consumption that he also began dealing both cocaine and marijuana. Finally his drug use became so flagrant that the police began surveilling him. He and a friend were arrested one night before entering one of his apartments to do drugs. He told the police, "I knew you were going to 'pop me.' I *knew* it was coming!" yet he had gone out to do drugs anyway.

Edward views his serial addictions as manifestations of a self-destructive urge he has had since childhood. "I kept searching for ways to destroy myself. . . . finally, [the night I was arrested], I did it. . . . I destroyed my career, my reputation, my family, my life." Edward was taken to a rehab institution for treatment for drug and sex addiction. He was in "complete denial" at first but now has come to recognize the "addictive pattern" of his life. He still has drug charges (dealing and possession) pending against him and feels he will likely go to jail ("do time") in the near future. While in treatment, the police raided his office and apartments and found drugs and drug paraphernalia. They also raided his house, but "they didn't find anything there. I would never take that stuff to my house, where my wife and son were."

David (b, m, 32). David drank alcohol heavily and "did acid" (LSD) in high school; he experienced conflicts with his parents over his drinking and drug use. He had always had a difficult time relating to other people but was a good athlete. David won a basketball scholarship to a college in California, and while there he began to do mescaline and drink more heavily. He also took acid occasionally. He found that he could not keep up with his college course work or athletic performance as a result of his drug and alcohol consumption. His father and mother came out to see him. At a meeting in the dean's office, David lost control of himself when his father pointed at another black student who was performing very well and asked why David could not be like him. David went to his apartment, broke some furniture, and ripped the phone out of the wall: "I guess I was having a nervous breakdown."

David dropped out of college after only one year and went to work as a computer operator. He began smoking "weed" (marijuana) heavily and continued to drink. He soon left that job and became a cab driver. He liked this job because "You worked a 12 hour shift from 5 P.M. to 5 A.M. Half the time you didn't care where you were going. Wherever somebody asked me to take them I would say 'That's o.k.' because I knew that place was near a reefer store or that place was near a liquor store. . . . I was always high and drunk [on the job]. . . . I would drink, I would smoke, I would crash the cab, but it didn't matter 'cause the garage would always fix it."

From David's drug contacts, he began to get into dealing cocaine powder. He became quite successful at this and was making thousands of dollars. "I would drive [my cab] from club to club. At each club I would go straight to the men's bathroom and tell them 'Hey, I got the best shit you've ever seen,' and I did. Soon I had a regular group of customers. I would make my rounds every day. I was rich. I had fine suits, leather coats, lizard shoes, gold chains. I was really making it." However, David decided to "sample some of my own product" and that "quickly led to my downfall. . . . I had never felt such a high. At first I would just do it once every few weeks, but then I was doing it every day; then I would do it for 6 or 7 days straight."

David became so addicted to cocaine that he could not deal it anymore. "If I had good stuff, I'd just snort it up myself. . . . I didn't want to give it to anybody else." From powder cocaine he moved to freebase and then to crack in the mid-1980s. "By 1986 I was using a stem (i.e., smoking freebase cocaine) and was heavily into crack. I would live in crack houses for a week at a time. It was just filth and dirt there, but I was comfortable with it. I used to like to sleep, but I found cocaine was better. . . . I used to like to eat, but found cocaine was better. . . . I used to keep myself clean, but my ass and balls would stink . . . all because of cocaine, cocaine, cocaine."

David has been in and out of rehab six times since 1986. The first few times he stayed only a short while, feeling that he could cure himself. However, that failed; each time he would return to crack. "I kept going back to the crack houses. Each time it would get worse. My addiction would progress faster. I was there during police busts. They'd put a shotgun to my head and push my face down on that filthy floor. I knew soon my time to die would come."

During one of his clean periods, he got a job as a computer programmer and got married. But he was unable to stay clean. "On the night of our wedding, I took all the money we got and bought crack and smoked my

stem. I kept a bottle [of alcohol] in my briefcase at work and two more in my car. I would stock up every night before the liquor stores closed because I was terrified to run out of alcohol. I sold my wedding ring twice to buy crack. If I had $50, it'd be gone in an hour. If I had $500, it'd be gone in an hour. If I had $5,000, it would last maybe two or three days."

David's most recent rehabilitation effort has kept him clean for almost 90 days. He wants very much to succeed this time and fears he may die if he fails. He believes he has suffered some brain damage as a result of his drug use. "I know my brain is sometimes dysfunctional. . . . The thing I really regret is that my disease has prevented me from ever reaching my potential [he is now 32]. I could have been a pro athlete. . . . I was intelligent. . . . I could have been a successful businessman. . . . But I lost all that."

Mike (w, m, 38). Mike recalls often making up excuses as a child that he did not feel well, so that his mother would bring him home from school, feed him, and love him. As a result, his grades were poor. When he was about 10, his family moved to a small town with a run-down school building. The children had to play in a damp moldy basement, which nauseated Mike. He was put on prescription tranquilizers and soon grew dependent on the feelings they gave him. Around the age of 13, an older cousin introduced him to drugs and alcohol. He began with beer and marijuana but soon progressed to mescaline, Quaaludes, and liquor.

Throughout high school, Mike's grades deteriorated. He got into frequent fights with other students and school administrators. He viewed himself as a hippie and "hung out" exclusively with other "hippie dopers." By age 18, he was frequently a nonattender at high school. When the parked car in which he was smoking marijuana was struck by a garbage truck in front of the school, he angrily quit ("That was the last straw!") and joined the army.

Once there, he discovered his older cousin was his platoon sergeant. They frequently got drunk and high and caroused together. Hearing that the drugs available in Korea were even better than those in the United States, Mike signed up for a tour there. In Korea, Mike did hashish, marijuana, and opium and began to mainline heroin. His arm and leg veins became "completely gutted." Mike was frequently arrested by the MP's for fighting and insubordinate behavior. Finally, he was sent to Fort Leavenworth, Kansas, for drug rehabilitation and imprisonment for striking an officer. While in the stockade, his girlfriend continued to supply him with drugs.

Given a medical discharge from the army, he returned to his hometown off heroin but still using other drugs. He met a young woman at a bar and "fell in love with her at first sight." She was an alcoholic, as was he. They married, and she became pregnant. During her pregnancy, they both gave up drinking and drugs. After their daughter was born, the wife began drinking and doing cocaine again in response to postpartum depression. Mike relapsed as well, and soon their addictions were full-blown again.

Mike has held a succession of skilled labor jobs, losing each as a result of his drug use. He and his wife separated because of her alcoholism and infidelity. Mike was arrested for driving while intoxicated (DWI) but convinced the counselor he was not an addict. Out of work, he and a friend held up a local convenience store ("We were so stupid we didn't even wear masks; the guy knew us!"). They were immediately arrested and jailed. Mike became "very frightened" that he might lose custody of his daughter. He entered a rehab program required by the state, after asking for "one more week to get high." He has now been clean for a year.

A PRIORI THEMES

Serial and/or Simultaneous Addictions

The addicted consumers I interviewed all exhibited a pattern of serial and/or simultaneous addiction, as well as the ability to identify a drug of choice, that is, a drug they preferred to all others. This was consistent with my own life experience, which contained two early bouts with anorexia, a 12-year stint of workaholism coupled with dependence on stimulants ("to get up") and occasionally alcohol ("to get down"), as well as intervening binges on wine and marijuana during my college years. It is also quite consistent with O'Guinn and Faber's (1989) finding that among their sample of compulsive buyers other forms of compulsive behavior including excesses in substance abuse, work, exercise, and sex were more common. Edward's case history of serial addictions to alcohol, money, gambling, sex, marijuana, and cocaine was among the most varied I encountered but was not unique. Others had consumed a wider variety of drugs than he and had done so over a shorter period of time. For example, Jerry (w, 45), a Vietnam veteran, had been addicted to speed and opium while in the army, returned to the States to become a marijuana user and dealer, discovered morphine to be his drug of choice, and began injecting Dilaudid and heroin. Tom (w, 20), an anthropology major at an Ivy League college now in his junior year, has experimented with LSD, mescaline, peyote, opium, and cocaine, in addition to his "regular" consumption of alcohol and marijuana.

Occasionally the addicted consumers I interviewed were able to quit using illicit drugs, only to find themselves compulsively engaging in other forms of consumption. One young man (w, 25), for example, a former marijuana and speed addict, now watches television 16 hours a day. He does not watch "old movies or something like that that would make sense. Instead I randomly hit the remote control switch every one or two minutes." Another young man (w, 26) has given

up his addiction to cocaine and alcohol but now "travels from city to city and state to state so I can see my favorite rock bands in concert."

Even in recovery several of the interviewed addicts continued to consume licit drugs, such as cigarettes and caffeine. When questioned about this, they typically responded that (1) "You can't give up everything, that's why I still smoke cigarettes/drink coffee" or (2) "At least smoking cigarettes/drinking coffee doesn't mess up my brain the way cocaine/heroin/LSD/alcohol, etc. did." Thus, it appears that it is extremely difficult for compulsive consumers to become noncompulsive. What they do appear able to do is to rechannel their compulsive energies into consumption venues that are legal and/or less socially condemned.

Role Transition and Personal Crises

In a recent study of persons undergoing plastic surgery, Schouten (1991) found support for the proposition that such actions were precipitated by changes in personal status and role transition. As Schouten (1991) observes, at such times, the consumer's self-concept is often under stress and various forms of "symbolic self-completion" may be sought. Similarly, addicted consumers may phenomenologically attempt to control their self-concepts through increased drug use during periods of role transition and personal crisis. The lives of the three addicted consumers just presented provide some evidence supporting this proposition. For example, Edward felt estranged from his mother and father as an adolescent and used wine to "kill the emotional pain." His stressful role transition to college student coincided with an upgrading of his alcohol dependency from wine to liquor. Similarly, David's transition from home to becoming a college student and athlete led to a broadening of his drug consumption, as well as an increase in his alcohol usage. On the night of his wedding—a highly significant and stressful role transition—he resumed his crack cocaine consumption.

Sunny (w, f, 23) was the daughter of counterculture parents. From early childhood, she had "felt different" from other people because of her parents' "hippie" lifestyle. As a child she would engage in compulsive consumption activities in order to deal with the social alienation she felt. Among these were (1) stealing from stores, (2) eating large quantities of sugar and candy, and (3) watching large amounts of television. At age 13 (a time of significant emotional distress due to role transition from childhood to womanhood), she "made a conscious decision" to become a drug addict because she believed that "other dopers would accept and befriend" her. When her sister died of a drug overdose, precipitating a large personal crisis for Sunny, she became more despondent and tried to "escape her feelings" through increased drug use. Similarly, Thomas (w, m, 20) was greatly saddened by his grandfather's death when he was 13. He "remembered that people were supposed to get drunk when they were sad," and so, while his parents were attending to the funeral arrangements, he got drunk on his parents' liquor. He soon "forgot all about my grandfather's being dead and my sad feelings."

These cases illustrate the self-medication aspects of compulsive consumption. Such consumption permits the individual to escape to a safe, controllable mental world when the real world is too overwhelming. Transitional events, such as a loved one's death, or strong feelings, such as loneliness and fear of social rejection, which seem beyond the person's ability to deal with, can be eliminated from consciousness through drugs.

EMERGENT THEMES

The lives of the three addicted consumers also displayed several themes that were common to the interviews with other addicts and consistent with the theoretical structure presented earlier. Among these were the addict's origin in a dysfunctional family, the addict's attempt to establish boundaries between the self and the addiction and between the addiction and personal relationships, the tendency to resort to crime and/or the deception of others in order to continue the addiction, the frequency of relapse coupled with rapid deterioration into full-fledged addictive status, and the commonness among addicts of covert and overt attempts at suicide as a result of feelings of loneliness and the disintegration of self. Each of these themes is examined in detail.

Dysfunctional Families

Most of the addicts to whom I spoke perceived their families of origin as dysfunctional; the most common form of family dysfunction was the presence of alcohol or drug addiction in one or both parents.[5] A secondary form of family dysfunction, often occurring in conjunction with parental addiction, was the presence of physical or emotional abuse among the parents and/or toward the child. Still others came from families that appeared normal, even exemplary, to outsiders, yet were premised on conditional love; that is, the child was only loved to the extent he or she performed according to parental expectations and demands. In their own way, families in which alcoholism, drug addiction, physical or emotional abuse, or conditional love are present may place the child at risk to become an addict.

John (w, 26) was the fifth and last child born to an alcoholic mother and a skilled laborer father. In 1966, the father was awarded custody of all five children. John lived with his father and his paternal grandmother. His father was a very strict disciplinarian who beat the boys if they misbehaved: "I remember some of my brothers

[5]This is consistent with both the genetic (i.e., hereditary) and social modeling theories of addiction.

gettin' throwed across the table a few times. . . . My father's hands could be as soft as a glove or as hard as steel." John began drinking at age nine and experienced his first alcoholic blackout at age 14.

Evan (w, 36) had an alcoholic father. He himself became an alcoholic in his early twenties. However, Evan does not hold his father responsible for his own or Evan's addiction to alcohol. "I know how helpless someone is who's addicted. How out of control. I've been there. I can't blame him, he just can't help himself."

Betsy (w, 17) describes her father as "a very important and demanding man." She remembers him sitting in his office in his "huge leather chair." She would bring in her report card, and he would examine it. If it was "satisfactory" (i.e., all A's), he would shake her hand and say "very good" to her. That was his only way and context of showing her love. Betsy is currently struggling with addictions to cocaine and alcohol. She has dropped out of prep school and is living with her parents and enrolled as an outpatient at a nearby drug rehabilitation program.

These three consumers have greatly disparate SES backgrounds: John comes from a blue-collar environment, Evan's father was a manager, and Betsy's father is the CEO of a corporation. Yet each of their families was seriously dysfunctional. Addicted parents not only may serve as negative consumption role models for their children but also may be incapable of displaying appropriate emotional commitment and, frustrated with their addiction, may become physically abusive. However, even in families in which everything appears exemplary (i.e., Betsy's), emotional detachment and love conditioned on a child's performance may sow the seeds for later addiction. One consumer researcher, who came from an addicted family background, commented: "In such families, the [child] addicts not only learned conditional love, but also developed manipulative skills, passive aggressive behaviors, and the fine art of lying convincingly." These are discussed in a subsequent section.

Boundaries

Several of the addicted consumers interviewed appeared to have an awareness of the damage that their compulsion to use drugs was doing to them and the people they loved. Because of this consciousness, they would attempt to draw boundaries between their addictive consumption and their families (see Hoch and Loewenstein 1991, O'Guinn and Faber 1989, and Rook 1987 for discussions of similar rules and strategies in compulsive consumption). Recall Edward's declaration that he kept no drugs at his home "because my wife and child are there." Two other examples are given below:

Dan (w, 30) and his girlfriend had a baby girl. After they broke up, he got to see the baby only on weekends. He would go to pick her up high on heroin, always making sure he had bought enough to make it through the entire weekend, so that he would never have to take his daughter to buy ("cop") more of the drug. He continued to see his daughter every weekend but became increasingly worried that his addiction was making him abusive toward her and kept "thinking about taking her along when I went to cop" heroin. Doing this would signal (in his view) "complete depravity."

Ralph (w, 30) is a heroin addict and alcoholic. His wife has separated from him and has sole custody of their three children. He gladly pays child support to her, even though he himself is homeless. "The group at work rag me about giving her money even though she won't let me see the kids. But they're still *my* kids. They'll always be my responsibility."

Despite their severe circumstances, both Dan and Ralph cling to the boundary that separates their sacred roles as parents from their profane and degraded status as addicts. In essence, they feel that, if they could not prevent their addictions from breaking down this last remnant of their maturity and familial competence, then everything would be lost. To the extent that they can still function as parents, they believe there is some shred of sanity and normalcy left in their lives.

Similarly, Sunny (w, 23) made up mental rules that she believed served as boundaries for her addiction: "As long as I put on my nightie every night, instead of sleeping in my clothes, I wasn't an addict." So she would stumble around her room high at night putting on her nightie, thus proving to herself that she was not an addict. As Sunny's addiction progressed, her mental rules changed. She no longer required herself to undress at night; instead, she deemed addiction to be indicated by being stopped by the police, as some of her friends had been: "I've never been stopped by the police, so I'm not an addict." After Sunny was stopped for the fourth time by the police, she changed her phenomenological boundary to actual arrest: "I've never been arrested, so I'm not really an addict." Finally, Sunny was arrested: "I was handcuffed, fingerprinted, and had my photo taken. As I stood there in the police station I finally realized, 'I'm an addict.' "

Crime and Deception of Others

In order to maintain their habits, drug addicts must consciously and knowingly deceive others. First, they must devise ways of hiding their drug use from their families, friends, and co-workers. Second, they must deceptively engage in activities that they know are illegal. Addicts are continuously conscious of the need to maintain their deceptions. In a phenomenological sense, the deception becomes a second-nature mental schema. The necessity of engaging in crime and deceptive behaviors acts to further isolate the addict from those s/he cares about. Because addicts cannot reveal their "true selves," the maintenance of a "false self"

when dealing with others serves to further isolate and alienate the addict from other people and, ultimately, from him/herself. As Kitty Dukakis described her deceptiveness as an alcoholic and drug addict, "When it comes to covering our tracks, we're consummate artists. At first, it was easy to fool Michael; all I had to do was go through the formal motions of normalcy when he was home. . . . While he was away, I entered my netherworld of alcoholism. Eventually, I became totally immersed and too far gone to deceive anybody" (Dukakis 1990, p. 20).

Several of the addicts I interviewed engaged in crime simply by the act of purchasing and using illicit substances. However, some of them also engaged in additional crimes to obtain money to acquire drugs; the most common of these were theft and drug dealing. In the case histories presented, two of the addicted consumers, Edward and David, acted as drug dealers, while Mike ultimately turned to armed robbery to support his addiction.

While the crime spawned by compulsive consumption may be directed at strangers or businesses (see Faber et al., p. 132), deceptiveness is often directed at the consumer's own family and friends, where it rapidly erodes trust and familial bonds. John's (w, 24) older brothers were more heavily addicted to drugs than he was; hence, they more often were unemployed and turned to him for resources: "They are always bogartin' off me; always taking things. Everybody's always done that to me."

Fred (w, 25) became a truck driver for his family's business after dropping out of art school. This required getting up at 3:30 A.M. In order to stay awake Fred began doing cocaine and, later, crack. He used marijuana to get back "down." Fred used both drugs in such quantities that he became a dealer; "but I still needed to take money from [my family's] till. . . . My father caught on and moved me inside the store, so he could keep an eye on me; but every chance I could I would leave to go get supplies or make a delivery so I could get high."

Julie (w, 23) was in graduate school at an Ivy League college when she placed herself (after her friends' urging) in a rehabilitation clinic for multiple drug addictions. Upon entry, she recalls "looking the nurse right in the eye and chatting with her as I used my hands to take valium out of a bottle and hide them in my pocket." Later, Julie turned in some of the pills to the nurses' station in the Anxiety Ward instead of the Addiction Ward "in the hopes they would give them back to me at discharge."

The crimes and deceptions that these addicted consumers committed against society and against their families and friends—as well as against themselves—often filled them with great shame, guilt, and self-loathing. "As humiliation, self-pity, and self-hatred overcame me, I drank more. I became very withdrawn and began to isolate myself for days on end. . . . I wouldn't talk to my friends. I wouldn't answer the phone. . . . I couldn't get over the irony that here was the governor's wife at a press conference on alcoholism, when she was nothing more than a drunk herself" (Dukakis 1990, p. 250).

Suicide

As addicts' attempts to control their compulsive consumption by establishing boundaries and maintaining elaborate deceptions fail, their lives disintegrate. This is experienced phenomenologically as a complete loss of control; facing a life that appears to be emotionally unmanageable and filled with overwhelming anxiety can lead to a state of desperation and hopelessness. Such feelings may cause addicts to turn to suicide as the only escape from or solution to their dilemma.

There are many ways to commit suicide, and several of the addicted consumers I interviewed had contemplated or attempted at least some of them during their addictions. In this they resembled other compulsive consumers. For example, thoughts of suicide and suicide attempts have been reported in bulimics (Abraham and Beaumont 1982; Russell 1979). One young addict (w, 25) bought cocaine in a dangerous section of his city, "but that got too tame 'cause all the dealers knew me, so I decided to up the ante and began buying on Avenue D in New York [a notoriously dangerous drug market]. Two of my friends who went with me at different times got ice-picked in the chest. I kept thinking 'Why wasn't it *me?*' I wanted to die, I just didn't have the balls to do it myself." Similarly, a young (w, m, 29) former heroin junkie stated that he "was so used to having hepatitis and drinking water out of puddles that now I'm amazed to be sleeping in a place that has electricity. . . . I usually was in places where I could have been killed at any time, and I didn't care." A black man (36) was so self-destructive during his addiction to crack that he planned "to take flying lessons so I could crash the plane into a mountain." An alcoholic (w, m, 24) "accidentally" crashed his car head-on into telephone poles after attending Christmas parties alone on two consecutive years.

Among the most poignant are the stories of teenage suicide. One young man (w, 17) from an affluent family related this story about his best friend: His group of friends "was heavily into marijuana, LSD, and alcohol." During a party at a friend's house, his best friend was having a "bad trip on acid" (LSD) and decided to walk the half mile home to his own house. After a few hours, his friends dropped by to see him only to discover he had never arrived. They drove around for hours searching for him but had no luck. The next morning the boy's body was found in a nearby schoolyard; he had hanged himself from a swing set. The teenager relating the story said this had convinced him to give up drugs completely: "My friend was depressed, but if he hadn't been on drugs he might not have done it."

Some former addicts try to consciously recall their attempted suicides in order to keep themselves from relapsing. An extremely pretty young woman (w, 24) wears several silver bracelets on both arms. Underneath the bracelets are slash marks from repeated suicide attempts: "I could have had them removed with plastic surgery, but I decided to keep them there as a reminder of how bad life was."

Finally, the conversations I had with addicted consumers suggested that in some cases overdose deaths (i.e., O.D.'s) may, in fact, be purposeful actions. One heroin addict (w, m, 30), for example, believed his wife had been unfaithful to him, so he "shot-up seven bags" in an effort to kill himself. However, "the police found me too soon, so I'm still here." A young alcoholic (w, m, 25) played a "death game" with himself in which he would drink sufficient quantities of alcohol to make himself "legally dead according to the Breathalyzer."

Within the present interpretive framework, therefore, suicide is viewed by addicts in a phenomenological sense as a final attempt to regain control over their lives by ending them. In essence, the addict is saying: "I can't go on in this condition anymore, but I can *stop*."

Relapse

Many researchers have commented on the high recidivism or relapse rate among drug addicts (e.g., Brister and Brister 1987; Peele 1985; Ray 1961). And indeed, most of the active addicts to whom I spoke have tried at least once to stop their drug consumption and most recovering addicts I spoke to have relapsed at least once. As clinical research studies suggest (e.g., Johnson 1980; Marlatt et al. 1988), addictions are very difficult to control over time. Some active addicts appear to be phenomenologically aware that their consumption is harmful to themselves and to others they care about and make sincere efforts to control or halt their usage of addictive substances. Unfortunately, these attempts often fail because the underlying emotional problems that helped stimulate and perpetuate the addictive behavior have not been remedied and, if left unattended to, are likely to reinitiate the addiction.

Many nonaddicts (and several researchers, e.g., Brister and Brister 1987; Peele 1985) believe that halting drug addiction is difficult primarily because of the physical pain of withdrawal itself, that is, that the heroin junkie or cocaine addict cannot stand the agony of withdrawal and hence must acquire a "fix" as soon as symptoms appear. While it is true that withdrawal from many addictive substances, including alcohol, tranquilizers, and caffeine, as well as narcotics, cocaine, and amphetamines, can cause intense suffering and craving in the addicted consumer, it is also true that some addicts are capable of undertaking withdrawal by themselves (Ray 1961). Some of those I interviewed have done this—suffering tremendously in the process—only to relapse when emotional or financial problems became overwhelming. Thus, unless the addicted consumer's underlying phenomenology of anxiety, depression, and alienation is remedied, s/he she will likely return to the addiction.

Bill (w, 40), a recovering heroin addict and alcoholic, has failed many times to maintain his recovery. "I've burned so many bridges, there's no rehab around here that will take me." He once had almost a year of clean time but "blew it and went right back to shooting-up [heroin]." There are few detox centers that will now work with heroin addicts, Bill claims, so he recently "detoxed himself" at his brother's house. "I got the shakes real bad, but at least there was a shower there so I could wash off." (Withdrawal from heroin causes severe muscle spasms and sweating.) Before his latest attempt to clean himself up, Bill had a "six bag a day" habit. When I saw Bill two weeks later he had restarted his heroin addiction. He had had another fight with his estranged wife, which made him "emotionally desperate." Unable to deal with his feelings, he had once again returned to heroin.

Another pattern common to the recovery/relapse cycle is for an addicted consumer to "get off" one of multiple substances s/he is using and to compensate by using more of the other substances. In one instance, a young man (w, 26) was addicted to crack, marijuana, cigarettes, and alcohol. The crack addiction was so damaging that he gave it up of his own volition. To compensate, he began drinking heavily five or six nights a week. A turning point came when he vomited on his friends' coats at a New Year's Eve party. He felt very ashamed and quit drinking. He was now "down to cigarettes and pot." He gave up cigarettes but began to smoke much more marijuana. When he ran out of money to buy marijuana, he switched back to cigarettes. He now has a two-and-a-half-pack-a-day cigarette habit.

However, every once in a while a long-term addicted consumer will "get clean" and "stay clean." The story of Sidney (w, 50) is particularly instructive in this regard:

Sidney, an alcoholic, had checked himself into rehab with the intention of "just sobering up long enough to get my affairs in order. My life was out of hand. But I never really intended to actually quit drinking; just to take a brief respite from it." He was released from rehab on a Friday and thought, "Oh, no, a weekend. I'll never make it through a weekend without a drink." But he did. He then "somehow" managed to make it all the way until the next Friday, and then through that weekend, and so on. "After a while, I began feeling better and better physically, so it became easier and easier not to drink. Now it's been two years. . . . I guess, like a true addict, I'm now addicted to sobriety."

TWO MORE LIVES

Let us now take a look at the lives of two persons who have consumed drugs (including alcohol and cig-

arettes) for an extended period of time but who do not view themselves as addicts.

Brian (w, 43). Both of Brian's parents drank alcohol and smoked cigarettes; his father was an alcoholic. Brian's uncles were also alcoholics and cigarette smokers, and his older brother became an alcoholic as well. Based on his family history, Brian believes it is not surprising that he also began consuming alcohol and cigarettes. Brian experienced some conflicts with his father but generally viewed his family life as normal. "I thought all families were like mine, even though I now realize it was very dysfunctional. I thought drinking and smoking like my father and uncles did was appropriate behavior."

Brian began drinking alcohol heavily at the age of "18 or 19" and continued to drink through college, the air force, and professional school. When his father died at age 62, Brian began to consciously reduce his consumption of alcohol and would only drink once a week or once a month. However, when he did drink, Brian would consume "a tremendous quantity of alcohol at one time."

Around the age of 30 or 35, Brian began to introspect about his father's early death from alcoholism. His doctor also began warning him repeatedly about the damaging effects his binge drinking was having on his heart and body. He recalled that his uncle had also died of alcoholism in his early sixties. He began to ask himself "what drinking was doing to me. It had caused me a lot of failures. I had once been suspended in college for a drinking-related incident. Drinking hurt my relationships with other people; it caused a lot of arguments between me and my wife. My hangovers were becoming worse and worse—horrible, terrible. I thought, 'This is insane.' "

Brian was, and is, also a cigarette smoker. He began smoking two to three packs a day when he was 16 years old and continued to smoke for 25 years. He has quit "a couple of times," the most recent being a three-and-a-half-year stint during which he chewed three packs of gum a day to avoid smoking. When he quit, his wife quit also, but recently she has begun smoking again. To celebrate their initial abandonment of smoking, Brian and his wife had all of the drapes and upholstery in their house cleaned to rid them of the smoke odor they had acquired. They still do not permit smoking in the house, so Brian's wife now smokes on the porch. Her smoking makes it very hard for him to resist returning to cigarette consumption. Brian reports that "we have picked another quit date for her." Currently he is chewing Nicorette gum to help him fight the intense craving to smoke. Recently, Brian borrowed two cigarettes from a friend and smoked them. It "frightened" him to discover that they were "just as good as ever." Brian borrowed the cigarettes because he was feeling "tired, depressed and anxious, so I lit up again." Brian believes that he has an addictive personality. "It's easy for me to get hooked on things. Right now I binge on chocolate, Mexican food, Jello pudding cups. . . . It tastes great. It's a reward to myself."

Brian is introspective about his drinking and smoking: "Why do people drink excessively in the first place? It must be a symptom of some underlying emotional problems." Brian believes that being a father and having young children have played a major role in his cessation of drinking. "I wanted to give my children a good home, not like my home."

Robert (w, 38). Robert had his first alcoholic drink at age 17, when he and a friend were touring different college campuses to decide where to attend school. Robert and his friends would occasionally take liquor from their parents' stock to supply their parties. Later, Robert found that his older appearance enabled him to purchase beer for himself and his friends from a liquor store. He did not drink heavily in college, although he did go on occasional binges at fraternity parties.

During his sophomore year, Robert came home for spring break and smoked marijuana for the first time with a friend. Upon returning to college, marijuana became adopted by several in Robert's fraternity. However, others in the fraternity were fearful of the drug, and dissension occurred. Ultimately, the pot smokers (including Robert) moved out. Once out of the fraternity, Robert began to hang out with a more bohemian group of college students: "We did pot all the time." However, his alcohol consumption "faded away." He has continued to smoke marijuana since then. Although he has not smoked "for the past few weeks," Robert considers himself a "pot fan and regular user."

Robert reported having a "few forays" with cigarettes in college. The experience made him "light-headed," and he did not like it. However, in professional school he smoked for two years. He then quit—"It was no trouble at all"—but then resumed the habit in 1987. He attributes this to the fact that several persons he admired at his job smoked, and he decided to imitate them. Robert has been smoking regularly since then. He states that he is finding it much harder to quit this time and is thinking of consulting a hypnotist. He has strong cravings for nicotine and uses Nicorette gum in an attempt to satisfy these cravings. He is now changing jobs and believes that in his new position his smoking will be viewed as "more deviant"; hence, he is strongly motivated to quit. He feels especially self-conscious about his current difficulties in giving up cigarettes because "I used to teach a stop-smoking clinic. . . . I must simply not buy them anymore. If I don't buy them, I won't smoke them."

Robert also had a four-month period during which he consumed cocaine: "It was an acutely addictive drug. . . . Once it gets into you, you just want more and more." He used Quaaludes to reduce the crash. The cocaine consumption was prohibitively expensive; at one point he took out a loan to support his consump-

tion. Ultimately, Robert "ran out of money; I bottomed out. I was seeing a therapist and I realized there was no future in using coke. It was clearly self-destructive, suicidal. . . . There were no benefits to it." Robert decided to give up cocaine and, despite experiencing some strong cravings for it, was able to abandon its consumption of his own volition. During the past 12 years since quitting, he has used cocaine only twice. On both occasions he regretted using it. "The morning after is absolutely the worst hangover in the world. I just *don't* like it!"

Marijuana has been harder for Robert to give up, although he has made only one or two "serious" efforts to quit: "I don't know where I'm going with that. It's good stuff, but it's expensive. I spend around $2,000 a year on pot. What would it be like, if I didn't do it? I don't know. It doesn't seem to be harmful."

Robert has been arrested once for DWI. After his arrest, he was required to attend A.A. meetings and attend a half-day program once a week for four months. This experience he views quite positively: "It really sobered me up, calmed me down. I did not resent it at all." Robert reports that prior to this, his drinking had been "out of control. I was drinking almost every night. I had some major binges. I was even driving drunk on the interstate." Robert will now occasionally still drink "and get a hangover, but I don't drive my car. I'm more responsible than I used to be. I still drink more than I should, but it's not a real problem."

Reflecting on his drug consumption, Robert observes that many have been "very gratifying experiences. . . . Sort of better living through chemistry. . . . These substances are so available, it's hard to say no. . . . In a sense, why should I? although some are dysfunctional. I am not at a point where I want to cold turkey everything. [However,] my sense of control may be an illusion."

A THEMATIC COMPARISON

The two persons whose drug-use narratives have just been presented are both successful, well-educated professionals, as are the four other consumers whom I interviewed in this group. Although all have used various drugs for an extended period of time, they do not label themselves as addicts. Further, none has ever entered a detoxification or rehabilitation institution, and only Robert has ever attended an addiction recovery group (A.A.). Thus, it is constructive to see how their drug use compares to that of persons who are self-labeled as addicts.

A Priori Themes

As will be recalled, support was found for the two a priori themes among the addicted consumers to whom I spoke. That is, patterns of serial and/or simultaneous drug use were found, and drug consumption was found to increase during stressful role transitions and personal crises. Of significant interest is the fact that both these a priori themes were evidenced among the nonaddicted, long-term drug users to whom I spoke as well. All six of those interviewed reported heavy, long-term consumption of at least two addictive substances simultaneously, and the majority reported consumption of three or more addictive substances over a multiyear period. Brian, for example, drank alcohol and smoked cigarettes for almost two decades. He has quit consuming alcohol but has been unable to completely abandon smoking. Robert was able to stop consuming cocaine, which he had used for a four-month period, but continues to consume marijuana, alcohol, and cigarettes. Similarly, George (w, 46) was able to give up cigarettes (after a 20-year usage) but continues to consume alcohol and marijuana on a regular basis. John (w, 35) and Mark (w, 42) were heavy users of both marijuana and alcohol in college. John also smoked cigarettes. Both abandoned marijuana use after college but continued to consume alcohol. Recently, John has quit smoking and has reduced his alcohol consumption to "one beer a week."

Of the six long-term drug users I spoke to, Matthew (w, 39) had the most varied experiences with drugs—cigarettes, alcohol, hashish, marijuana, speed, LSD, MDA, cocaine, peyote, and mescaline—but many of these were limited to his college years. His current drug consumption is restricted to the regular use of marijuana and alcohol, with cocaine reserved for holidays.

What is intriguing about these drug-use patterns is that, although quite lengthy and diverse, in only one instance (Robert) have they led to negative interactions with legal authorities. Further, although some of those I interviewed indicated that their drug use had occasionally caused them interpersonal problems, none had suffered a serious career setback (e.g., being fired) due to drug use. This suggests that drug addicts may differ from nonaddicted drug users not so much in terms of their depth or breadth of drug use, but rather in the coping skills and self-control strategies they have developed to compensate for their drug use. This will be discussed in greater detail later.

The second a priori theme dealt with the intensification of drug use during role transitions and personal crises. The interviews with the six nonaddicted consumers supported this proposition as well. All of those interviewed increased their pattern of drug consumption in college—a significant time of role transition to adulthood. Further, the four informants who had been divorced or ended a long-term relationship reported using drugs (especially alcohol) to "escape" or "deal with" their feelings of loss or loneliness at that time.

Around five years ago, John's marriage began disintegrating. He began drinking on a daily basis during that time; he recalls "looking forward to some drinks at the end of the day." During this period of time, John describes his drinking as "chronic psychological dependence. I enjoyed coming home and opening a bottle."

Similarly, when Matthew's marriage was failing, he would "drink bourbon every night; it would numb me." And George believed that he had turned to marijuana to escape a failing relationship: "I could construct my own little world and crawl into it."

Thus, the use of drugs to escape the angst of stressful relationships is not restricted to drug addicts but appears to be characteristic of these drug users as well. However, there was one highly significant exception to this pattern. Brian, a binge drinker, *stopped* consuming alcohol in response to the early deaths of his father and uncle due to alcoholism. Contemplating the negative consequences of drinking on his own life and the early deaths of two loved ones, he observed, "This is insane," and abandoned alcohol completely. The ability to distance oneself from one's dependence on an addictive substance and make a judgment that continued compulsive consumption is detrimental to one's life seems to be an important factor distinguishing addicted drug users from nonaddicted users. Hoch and Loewenstein (1991, p. 500) term such coping strategies *willpower:* "Willpower, in this context, can be viewed as the efforts of the far-sighted self to constrain the behavior of the myopic self." Consumers who use drugs but who do not become full-fledged addicts appear to be able to halt their compulsive behavior before it becomes out of control and unmanageable.

This line of reasoning was supported by comments from the consumer researcher who was a long-term drug user:

"I would add the fear of being out of control as a deterrent to addiction for some drug users. I speak here from my experience of fearing that the world was falling apart when I did drugs and that I needed as much to escape them as the world itself. I feared losing control completely and falling from the middle class into chaos. Thus, even though in the late sixties and early seventies I took to the streets and took copious amounts of drugs, my 'boundary' was always set somewhere within range of the middle class so I could recover or as I put it, 'I could fall back into the middle class.' "

The nonaddicted users also seemed to be somewhat more skillful in devising self-control strategies (Hoch and Loewenstein 1991) for abandoning drug use once they judged it to be destructive. As one reviewer commented, these users appeared to have access to a greater variety of constructive self-control behaviors, perhaps learned from family and friends. They might also have benefited from a stronger network of social support in constructing and maintaining boundaries on their drug use. John, for example, got past his nicotine cravings by breaking small objects—thus venting his frustrations and diverting his attention—until the cravings subsided. Others ate food, chewed on pretzel sticks or gum, or devised "desensitization regimens" (Matthew) for themselves. Others simply stopped purchasing the substance they had been dependent on after discovering that "if it's not here, I won't use it." These strategies were quite similar to those described by Rook and Hoch (1985, p. 26) in their study of impulse purchasers: "People have developed broad repertoires for maintaining self-control. . . . The most commonly mentioned means of impulse control involves reasoning with oneself, i.e., increasing the saliency of the negative consequences."

However, for some of the long-term, nonaddicted drug users, their perceived ability to control their consumption voluntarily may be somewhat illusory. Some recognize that they are simply switching from one drug to another. George, for example, believes he is currently substituting wine for his "usual" dependence on marijuana. The increased alcohol consumption has caused him to gain weight and suffer severe hangovers, so he is contemplating using marijuana again, reasoning that its side effects are less damaging.

In my own case, since giving up stimulants and alcohol, I have found myself "cheating at the margins." Despite a medical ban on all caffeine products, I began "allowing myself" one teabag a day about a month after I left the hospital. Three years later, I still restrict myself to the one teabag but cheat by supplementing it with chocolate (which contains a stimulant) and "half-cups" of tea at work. I also maintain a chocolate "stash" in the house. The obviously compulsive nature of these consumption behaviors closely resembles Brian's reported binging on "chocolate, Mexican food, and Jello pudding cups." Thus, as will be argued in the closing discussion, it is possible to get addicts away from one or more drugs; however, it is extremely difficult to get them away from their own internal compulsions.

EMERGENT THEMES AND NONADDICTED DRUG USERS

In contrast to the phenomenological evidence supporting the two a priori propositions for the nonaddicted-drug-user group, there was less support for the five themes that emerged from the interviews with the addicted consumers. First, none of the nonaddicted drug users reported engaging in criminal activities to support their consumption, in contrast to the prevalence of this behavior among interviewed addicts.[6] Further, the narratives contained no descriptions of deceptive behaviors (e.g., lying to friends, stealing from family members).

Second, none of the nonaddicted drug users reported thoughts or attempts of suicide. This contrasted with the interviews conducted with some addicted consumers, who did contemplate or attempt to commit suicide. The nonaddicted consumers interviewed did not seem as emotionally desperate or as deeply dissatisfied with

[6]Some nonaddicted consumers did, of course, commit crimes in *purchasing* controlled substances.

their lives as did many of the drug addicts to whom I spoke. Although it is impossible to make a firm conclusion based on the evidence collected, my own sense is that many of the addicted consumers suffered from more far-reaching emotional problems than the nonaddicted consumers did *prior to* their initial use of addictive substances. Their heavier dependence on these substances coupled with initially higher levels of emotional instability may have led a greater number to think or act in a self-destructive fashion.

Providing some support for this interpretation is the fact that only one of the six nonaddicted drug users (Brian) reported growing up in a dysfunctional family. Both of Brian's parents and several of his relatives were drinkers and cigarette smokers; this, he believed, contributed to his own adoption of these substances as a teenager. Further, Brian reported experiencing emotional conflict with his father. However, none of the others in this category mentioned family problems or conflicts or the presence of addictive behavior among family members. In light of this, it appears plausible that one explanation for nonaddicted drug users' ability to "better manage" their compulsive consumption is a higher level of emotional stability and greater feelings of self-worth, which enable them to better detect and control the destructive effects of drugs on their lives.

Nonaddicted drug users did, however, report evidence supporting the presence of boundaries in their compulsive consumption, in congruence with addicted users. In one striking instance of this, Brian reported that both he and his wife have stopped smoking cigarettes in their house. Brian no longer smokes cigarettes (although he is chewing Nicorette gum); his wife continues to smoke but now confines her consumption to the porch so as not to contaminate their house. This is an example of a spatial boundary. Other nonaddicted users had constructed time and occasion boundaries that demarcated their drug consumption. John, for example, now limits his alcohol consumption to "one beer on Friday night with friends." Thus, he has created both time (Friday night) and occasion (social) boundaries around his usage, which help him control consumption. John's alcohol and marijuana use in college followed a similar bounded pattern: When he felt he could afford to take a break from his studies, he would drink or smoke for four days straight and then "dry out": "I would plan for it, set a time for it, do it, and then come out of it." Similarly, Matthew limits his consumption of cocaine to "holidays [spent] in a resort area with friends." Thus, his boundaries for use of this substance include a special context (holiday), a social occasion (with friends), and a special place (a resort).

Boundaries are constructed by addicts and nonaddicts alike to help them control their drug usage, to demarcate portions of their lives that are considered off-limits. When these boundaries are violated by the drug user, there is often an intense sense of being out of control (see Rook and Hoch 1985, Faber et al. 1987, and O'Guinn and Faber 1989 for discussions of this phenomenon with regard to impulsive and compulsive purchasing). Among recovering addicts, this is experienced phenomenologically as a relapse, that is, a return to earlier patterns of drug consumption that one has come to see as unmanageable and destructive. Analogously, the nonaddicted drug users to whom I spoke, although not viewing such instances as a formal relapse, did express concern over their perceived inability to enforce desired boundaries on their drug usage.

George, for example, is concerned about his inability to control his increasing nightly consumption of wine, to which he had switched in order to curtail his use of marijuana. Brian, chewing Nicorette gum to manage his craving for tobacco, recently borrowed two cigarettes and smoked them. He was "frightened" when he discovered the experience was so intensely pleasurable. His fear is derived from the recognition that he has crossed the boundary into active use again and is afraid that the positive reinforcement received from violating his own boundary may draw him back once again to full-time smoking. As Hoch and Loewenstein (1991, p. 498) observe, he is in conflict between primary-process thinking that seeks immediate gratification at all costs and secondary-process thinking that is logical and willing to postpone gratification in order to achieve long-run goals (e.g., self-preservation).

However, their concerns over loss of control do not appear to be as serious or as damaging to self as those of the addicted consumers to whom I talked. Recall the excerpts presented from the cases of Edward, David, Sunny, and Mike. Edward was unable to control his drug and sex compulsions even though he knew he was under police surveillance and would inevitably be arrested. David sold his wedding ring twice to obtain money for crack cocaine. Sunny broke self-set boundary after boundary until she was finally arrested on drug charges. Mike did not seriously consider controlling his drug addiction until confronted with losing custody of his daughter.

These patterns suggest that "true" or genuine addiction to a substance or behavior can perhaps be differentiated from long-term compulsive use of those same substances or behaviors by the consumer's (in)ability to establish and maintain some self-controlled boundaries on his/her consumption. Compulsive, but nonaddicted, consumers engage in consumption patterns that are potentially addictive and yet are able to stop—or at least control—themselves before accruing major negative consequences. Addicted consumers engage in compulsive consumption and—despite recognizing and realizing its damaging effects on themselves and others they care about—are unable to stop. Edward's words to the police the night of his arrest are poignant testimony to this loss of control: "I knew you were going to 'pop' me. I *knew* it was coming!" and yet he had been unable to control his compulsion to use.

THE CONSCIOUSNESS OF ADDICTION

At the outset of the discussion of addiction, three questions were posed: What does it feel like to be an addict? How does one become an addict? How do addicts differ from nonaddicted consumers of drugs and alcohol? The latter two of these questions have been addressed in the foregoing discussion, and it is to a consideration of the first that we now turn. Several of the addicts to whom I spoke described their thoughts and behaviors as being extreme, and, indeed, addictive consumption is consumer behavior in extremis, that is, beyond the confines of normal, everyday consumption. Addicts experience life at the edges of emotion and rational thought. They may even occasionally (or often, in some cases) cross over that amorphous boundary that separates sane from insane thought and action. Several recovering addicts that I interviewed described their lives during active addiction as "crazy," "nuts," and "unbelievable." They reported looking back at selves that seemed almost unrecognizable in their current sober or drug-free state. Yet when they had been there, it had seemed, if not normal, at least rational and necessary given the existential circumstances in which they had perceived themselves.

Thus, the consciousness of addiction must be viewed both from outside and inside. From the outside, the recovering addict can comprehend that the experiential state of his/her active addiction was "insane"; that is, it was disordered, illogical, fragmented, destructive, and nonsensical. Yet, it is one of the great ironies of addiction that when one is immersed within it, it appears to be ordered, logical, coherent, productive, and highly sensible. What active addicts construct for themselves is, in essence, the illusion of an orderly life, the illusion of self-management and self-control, and the illusion of self-identity. Inside this self-constructed world, everything makes sense; but from the outside it is seen as insane.

Actor Val Kilmer, preparing to play the role of addict/alcoholic Jim Morrison in the film *The Doors,* immersed himself in every aspect of Morrison's life. His goal was to comprehend what life was like on the inside of Morrison's mind. One night he had a dream in which Morrison came and spoke to him: "He and I were just talking, just having a chat. Then all of a sudden his head turned, and I could see his brain, the water in his brain. I could see the booze, and he became a dumb, sad drunk. I got a glimpse inside his head at the moment of his transition from an erudite scholar and a gentleman . . . into a lunatic wacko" (Ressner 1991, p. 38). What Kilmer accurately glimpsed was the disintegration of self due to addiction. Or as Drew Barrymore (1990, p. 153) writes of her own experience with cocaine, "Coke allowed me to soar above my depression and sadness. What I couldn't see is that eventually it makes you go crazy."

In the subsequent discussion I will describe the construction and deconstruction of self within addiction. The discussion will be grounded with the seven themes developed from interpreting the phenomenology of addiction (i.e., dysfunctional families, boundaries, crime and deception of others, relapse, suicide, simultaneous/serial addictions, and role transition and personal crises).

Constructing and Deconstructing the Self within Addiction: Origins of the Inauthentic Identity

As noted earlier, addicts commonly originate in dysfunctional families. The genetic, social modeling, and even subcultural models of addiction etiology may all be operative here. However, the key factor from a phenomenological perspective is that, within such families, children typically construct self-identities that are incomplete, inadequate, or inauthentic in various ways. In physically or emotionally abusive families, the child will construct a self that is capable of rapid personality shifts in response to the parents' unpredictable, and often violent, mood swings. Barrymore (1990, p. 121), for example, describes her childhood this way: "Our house seemed so quiet and empty and lonely. My mom was off working and my [alcoholic] dad was out of his mind. One time a friend asked why my father didn't live at home. 'Because,' I said, 'when he's here he beats the living daylights out of us.' " Addicts I spoke to mentioned being unable to manage their addicted parents' behavior and emotions (e.g., "I just never knew what kind of mood Dad was going to be in at night"), so they learned instead to carefully manage and control their own behavior and emotions.

Analogously, in homes where parental love was premised on the child's successful performance of parental demands, the child soon learned to suppress his/her own needs, feelings, and desires and to substitute those required by the parent. As Dukakis (1990, p. 61) writes, "I looked up the word 'perfection' in the dictionary, and among the synonyms are flawlessness, superiority, excellence, precision, and purity. . . . Those are all the qualities my mother expected of me." In both cases, the child learns to create a boundary between the self and his/her genuine feelings. Feelings, especially anger, come to be viewed as dangerous because they can lead to violent reprisal by an addicted parent or to rejection by a demanding, controlling one.

Thus the addict's early, childhood self is already one that is emotionally inadequate and whose identity is false—an inauthentic self. As the child grows, s/he is likely to come into contact with substances, such as alcohol and other drugs, that can help provide positive, albeit temporary, feelings of comfort and security. Further, unlike the mercurial moods of parents, siblings, and friends, the results drugs provide are predictable and available whenever needed. Even in the absence of

drugs and alcohol, the child may find escape to a more comfortable self possible through other means. Recall Sunny's excessive television watching, candy eating, and shoplifting in response to her feelings of isolation and alienation as a child. Over time the inadequate and inauthentic self may pass through a series of such external props in search of completeness and respite. For some consumers, a collection of such props may be necessary to get through a single day, and a pattern of serial and/or simultaneous addictions becomes established.

Although addictive consumption provides much needed positive reinforcement and a safe haven from destructive emotions such as anger, fear, and loneliness, it causes the consumer to construct a mental-emotional environment that is disconnected from external reality. Within this insulated and isolated world, the inauthentic self prospers and evolves. Here life, if not uniformly happy, at least seems manageable and under control. Information from the outside world is carefully filtered and transformed to fit with the internally constructed reality. Major discrepancies are ignored, if possible, or met with anger and hostile denial.

What outsiders to this internal world do not understand is that its maintenance is perceived as absolutely vital to the addicted consumer, for it is the only place where s/he feels real and genuinely alive. The great, tragic irony, of course, is that the place where the self has retreated to escape from its perceived inadequacy and inauthenticity in external life is also inadequate and inauthentic. It is a self that has obtained management and control by wrapping itself around something not-self—a drug, a drink, a card game, food, sex, work. Thus, the self-*without*-the-addiction is not authentic, because it never grew to wholeness within the originating family. The self-*within*-the-addiction is not authentic because it was constructed disconnected from the external world. It exists only as a coconstituted reality between the self and the addiction. Given this existential state of affairs, it is little wonder that addicts will resort to crime and the deception of others (including even their friends and family) to maintain their addiction, for without the addiction they believe they are nothing.

"I was dependent on those pills. I was addicted to them. For twenty-six years I had taken them and everything I had accomplished I attributed to the chemicals ruling my body. I felt that without them none of these achievements would have been possible. . . . As a result, I had led what was in effect a double life" (Dukakis 1990, p. 13).

Addicts, therefore, are at the extreme reaches of current consumer behavior conceptualizations of possessions and the self. Bergadaà (1990, p. 292), for example, observes that "individuals are thus motivated in the search for their own identity through the objects that surround them." Addicts differ from the presumably normal persons she studied in that her informants appeared to have established a stable sense of identity *prior to* acquiring a particular product. The product was then chosen to enable the consumer to better express or communicate a sense of self to others (or even to oneself). With addicts, however, the addictive substance or behavior is used to *create* and *maintain* a stable sense of self. In its absence, the individual disintegrates and experiences a loss of identity.

Similarly, Belk (1988) presents a well-reasoned set of arguments proposing that consumers extend their identities and sense of self by incorporating larger numbers and types of products within a sense of personal possession or control. For addicts, however, as the addiction progresses the self becomes more and more narrowly confined and defined by its relationship to the addictive substance or behavior. As Julie (w, 23) stated at the outset of this article, "[Drugs] were the focal point of my whole life. They were all I thought about." And as Dukakis (1990, p. 11) writes, "My whole being was concentrated on that glass [of vodka] . . . this moment became the focal point of my day."

Self-Control and the Out-of-Control Self

In their insightful analysis of married women's everyday consumer experiences, Thompson et al. (1990, p. 355) develop an interpretation of the phenomenological theme of being in control/being out of control, one aspect of which is completeness: "Completeness seems to be one ground for the experience of being in control: Completeness is *organized, bounded,* and *known,* whereas incompleteness is experienced as *disorganized, unbounded,* and at best *only partially known*" (italics added). For their informants there were both positive and negative aspects of seeking completeness and control in their lives. This is because for these consumers (again, presumably normal) too much control over their consumption "needed" to be relieved by excursions into an out-of-control state. Similarly, too-severe deviations into impulsive, out-of-control consumption prompted them to rebound back into comfortable routines and buying patterns. Normal consumers, such as these, phenomenologically experience moderate swings from being in control to being out of control and back again. These swings, because they can be appropriately monitored and responded to, create a feeling of diversity-within-sameness that is comfortable and comforting to most people. Their lives are balanced between feelings of completeness and incompleteness—the warp and woof of the life experience.

However, for addicted consumers, the lack of an authentic self-identity and sense of inner stability creates an unbalanced momentum that can swing them radically from one extreme of rigid self-control to the other extreme of free-fall, self-less chaos. These swings were most commonly reported by those I interviewed during stressful role transitions (e.g., marriage, divorce, new job, job loss) that directly affected their sense of self-identity. New and difficult role requirements can confront the addict with the need to construct new facets

to his/her identity. For an identity that is largely being "faked" in the external world anyway, this can create enormous pressures to retreat further into the safe, known, internal world of the addiction.

After her husband's unsuccessful run for the presidency, Kitty Dukakis became an alcoholic binge drinker and was admitted to a sanitarium for treatment: "The psychiatrist told me I was like a piece of camouflage without any understanding of who I was behind the mask. . . . I lived in fear that if people found the real me, they wouldn't like her" (1990, p. 299). Recall David's reporting of his relapse into active crack use the night of his wedding. Confronted with the social requirement to act now as a responsible, mature husband, David swung instead to the opposite extreme of selfish, immature (but experientially safe and comfortable) crack consumption. There was no middle ground for him to stand on, because—unlike most consumers—David, an addict, had no centered sense of self.

The retreat of the addict into his/her internal world of oneness with the addiction often comes at a great cost to his/her connections to the external world. Family members, friends, co-workers, and colleagues become increasingly exasperated over what appears to them (and essentially is) a boundary between themselves and the addict. They perceive that the addict is emotionally distant and isolated from them, and they are correct. They perceive that the addict is more deeply committed to the object of his/her addiction than to them, and often they are right. With good intentions, they may knock on the door of his/her consciousness from time to time and ask to be let in, but often their knocks go unanswered.

Andrew (w, m, 26) reported an incident that happened in high school. He was in his darkened room with the lights off (it was midday on Saturday) and the shades drawn. He was listening to a heavy metal band at full blast and was high on grass. He saw a shadowy figure tapping at his window but did not remove his headphones or get up from his bed to see who it was. After a while the figure went away. That night when he finally emerged from his room for food, his mother asked, "Did you have a good time talking to Jeff [his best friend]? It was nice of him to come by to see you this afternoon."

After a while, the knocks usually go away. The outside world becomes a more and more distant place, rarely glimpsed or attended to. Recall David's words:

"I would live in crack houses for a week at a time. It was just filth and dirt there, but I was comfortable with it. I used to like to sleep, but I found cocaine was better. I used to like to eat, but I found cocaine was better."

And compare them with those of a 56-year-old affluent white woman: "Vodka was my drink of choice, but I had no true allegiance. When the vodka ran out, I switched to gin. And when the gin disappeared, I turned to scotch, then to bourbon, without skipping a beat. When the vodka, gin, scotch, and bourbon were gone, I drank brandy. It didn't matter what I was drinking as long as I got the desired effect—oblivion. I was gone" (Dukakis 1990, p. 247).

As the addiction progresses, the physical pain increases and the emotional estrangement both from others and from oneself intensifies. Connections to the outside world become very tenuous or collapse completely. A thought dawns in the addict's consciousness: I have no life *with* drugs; I have no life *without* drugs, I have *no life.* And suicide—fantasized, planned, masked, or actualized becomes a meaningful option. Of a suicide attempt at age 11, Barrymore wrote, "My depressions were more frequent and deeper than ever before, and getting loaded [with alcohol] was the only way I could rise above those depths. . . . I had an awful fight with my mother. . . . I sat down [with] a bottle of extra strength aspirin. . . . I was meditating on the possibility of death. Suicide. . . . Just to close my eyes and be done with the suffering. . . . Death seemed so peaceful. All those pills. I wondered how fast I could get them down" (Barrymore 1990, p. 128).

Experientially, what does suicide represent to addicted consumers? Is it viewed as an ending, a choice, an escape, a solution? Among the addicts to whom I spoke, as well as in other accounts (e.g., Barrymore 1990; Dukakis 1990), suicide was most often viewed as an escape from unendurable emotional pain and/or as a solution (the ultimate, final solution) to the disintegration of self. In the passage above, for example, Barrymore perceives the possibility of purposeful overdosing on aspirin as an ending to emotional suffering that seems unendurable. Typically, as an addict, she chooses a drug as her means of accomplishing this goal. Recall Bill's story about purposefully overdosing on heroin in response to severe emotional trauma. In both these cases, the suicide choice was consciously deliberated.

In other instances, however, suicide attempts by addicts may be perceived by themselves as desperate "cries for help" designed not to end their lives but rather to signal to those in the external world that they cannot continue to live unless given immediate emotional support. In a later suicide attempt (at age 14), Barrymore called a close friend to her house and then slit her wrists with a knife as the friend watched. The friend immediately rushed her to a drug treatment center. As Barrymore (1990, p. 291) observes of her actions, "I didn't want to kill myself. . . . I [wanted] Edie to hear my cry for help and to convince her I needed professional attention . . . fast." Prior to this, Barrymore had been in therapy for drug addiction for an extended period of time and had made substantial progress in reconnecting herself to her feelings and to other people. Her suicide attempt was stimulated in part by a relapse that she had not reported and that had eroded her self-esteem. In this case, the suicide attempt was a drastic, but emotionally healthier, act than her first attempt because it was used as a communication device to signal the "outside world."

Dukakis (1990) reports two binges that were viewed as suicide attempts by her family and drug counselors but that she denies were intended to take her life. In the first, she drank rubbing alcohol (unaware it was poisonous) after being unable to locate any ethyl alcohol in the house. However, in later binges, she consumed not only mouthwash (which is ethyl alcohol), but also hairspray ("I just pulled off the spray top and gulped the ingredients," p. 304) and nail-polish remover. Both of these products contain no alcohol and are labeled as poisons. Dukakis states, however, that she was not intending to kill herself, only attempting to achieve "oblivion." In this instance, the internal denial patterns of the addicted consumer are evident. From the outside, one can clearly see that to drink poisons is to attempt to kill oneself, yet from the inside the intended result is oblivion and not death.

Dukakis's second binge appears analogous to the behavior of the heroin addict I interviewed who reported being "in places he could be killed at any moment" and not caring. They each represent an indifference to the consequences of addiction on one's life and the acceptance (and perhaps hidden desire) at some level of consciousness of the possibility of one's death. In essence, the desperate need to achieve oblivion is given higher priority than staying alive.

A different state of consciousness is represented by the alcoholic's reported crashing of his car into a tree on two consecutive Christmases, the crack addict's fantasy-plans to take flying lessons so he could crash a plane into a mountain, and my own suicidal daydreams about "accidentally" running a red light and being hit by a large truck. The alcoholic's crashes and my daydream have in common their "accidental" nature. By having purposeful accidents we could solve our problem of a life out of control by letting external natural forces cause death, instead of consciously, actively doing it ourselves. In this, we resemble the young cocaine addict's reporting of making drug buys in dangerous areas knowing/hoping that he may be killed in the process. As he observed, "I wanted to die, I just didn't have the balls to do it myself."

The crack addict's fantasy about crashing an airplane into a mountain and my car wreck daydream share their internally generated, imaginary nature. Seeking relief from what were perceived as overwhelming problems, we both created internal scenarios that effectively "ended it all"; that is, if I could just crash that plane, if I could just get hit by that truck, then it would all be over. Very revealingly, my own fantasy had two possible outcomes. In one I was hit by the truck and killed instantly. No pain, no thought. In the second outcome, I was hit by the truck and my arms and legs were broken (i.e., I was completely incapacitated). I would be taken to the hospital for a year, where I would lie in bed, be fed, cared for, and watch television. I viewed this as very good because I was guiltlessly freed of all my overwhelming responsibilities—no work, no laundry, no cooking, no cleaning, no teaching, no being the perfect wife, mother, daughter, researcher, and so on. To me the truck represented a way out of a life that had become completely unmanageable but that I felt powerless to do anything about.

CONCLUDING COMMENTS

The preceding analysis has examined the phenomenology of drug consumption among addicted and nonaddicted consumers. For those personally unfamiliar with the consciousness of addiction, it is hoped that the interpretation provided of these consumers' lives and thoughts has stimulated understanding in a *Verstehen* sense (Gadamer 1975). For those who daily confront their own struggles with addictive and compulsive consumption, it is hoped that a common bond has been communicated and, perhaps, a pathway opened toward recognition and recovery.

The interpretations offered in the present inquiry are necessarily limited in scope, breadth, and context not only by the characteristics of the persons who contributed to the study but also by the very nature of the phenomenon itself. Addiction and compulsive consumption are states of being that are not fully comprehensible even to those persons who are directly experiencing them. So powerful and often so overwhelming are their demands on individual consciousness that they may elude direct introspective attempts to consider them rationally or, at times, even to recognize their full influence on one's life.

The present inquiry sought testimony from persons whose minds and lives have been controlled for various periods of time and with varying degrees of depth by addiction. Depending on their present capability to observe (and not just participate in) their addiction, and to communicate their understanding of its nature, they can provide us with a sense of what it is like to be there. Similarly, my ability to translate their experiences into a gestalt portrayal of the consciousness of addiction is shaped, as well, by the level of insight that I have obtained (or that still eludes me) in seeking to comprehend my own addictions. Perhaps the greatest irony of addiction is that when you are immersed within it, you can *feel it* but *not see it.* Once you emerge from addiction, you can *see it* but *not feel it*—at least (thankfully) not feel it with the intensity you once did. Thus, the interpretations presented here are based on the contents of consciousnesses arrayed at different levels of seeing and feeling the phenomenon of addiction. Interviews with addicted and compulsive consumers at different stages of immersion or recovery would very probably provide additional insights to those offered here and are greatly encouraged.

At present, there are no known cures for addictive consumption, but there are viable remedies, such as learning self-control strategies, rehabilitative counseling, support groups, and 12-step programs, which may

help the addicted consumer come to grips with his/her compulsions (for detailed discussions of these see Brister and Brister 1987, pp. 275–286; Hoch and Loewenstein 1991, pp. 499–504; Peele 1985, pp. 142–158; Pittel 1985). At the heart of each of these remedies is an emphasis on rebuilding and reintegrating those emotional aspects of the consumer that have been damaged or underdeveloped. Most of the addicted consumers to whom I spoke, regardless of physical appearance, age, gender, race, or socioeconomic status, did not like themselves. Several reported feelings of never being "good enough" or feeling unworthy and inadequate. Some, as in the case study of Edward, despite financial and career success, have been "trying to destroy themselves" virtually their entire lives.

Because the roots of addictive consumption often lie in personal feelings of inadequacy and inauthenticity, and not in chemical dependencies per se, they cannot be remedied by merely removing the addict from his/her compulsion, whether it be cocaine, alcohol, or purchasing. Addicted consumers appear to have in common an emotional vacancy that they are compelled to fill with *something.* If one substance or behavior is denied to them, they will simply seek out another. What addicts seek most is to escape themselves, their own minds, and their own thoughts. They find it very painful to inhabit their own consciousness. Thus, virtually any substance or activity that will alter, numb, or erase that consciousness becomes acceptable, if their preferred drug of choice is unavailable.

Viewed in this way, it becomes apparent that all possible drugs cannot be removed from the addicted consumer. Addicts are remarkably resourceful in obtaining more. What must be done, instead, is to repair the emotional hole in the addict's psyche. This takes time, and perhaps even more important, it takes people committed to helping addicted consumers understand the sources of their feelings of inauthenticity and to help them work toward self-acceptance. Consumer research directed toward enhancing and supporting that quest would be not only extremely rewarding for the addicted consumers whose lives it would greatly improve, but likely quite personally satisfying for the researcher as well.

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