City Research Online

City, University of London Institutional Repository

Citation: Corcoran, P. (2008). An exploratory study of the social representations of heroin and heroin users. (Unpublished Doctoral thesis, City University London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: https://openaccess.city.ac.uk/id/eprint/19635/

Link to published version:

Copyright: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

Reuse: Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

City Research Online: http://openaccess.city.ac.uk/ publications@city.ac.uk

An exploratory study of the social representations of heroin and heroin users.

Paula Corcoran

Department of Psychology

A thesis submitted in partial fulfilment of the requirements of City University for the degree of Doctor of Philosophy

August 2008

IMAGING SERVICES NORTH
Boston Spa, Wetherby
West Yorkshire, LS23 7BQ
www.bl.uk

THE FOLLOWING HAVE BEEN REDACTED AT THE REQUEST OF THE UNIVERSITY

PHOTOS ON PAGES 68,69,70,71,273,274,275,276

Table of Contents

Chapter 1 From the sublime to the grime **1**

1.1	The aim of the thesis	1
1.2	A short review of the history of opium	4
1.3	Opium as a medicine	6
1.4	The role of the medical profession	7
1.5	The war on drugs	9
1.6	The impact of the links with crime	11
1.7	A changing society	13
1.8	Heroin: the poor man's drug	14
1.9	AIDS, the eighties and the stigmatised image	17
1.10	The social image of the heroin user	21
1.11	A different perspective of heroin	24
1.12	Treatment options in the UK today	28
1.13	Conclusions	31

Chapter 2 Heroin use: a matter of common sense **33**

2.1	Introduction	33
2.2	Attribution theory	33
2.3	Research on attribution theory	38
2.4	Biases and other problems with attribution theory	40
2.5	How much information is actively processed?	42
2.6	From attribution theory to social representations theory	42
2.7	The social representations approach	46
2.8	Forming social representations	50
2.9	Social representations and heroin use	55
2.10	Social representations and the media	56
2.11	Social representations and health psychology	58
2.12	Conclusions	62

Chapter 3 Comparing heroin use to other behaviours. **65**

3.1	Introduction	65
3.2	Design and procedure	65
3.3	Method of data analysis	75
3.4	The main themes of heroin and heroin users	81
3.4.1	The impact of heroin	81
3.4.2	Control	87
3.4.3	Perceptions of heroin users	96
3.5	Looking at heroin comparatively	99
3.6	Conclusions	104

Chapter 4 Media analysis of heroin use **107**

4.1 Introduction 107
4.2 The media sources 107
4.3 Method of data analysis 110
4.4 Police Review **112**
4.4.1 Crime 112
4.4.2 Demand reduction 115
4.4.3 The legalisation debate 119
4.4.4 The heroin users' environment 122
4.5 British Medical Journal **124**
4.5.1 Death 125
4.5.2 Perceptions 129
4.5.3 Impact 132
4.6 Newspapers **133**
4.6.1 Perceptions 134
4.6.2 The legalisation debate 141
4.7 Similarities and differences across themes 144
4.7.1 Perceptions of heroin users and the heroin users' environment 144
4.7.2 Distinctions between the heroin user and the dealer 147
4.7.3 Prescribing and demand reduction 148
4.7.4 The legalisation debate 149
4.8 Conclusions 149

Chapter 5 Individual perceptions of heroin users **151**

5.1 Introduction 151
5.2 Design and procedure 151
5.2.1 The vignette – *Billy* 152
5.3 Method of data analysis 159
5.4 The semi-structured interviews 161
5.4.1 Death 162
5.4.2 Control 164
5.4.3 Stigma 169
5.4.4 The heroin users' environment 171
5.6 Summary of interview findings 175
5.7 *Billy* – a vignette 176
5.7.1 Invisibility 176
5.7.2 Control 178
5.7.3 Death 181
5.7.4 Stigma 183
5.7.5 Perceptions 187
5.8 Heroin and associations with other drugs 189
5.9 Participants discussion of *Billy* and their own experiences 195
5.10 Conclusions 199

Chapter 6 Social representations of a heroin user 201

6.1 Introduction 201
6.2 The impact of heroin 202
6.3 The nature of heroin users 205
6.4 The heroin arena 207
6.5 The legal status of heroin 210
6.6 Analysing and searching for social representations 211
6.7 Social representations of heroin 214
6.8 Heroin as addictive 215
6.8.1 Loss of control 216
6.8.2 The nature of heroin users 217
6.8.3 The impact of heroin 219
6.9 Heroin as bad 220
6.9.1 The heroin user as threatening 220
6.9.2 Undesirable behaviours 221
6.10 The heroin user as a threat and helpless 222
6.11 Anchoring and objectivity 225
6.12 Conclusions 229

Chapter 7 "At least I don't use heroin" 231

7.1 Introduction 231
7.2 Attributions as part of the social representations process 233
7.3 From attributions to social representations 236
7.4 Health and 'the Other' in western cultures 239
7.5 Looking into the heroin arena 243
7.6 Health, responsibility and control 247
7.7 Implications for policies and treatment options 250
7.8 Impact on drug campaigns 253
7.9 Conclusions 255

References 258

Appendices 270

A Standardised instructions for focus groups in study one 270
B Questionnaire for the participants in study one 271
C Consent form for participants in study one 272
D The pilot study from study one 273
E The coding frame for study one 278
F A list of the articles from Police Review 281
G A list of the articles from BMJ 283
H A list of the newspaper articles 285
I The coding frame for the 40 Police Review articles in study two 287

J	The coding frame for the 40 BMJ articles in study two	289
K	The coding frame for the 40 newspaper articles in study two	290
L	Semi-structured interview schedule for Study Three	291
M	Questionnaire for the interviewees in study three	292
N	Consent form for interviewees in study three	293
O	Coding frame for the interview data in study three	294
P	Coding frame for the interview discussion of *Billy* in study three	296
Q	A table of themes for the super theme, the impact of heroin	298
R	A table of themes for the super theme, the nature of heroin users	299
S	A table of themes for the super theme the heroin arena	300
T	A table of themes for the super theme, the legal status of heroin	301

List of Tables

1.1	Estimated numbers of 16 to 59 year olds who have taken Drugs in their lifetime, in the last year and in the last month (taken from BCS, 2005/0, p. 11).	3
1.2	Definitions of Tier 1 to Tier 4 interventions (NTA, 2006, p. 20-23).	29
1.3	The three main settings for inpatient treatment (NTA, 2006)	30
2.1	Markova's (1982) Cartesian and Hegelian frameworks	48
3.1	Reported alcohol, tobacco and illicit drug use of male participants.	72
3.2	Reported alcohol, tobacco and illicit drug use of female participants.	73
3.3	An example of a coding frame from study one	78
3.4	Estimated no. of deaths per year, from obesity, alcohol tobacco and heroin and morphine	79
3.5	Distribution of money (in millions) for health benefits allocated to four categories from study one	80
3.6	Summary of attributions for all four categories in study one	105
4.1	An example of a coding frame for all four categories in study one	111
5.1	An example of a coding frame	152
5.2	Demographic details of interviewees by occupation, age and ethnic origin	156
5.3	Reported alcohol, tobacco and illicit drug use of female interviewees	157
5.4	Reported alcohol, tobacco and illicit drug use of male interviewees	157
5.5	An example of a coding frame from the semi-structured interviews	161
6.1	A summary of all the theme across the three studies	201

List of Figures

1.1	Poster of health campaign 'Heroin screws you up'	12
3.1	A picture of a man smoking a cigarette	68
3.2	A picture of a man about to inject his arm	69
3.3.1	A picture of an obese man sleeping in a chair	70
3.4	A picture of an old man sitting on a bench with dirty clothes and two empty bottles of wine	71
3.5	A picture of small children from the pilot study	273
3.6	A picture of a pregnant lady from the pilot study	274
3.7	A picture of a lady in a wheelchair from the pilot study	275
3.8	A picture of an elderly man smiling from the pilot study	276

Acknowledgements

I would like to thank my supervisor, David Marks, for his support and encouragement throughout this process. Thank you for your feedback and insights on my work and your enthusiasm for a controversial topic. I would like to thank James Hampton for stepping in at the last minute, during David's absence and for all his feedback and support. I would like to thank the Department of Psychology, City University, for the opportunity to do this thesis. I would like to thank all my Phd peers in the Psychology Department for all the fun and academic support, particularly Kate Nicholls who was my 'wing-girl throughout. Thank you Kate for being a true friend and a real support. I would like to thank the psychology department academics for all their valuable feedback and critical thoughts at the annual presentations.

I would like to thank my family for all their never ending support and encouragement and for never losing faith in me. I thank my mother (Kathleen Corcoran) for all her financial assistance and moral support and encouragement. I would like to thank all my dear friends who were a part of this journey and stuck by me all the way. I would like to thank Jane and Billy for making their home, my home. I would also like to thank Sarah for the music and all the adventures we have had. I would like to thank my husband, Peter Maclatchy for all of his love and support and encouragement and for never wavering in his belief in me.

I would like to thank all the participants who took part in this research, giving up their time freely and willingly to help me out. Lastly, I would like to thank all the clients I have worked with in the past seven years, who struggled with heroin addiction but who showed courage and determination.

This thesis is dedicated to all of you.

I grant powers of discretion to the University Librarian to allow the thesis to be copied in whole or in part without further reference to the author. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Abstract

The aim of this PhD was to explore the social representations of heroin and heroin users. There are an estimated 300, 000 heroin addicts in the UK today (NTA, 2008) and despite the normalisation of other illicit drugs (Parker, Aldridge & Measham, 1998) this group remains marginalised and stigmatised in comparison to other recreational drug users. Social representations (Moscovici, 1984) are formed through social interaction and these shared representations allow individuals to make sense of their social reality, providing a basis of references with which to guide their relations to the world. Therefore a social representations approach was used in order to gain a greater understanding of how this group is perceived within society today.

Three studies were conducted in this research using focus groups, a media analysis and semi-structured interviews. These studies provided the corpus of data which was analysed using a content and thematic analysis (Joffe & Yardley, 2004). Two core social representations emerged from the data set and these were the social representations of heroin as addictive and heroin as bad. I found that participants distanced themselves from heroin users and distinguished between their own recreational drug use and the behaviours of heroin users. The role of control and responsibility were important dimensions in this process and a lack of control was feared by most participants. The social representations showed that this drug remains distinct from other recreational drugs and the heroin user was perceived as an addict, a criminal and a patient at the same time. Implications for anti-drug campaigns and treatment approaches were considered.

Abbreviations

AA	Alcoholics Anonymous
ANOVA	Analysis of variance
BMJ	British Medical Journal
CARAT	Counselling, assessment, referral, advice and through-care services
DAAT	Drug and Alcohol Action Teams
DIP	Drug Intervention Programme
DTTO	Drug Testing and Treatment Orders
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitory System
NTA	National Treatment Agency
OA	Overeaters Anonymous
PCT	Primary Care Trust
PTB	Pooled Treatment Budget
RSA	The Royal Society for the encouragement of Arts, Manufactures & Commerce.
SHA	Strategic Health Authorities
SRA	[A] Social Representations Approach

In memory of John Corcoran

Preface

Before I began this thesis I took some time to address my own attitudes to heroin and heroin users. I am aware of the illegal status of heroin and of some of the behaviours that are associated with heroin use. I have, however, in the course of my personal career developed empathy for the clients I have worked with. It is important therefore to explain my background, working with this client group, and to acknowledge how it may have influenced my attitudes. As a teenager in the eighties I remember the media headline stories that associated intravenous heroin use with AIDS. There were also stories about heroin users dying of overdose, images of skinny young addicts with bad skin and dark haunted eyes. This was my first knowledge of heroin and heroin users and at the time I was scared not only of heroin but the people who used heroin.

I was a big Thin Lizzy fan and it came as a shock when the lead singer, Phil Lynott died at a young age. The media attributed it to his heroin use and suddenly it became clear to me as a young person that heroin addiction could lead to death. Therefore, I knew it was a drug to be avoided. I didn't have much experience with drugs myself. There was cannabis in my circle of friends and this was perceived as something you do for a laugh. It was not serious. I knew some of my other friends used ecstasy at weekends but this was not something that interested me.

I began volunteering in a drop-in service, The Blenheim Project, in Portobello road several years ago. It was just before I began this thesis. At this point in my life I had not known anyone who had taken heroin and I myself had never tried heroin either. I wanted to do this research because my primary interest was in marginalised groups. However, I believed in order to research the field I wanted to have some first hand experience.

I was nervous when I began this voluntary work, for the primary reason that I did not know much about heroin use. I was concerned that some of the clients would think I was a fraud. For me, it was like entering a new and mythical world. I was meeting people I had only read about in the papers. These were the people you were told to stay away from when you were growing up, for fear they would

corrupt you. I spent two years volunteering (2 shifts a week) at The Blenheim Project and in that time I felt my whole perspective on heroin users began to change. I learnt about the trials and tribulations of using heroin and watched as week after week I saw people struggle with their plight. We had supervision and in house training but my greatest learning came from listening to the clients themselves who shared their experiences in a humbling way.

I began to work for an agency who placed me in drug and alcohol projects. This work was part time but I began to grow in my knowledge and confidence and found that this was a group of people I really enjoyed working with. I eventually took a job working in a rehabilitation centre in Lewisham and facilitated weekly groups. I was struck by the humbling efforts these clients had to make on a daily basis to stop themselves going out in the community to use drugs. I was also struck however by the levels of low self esteem and fear that I saw in front of me every day. These young people were very aware of how their families and communities perceived them and this hung heavily on their shoulders. It soon became part of my work to try to help these clients overcome their shame and to rebuild their fragile self esteem.

For the past two years I have worked for a Housing Association, managing a unit for chaotic heroin users who were street homeless. These clients are still using drugs whilst they reside on the unit. My focus, with the help of a dedicated team, is to provide interventions that will reduce the risks of drug use and seek to motivate clients to consider detox and treatment services. I have found the work challenging and rewarding. In the past year I have also been appointed manager of a small aftercare project for clients leaving rehabilitation services. The focus of this work is to support these clients to reintegrate fully into the community and to remain abstinent.

Working with these clients has enabled me to get a closer look at this social problem and to see for myself the day to day struggle that some of these drug users face. The problems that these clients face are not just the addiction but the complex world they live in, social problems, lack of self esteem, lack of education and training but most of all, lack of empathy from an unforgiving society. These

clients face prejudice on a daily basis and sometimes this means they will avoid accessing medical or legal support for fear of how they will be perceived. I am still interested in this client group because they are a marginalised group. My work has taught me however that heroin users are human beings too and there really is nothing to fear.

Chapter one: From the sublime to the grime

1.1 The aim of the thesis

The aim of this thesis was to explore the social representations of heroin in society today. A particular objective was to explore why heroin has become so detached from other illicit drugs that are used recreationally? Illicit drug use is prolific within society today despite years of government health warnings. Although heroin is still used by only a small percentage of the UK population, an estimated 250-300, 000 persons, they are accredited and blamed for a large percentage of petty crime (Tackling Drugs Changing Lives, 2008). In the 1980s government health campaigns focused on heroin with the 'Heroin Screws You Up' campaigns. In the 1990s, however, the focus shifted to ecstasy with new government health warnings. In the last ten years heroin use has risen again. My aim was to explore knowledge of heroin within a random sample of the population, using focus groups and semi-structured interviews. The media are a primary influence on social representations (Farr, 1993) and for this reason I conducted a media analysis. Finally I focused on the implications of the social representations that emerged from this research.

In this chapter I intend to briefly describe opiate use throughout the centuries and the subsequent emergence of heroin, initially as a medicine and subsequently as a recreational drug. I will explore the history of heroin use in the UK paying particular attention to associations with negative imagery and stereotypes. I will attempt to trace the shift in opinions about heroin and attitudes towards heroin users in the last century, exploring the circumstances that have led to current opinions

about heroin users. Finally, I will focus on current UK drug policy and treatment options and consider their implications for the contemporary heroin user.

It is difficult to get a clear picture of the number of heroin users in the UK today. Polydrug use is more common amongst young people (Parker, Aldridge & Measham, 1998) and regional variations will have an impact on any attempts to arrive at a national estimate. In the late 1960s there were approximately 3,000 known addicts in the UK. It was in this decade that conversation surrounding drug taking began to concentrate on it as a growing social problem (Bean, 1974). It was not until the 1980s that heroin became, or was perceived as becoming, a large social problem for many large cities in the UK (Pearson, 1987). By 1986, the national prevalence estimate had risen sharply to a possible 100,000 heroin users (Robertson, 1987). The number of estimated heroin addicts in the UK today is believed, by some sources, to be 300, 000 (NTA, 2008) although this figure is not represented in table 1.1 below.

One of the most thorough studies of adolescent drug practice was carried out by Parker et al. (1998). They conducted a five-year survey into young peoples' drug-taking habits in the north-west of England. From interviews and survey research they developed a normalisation thesis. They found in their research that some drugs (cannabis, but also nitrites, amphetamines, LSD and ecstasy) were so pervasive and accepted, that their use was accepted by users and non-users as a normal part of their everyday social structure. The research of Parker et al. (1998) concluded that social conceptions of drug use had changed rapidly in the 1990s. The rise in drug-taking during this period had resulted in a 'pick 'n mix' attitude

towards drugs (Parker & Measham, 1994). Table 1.1 shows that the use of heroin is higher than glues and anabolic steroids only. All other recreational drugs in this table far exceed the use of these three with cannabis being the most frequently used drug followed by 'any cocaine'.

	User Ever	Used last year	Used last month
Drug			
Class A			
Any Cocaine	2,310,000	776,000	376,000
Cocaine powder	2,273,000	769,000	368,000
Crack cocaine	270,000	53,000	25,000
Ecstasy	2,279,000	502,000	216,000
Hallucinogens	2,968,000	338,000	84,000
LDS	1,733,000	83,000	25,000
Magic Mushrooms	2,311,000	302,000	68,000
Opiates	272,000	47,000	35,000
Heroin	203,000	39,000	23,000
Methadone	149,000	33,000	24,000
Class A/B			
Amphetamines	3,655,000	426,000	176,000
Class B/C			
Tranquillisers	868,000	118,000	64,000
Class C			
Anabolic steroids	194,000	42,000	20,000
Cannabis	9,475,000	2,775,000	1,644,000
Not Classified			
Amyl Nitrite	2,661,000	397,000	179,000
Glues	751,000	30,000	11,000
Total			
Class A	**4,416,000**	**1,082,000**	**513,000**
Any Drug	**11,075,000**	**3,329,000**	**1,990,000**

Table 1.1 Estimated numbers of 16 to 59 year olds who have taken drugs in their lifetime, in Last year and in the last month, (taken from Drug Misuse Declared, 2006 p.11)

Notes:

1. Estimates are derived by multiplying the prevalence rate by the estimated population aged 16 to 59 in England and Wales.
2. The figures are calculated using population estimates provided by the Government Actuarial Service.

Despite the normalisation theory and the comfortable co-existence of non-users and users, for many young people heroin is still seen as a 'hard drug' and not something they would wish to try. In their studies Parker et al. (1998) found that most young people see "taking hard drugs and actually injecting as anathema: a Rubicon they will never cross" (p. 132). Popular beliefs about heroin are that it is highly addictive and intrinsically linked to a life of crime (Robins, Compton, & Horton, 2000). Perhaps more dramatically, many still see heroin use as "the major, if not greatest social evil of our times" (Robertson, 1987, p.43). Why then has heroin become so detached from other illicit drugs?

1.2 A short review of the history of opium

In the midst of the current moral and legal debates about heroin it is easy to forget that opiates, which are drugs like heroin derived from the opium poppy, have been in use for centuries. In Galen's time opiates were allegedly used to cure such ailments as vertigo, epilepsy, and even deafness (Scott, 1969). It was also used as a medicine amongst the Ancient Greeks with Hippocrates referring to the opium poppy as a narcotic painkiller and Aristotle referring to it as a hypnotic (Levinson, 2002). By the 7th or 8th century AD the opium poppy was commonly used in Chinese medicine.

Use in China became widespread and this caused great concern to the Emperor and the authorities. The East India Company imported most of the opium for the Chinese market from India. This was a British company and they became the main opium suppliers to China using the opium grown in conquered lands from India. The British government benefited greatly from the tax revenues from this

transaction. In an attempt to stop widespread opiate use in China the Chinese authorities introduced harsh laws but these were not affective. So in 1839 they seized opium from British ships in Canton and spilled it all into the sea. The British sent in troops to retaliate and the Chinese authorities were obliged to back down (Berridge, 1996).

A similar incident in 1856 led to the second 'Opium War' and this resulted in the British navy shelling Canton and consequently opening up other ports. As a result the opium trade increased again with an estimated 15 million Chinese becoming regular opium smokers. The Chinese authorities changed their approach and made opium legal and also began to grow their own poppies. Within a few decades Chinese opium production was greater than the Indian supplies and eventually British sales and influence in China declined. Ironically, China eventually became a main supplier for opium use in Europe in the twentieth century (Levinson, 2002)

It was the ramifications of drug-use in the Far East that eventually contributed to global controls. The US wanted to increase its economic importance within China but also there was pressure from American missionaries within China and the Philippines whose motives were mainly moral (Berridge, 1996). Afghanistan is now accredited with supplying 80% of heroin to Europe. Since the war began following 9/11 in the USA, Afghanistan has experienced an increasing economic crisis for the general population. A farmer will now make more money growing opium than other legal crops such as wheat or maize. One focus of the current war has been the destruction of the opium poppy fields by the British and American troops which is ironic given the earlier opium wars of the 1800s.

1.3. Opium as a medicine

Opium was used in the UK (and the rest of Europe) in medicines from the 1550s and by the 17th century drugs like laudanum – a mixture of opium and alcohol – were used for all sorts of ailments including pain, insomnia, coughs, diarrhoea, period pains and for toothache and colic in babies (Berridge, 1999). This trend continued well into the 19th century with the availability of many opium-based medicines bought from grocery stores and use of opium by many famous writers and poets, such as Coleridge and De Quincey. Throughout much of the 19th century elixirs and patent medicines that were liberally laced with opiates were also on sale in most general stores in the USA (Conrad & Schneider, 1992). Grave concerns began to develop, however, as there was an augmentation in the number of deaths caused by opium overdose and this saw the emergence of the first controls on sales of opium in 1868 (Berridge, 1996).

Historical sources suggest that morphine was first synthesised from opium in 1806 by a German chemist, Frederich Sertürner, and was advertised as a new wonder medicine that was non-addictive and could even be used for the treatment of opium dependence (Parrott, Morinana, Moss, & Shcoley, 2004). About 1850, the hypodermic syringe came into use and at that time people believed that smoking opium rather than injecting opiates led to dependence. Thousands of soldiers in the American Civil War came home addicted to morphine given to them to ease the pain of their injuries. Although many people in the USA were addicted to medical opiates, all the press attention was focused on the Chinese community and the evil Fu Manchu image of the Chinese community became a standard racist stereotype in

both the USA and Britain. In 1874, again in Germany, heroin was first made from morphine and yet again it was advertised as non-addictive. Heroin was now being promoted as a substitute for morphine which was now believed to be addictive.

1.4 The role of the medical profession

The second half of the twentieth century saw the medical establishment form itself into a body of increasing authority and power, moving from a loose confederation of orthodox opinion to a powerful lobby which extended its influence into the statutory and legal arenas, to the point where it became enshrined to an unprecedented extent in the fabric of Western government. There were many dimensions to this increase in medical power and influence, but none were more ambitious, or successful, than its gradual transformation of opium from a popular folk remedy into a controlled substance and, eventually, a professional monopoly (Berridge, 1984).

Until the 1860s there was not and never had been such a thing as 'controlled substance'. Broadly speaking, anyone could sell anything to anyone else and make whatever claims for it they wished. But the notion was developing that, as public health policies around hygiene and disease began to take effect, the supply of some substances, such as poisons, should be brought under a tighter rein. Different interested parties presented various suggestions as to how this should be done. The recently formed associations of doctors – the British Medical Association and the General Medical Council – made the case that the supply of poisons was a medical matter and one which should be brought under their aegis.

But they faced competition from the ambitious and newly formed association of chemists, the Pharmaceutical Society, keen to impress on government and public alike that pharmacy was a skilled and responsible profession which could effectively control and regulate the supply of opium by taking it out of the hands of all its other suppliers and turning it over to the new breed of retail specialists. The 1868 Pharmacy Act marked both the successes of the pharmaceutical lobby and the first legal step towards controlling the supply of opium. It stipulated that anyone buying any of a list of poisons such as arsenic, cyanide or prussic acid, a list to which opium was promptly appended, was obliged to do so from a registered chemist, who in turn was obliged to record their name, the date and the quantity purchased. The effect of this was slight, although it increased public confidence in the safeguards around opium use, and led to a modest reduction in the number of deaths by poisoning.

There has been an enduring tension in British national drug policy between medical or legal forms of control. Home Office activities in the 1920s were concerned with eradicating addiction completely. However the 1926 Rolleston report, which was modelled on the 1914 Harrison Act of the USA, defined addiction absolutely as a disease that required medical treatment. The report also legitimised maintenance prescribing of morphine and heroin to addicts who could not otherwise function (Berridge, 1984). Despite this report doctors still had to work within the law and possession of heroin was still a criminal offence. What Rolleston signified, however, was a reconciliation between legal and medical approaches. The balancing act between medical and legal approaches has shaped drug policy in the

UK ever since. It is a balance that can shift over time as was seen in the AIDS crisis of the 1980s.

The 'disease model of addiction' is the lasting legacy of this otherwise largely ignored episode in medical science. The enduring belief that opiate use is a 'deviant' pleasure survives in today's official discourse, particularly terms like 'drug abusers' and 'drug misuse' which still have the hybrid qualities of clinical diagnosis and moral judgement. The progress of the controls against opium contributed to the preservation of the opinions of the medical profession in law. This meant that someone caught with controlled opiate drugs was either a criminal or a patient, depending largely on expert medical opinion.

This type of power developed in other areas at around the same time, for example, the institution of a criminal insanity plea between 'guilty' and 'not guilty', was also at the discretion of medical opinion. It was an extraordinary accomplishment for a professional body which had barely existed fifty years before to become a significant constitutional authority in areas of judgement which were, then as now, by no means easy to distinguish from matters of opinion and intellectual fashion.

1.5 The war on drugs

There are many who argue that the war on drugs was a political crusade created by Nixon and his supporters (O'Toole, 1999; Elwood, 1994). A campaign of this sort provided a problem, i.e. a war on heroin, in which the president could become a hero in the eyes of the voters. Ronald Reagan adopted the same campaign in the mid-eighties as did his successor George Bush Snr. and it proved to be a public

relations winner for both presidents, probably most remembered for Nancy Reagan's 'Just Say No' campaign. A declaration of war on drugs was clear proof to the electorate of the presidents' commitment to a domestic agenda, a definite vote winner.

It was the American press that finally launched its own attack on the use of the war metaphor which it deemed inappropriate for understanding something as complex as a national drug problem. The argument against this metaphor was that in order to wage a war you must expect someone to be a winner. Bush himself eventually conceded that this was something that would probably not happen in his lifetime (Elwood, 1994). The war metaphor persists today in the public imagination, however, mainly due to the lack of a suitable replacement. One of the main impacts of this metaphor was the public perception of drug users and the drug problem. It turned what many saw as a health and social problem into a law-and-order problem instead. (O'Toole, 1999).

It is also crucial to consider the impact of the rhetoric of Reagan and Bush's campaigns and the media commentary at that time. Much of the debate and political commentary concentrated on the link between drugs and crime thus creating the image of the drug user as a menace or threat to mainstream society. Ivie (1974) pointed out that the rhetoric of the war on drugs has typically included the image of a threatening other. The political advantage of this is to provide the electorate with specific enemies that political leaders volunteer to defend the country from. The problem of creating 'the Other' is central to this thesis, and it raises questions of how reformed users can be accepted back into society when they

are no longer involved in heroin use. Falco (cited in Elwood, 1994) argued that "once we make drug addicts into the enemy, society has a tough time taking them back in" (p.131).

1.6 The impact of the links with crime

There are many groups within society today that can be described as 'tentative groups' because they are held together predominantly by a particular mindset. Health is a good example of this. Smoking is one issue which has clearly defined in-groups and out-groups. Obesity versus healthy eating is another. Physical appearances or behaviours are strong indicators in both of these examples. The eighties brought about the existence of many stereotypical images of heroin users, mainly from the governments health campaigns such as figure 1.1 below. These images focused mainly on the appearance of the heroin user and introduced the association with weight loss.

Despite the changes in the working practice of most service providers in the eighties with the onset of AIDS (see section 1.9) the Government was unwilling to review the 1971 Misuse of Drugs Act. Despite the new approach to minimise the harm associated with drug use this Act means many users won't present themselves for treatment due to the fear of legal repercussions. There were also repercussions for young people who were normally law abiding except for the occasional or weekend use of recreational drugs. If they were caught it would lead to a criminal conviction and they would then hold a criminal record. This could then have serious implications for a young person's job opportunities, and perhaps totally limit their choice of career.

Fig. 1.1 Poster from the government campaign 'Heroin Screws you Up'.

New measures in drug policy in the late 1990s saw a shift in focus from health issues to legal issues. This period saw the introduction of mandatory drug testing in prisons (Criminal Justice and Public Order Act, 1994) and DTTOs that offered the choice between imprisonment or compulsory rehabilitation treatment monitored by regular urine tests and court reviews (Crime and Disorder Act, 1998). It was also in the late nineties that a minimum of seven years imprisonment for any third offence of Class 'A' drug trafficking was recommended (Crime Sentences Act, 1997).

The introduction of preventative policies and schemes and punishments for those who are caught using illegal drugs have made little or no impression on the use of illegal drugs in the UK. In fact there is evidence to suggest that illegal drug use is now considered to be a 'normal' recreational activity by a whole generation of young people (Parker et al., 1998)

1.7 A changing society

Young (1999) examined the effects the changing job market in the 1970s and 1980s had on society in his examination of *The Exclusive Society*. He argued that, "the market forces which transformed the sphere of production and consumption relentlessly challenged our notions of material certainty and uncontested values, replacing them with a world of risk and uncertainty; of individual choice and pluralism and of deep-seated precariousness, both economic and ontological" (p.1). Hobsbawm (1994) saw this shift from modernity to late modernity, following the cultural revolution of the 1960s and 1970s, as the onset of the rise of individualism and he argues that this brought a wide scale deconstruction of accepted values. Everything which had seemed certain at the time, family, work and economic security, was now coated in an aura of ambiguity. Young (1999) pointed out that, "for the same market forces which have made precarious our identity and unsure our future have generated a constant rise in our expectations of citizenship and, most importantly, have engendered a widespread sense of demands frustrated and desires unmet" (p.1).

Baumann (2001) too explored the precariousness of the late modern experience, examining the allure of instant gratification in the absence of long-term security. Modern consumerism is designed to provide short-term gratification to consumers and thus creates an atmosphere of constant need. If we chart the change in the music industry from vinyl records to music tapes to CDs and now to Ipods and MP3 players, we can see how clever marketing also creates the belief that nothing lasts forever but everything is replaceable. Baumann (2001) believed that in the face of this insecurity it would seem logical to grab pleasurable opportunities where presented as there seems no guarantee of what the future holds. He argued that "a world saturated with uncertainty, and lives sliced into the short-lived episodes required to bring instant gratification, aid and abet, support and reinforce each other" (p.158).

1.8 Heroin: the poor man's drug

Parker et al. (1998) posit that heroin uptake is usually associated with poverty, educational under-achievement and unemployment and surmise that "the least worst scenario is that heroin 'trying' does not become accommodated within the far larger 'recreational' drugs scene but remains predominantly associated with 'degrees' of social exclusion. The whole issue needs careful monitoring and profiling" (p. 45-46). According to Parker et al. (1998) it is in the poorest estates that heroin uptake is primarily found. This would suggest that it is more than availability that is causing the rise in current heroin users. In order to understand the latest outbreak it is crucial to understand the individual factors that contribute to its use and to understand the individual in their social environment.

If we perceive heroin as a drug that exists amongst the poorest members of our community then it could be viewed as a 'painkiller of the poor'. MacDonald and Marsh (2002), looking at the rise of heroin use amongst the poorest members of Northeast England, concluded that "it is not too difficult to understand heroin's appeal *in this context* as a poverty drug; a form of self medication for the socially excluded, a drug that they find compelling because its pharmacological effects 'blank out' the day to day realities of their social exclusion" (P. 36). Goldberg (1999) in his attempt to *Demystify Drugs* concurred that "much of what I have observed in the field can be best explained by the attempts of problematic consumers to escape – escape from the past, from the present, from society, from their feelings, from everything that passes through their heads, and from not having any future" (p. 133).

So whilst there is research to show that contemporary heroin use is often associated with the underclass and most socially excluded of our society, others manage to exist in the same social environment and remain abstinent from all illicit drugs (MacDonald et al, 2002). Clearly it is not one factor alone that contributes to heroin addiction but the combination of many factors that makes up the user's individual biography. These findings merely serve as a reminder of the importance of understanding heroin use in context and the dangers of stereotyping all heroin users with the same characteristics. This merely leads to misunderstanding and possibly hampers the possibility of providing the correct help and support.

It is important to note that problematic drug-use and addiction problems do not evolve in isolation but are often linked to psychological, social or environmental

factors such as poverty, social exclusion and co-morbid psychological problems (Gossop, Marsden, Stewart & Treacy, 2002). Further problems can emerge for those who are addicted to illegal drugs, such as, criminal involvement, social exclusion and alienation. In this thesis I am interested in exploring the effects these factors have on the participants' perceptions of heroin addicts and what impact, if any, these may have. Meyers and Miller (2001) advocated educational and employment-related services for treatment programmes in order to help ex-users tackle urgent and immediate problems in their social environment.

Many societal changes occurred in the 1980s which many believe contributed to this new outbreak of heroin use in the eighties. The end of the 1970s also saw changes in global trafficking patterns which meant a greater availability in cheap heroin coming into Britain from South East Asia (RSA 2007). There was widespread unemployment throughout the country due to a period of de-industrialisation. Jobs were no longer guaranteed, particularly for the semi-skilled or un-skilled and this led to social and economic marginalisation for a whole generation (Hutton, 1995). The Conservative Government ignored the impact of these changes in the employment market and chose to blame the victim instead (Buchanan & Young, 2000).

As well as all the societal changes of the eighties, there was also a greater availability of cheap heroin on the streets and thus all the ingredients were in place for a rising drug problem which spread through many inner cities. Margaret Thatcher, the UK Prime Minister of the time, looked to the US and her close political ally, Ronald Reagan, and adopted a similar approach to the growing UK

drug problem. Echoing the 'Just Say No' campaign of the US, Thatcher launched her own campaign which centred around the slogan 'Heroin Screws You Up' (see fig. 1.1). However, many believe that the underlying message of both campaigns was that heroin users threatened the fabric of society and one of the enemies in the War on Drugs was the drug addict himself (Buchanan & Young, 2000). However, things were about to change in a way that could not have been foreseen and were to change the way drug workers and other professionals worked with intravenous heroin users forever.

1.9 AIDS, the eighties and the stigmatised image

AIDS has become synonymous with deviant persons and excessive behaviours and is most strongly associated with gay men and intravenous drugs users, namely heroin users (Crawford, 1994). The first cases presenting with AIDS in 1981 were identified among a group of homosexual men who had a history of sexually transmitted diseases due to a promiscuous lifestyle. Soon other cases were identified amongst intravenous drug users and haemophiliacs and it became apparent that the form of transmission was through blood. In the eighties the main focus of both the medical profession and the media was on the behaviour patterns of those who had contracted AIDS in order to be certain how exactly transmission occurred.

The media took a particularly moral stance on the subject and called into question the lifestyles of those who had contracted the AIDS virus. Because of the media sensationalism of AIDS public concern grew and a new public threat was

perceived. Headlines such as 'Virus victims swirling in a cesspit of their own making' and Spread of AIDS blamed on degenerate conduct' (Markova & Wilkie, 1987) helped to turn AIDS into a moral issue for all. Markova and Wilkie (1987) argue that it is understandable that in an age of individualism it is accepted that a person somehow deserves punishment for behaviour if it is deemed to be improper by mainstream society.

Crawford's (1994) theories on the self and the unhealthy other show how a post-modern society that is controlled by production and consumerism, differentiates between an ideal healthy way of living and the unhealthy other. According to Crawford the unhealthy other abandons Calvanistic and puritanical ideals and adopts hedonistic behaviour resonant of the swinging sixties. The image of the self-indulgent unproductive heroin addict has also become strongly associated with AIDS. This mark of AIDS and other untold illnesses associated with this lifestyle is a total inscription of otherness, as defined in Crawford's terms.

People who have AIDS face not only health challenges but social stigma as well. Parallels can be drawn between the fear and stigma associated with tuberculosis in the last century (Sontag, 1978) and the public reaction to AIDS today. "Similarly today, AIDS means not only a life-threatening illness for which there is still no cure, but also the very real possibility of public ostracism, stigma and rejection" (Sontag, 1978, p.399). In terms of the heroin user, who may already be socially excluded for their drug of choice, there is further rejection due to the fear of AIDS associated with intravenous heroin use. "Indeed fear of AIDS has become as much

a social reality as the illness itself. This fear, as we shall see later, is translated into a discrimination against the at-risk groups" (Sontag, 1978, p. 399).

Sontag (1978) in her *Illness as Metaphor,* suggested that illness has always been used as a metaphor to support those in favour of the argument that society is corrupt or unjust. She maintains that the use of imagery in discussing disease can be a method of expressing concern for social order. Publicity surrounding AIDS also demonstrates a concern for social order, for maintaining a familiar and comfortable pattern of life. Crawford (1994) also explored the idea of how an 'at-risk' unhealthy individual can have implications for greater society who are striving to be healthy and therefore put off the idea of death as a probability in their lives. He argued that health is vital to survival as being unhealthy can make the possibility of death a bigger issue. It therefore makes sense that those who are healthy need to protect themselves from unhealthy others. Crawford believes that one way to do this is through identity. The more distance one keeps from those who are unhealthy the less chance one has of being touched by contagion. There seems to be even less sympathy for those who are unhealthy due to their own behaviours (Crawford, 1994).

Markova and Wilkie (1987) identified two factors which have a strong effect on the way public representations of AIDS are being formed today, namely, the homosexual community and the media. The gay community is organised and through their efforts to oppose repressive sexual legislation, has managed to forge a more positive identity of their own. The media still has a lot of influence on the formation of representations of AIDS and also on heroin users within the

community. Heroin users get attention in the media and regardless of whether it is intended to be negative or educational, it still interacts with the existing viewpoints of society and contributes to the formation, change and maintenance of the social representations that exist today.

The phenomenon of AIDS has a double impact on health promotion with heroin users. Firstly, it shifted the focus from a zero tolerant approach to one of harm minimisation. This saw the introduction of needle exchange programmes and a new awareness of the need to engage with this drug using group. It also meant, however, that there was a new stigma associated with heroin use. It was no longer just a moral or a legal issue, it was now a serious health issue also and the heroin user became part of the 'threatening other' (Crawford, 1994). AIDS was a key issue in shaping the drug policies of the time and a report on *AIDS and Drug Misuse* states:

> "We have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse".
>
> (Advisory Council on the Misuse of Drugs 1988: 17)

Therefore the Conservative Government of the time was taking a complete zero tolerance approach to drug use, but particularly to heroin use and heroin users. Heroin users were seen as social deviants and this was reinforced by the health promotion images of the eighties which depicted heroin user as abject creatures with multiple health issues. However, the arrival of HIV/AIDS in the mid-eighties led to a complete review of the national response to the drug problem. Heroin users were considered particularly vulnerable due to the preferred method of taking heroin intravenously. Service providers had to adopt a shift in their approach from

a zero tolerance approach to one of harm minimisation. New services such as needle exchange, free condoms and practical health education were made available in an attempt to prevent the spread of HIV/AIDS amongst intravenous heroin users.

1.10 The social image of the heroin user

Jay (2000) discussed the family of opiates, namely heroin, opium and morphine, and recalled that heroin was once a 'medicine' whereas opium was sold by 'Chinese gangsters' (p. 51). He argued that these drugs are not just distinguished due to their chemical differences but there are social and moral implications also. "The drug has one name when it is the servant of progressive clinical practice, used by medical authorities for the treatment of pain, and another when it is being used by lay persons in the community for what some people consider to be their own personal pleasure" (Jay, 2000,p. 52).

In the early decades of the 20th century drug addiction took on a new face, changing from being 'a pathetic condition to a stigmatised one' (Courtwright, Joseph & Des Jarlais, 1989). It is in the last century that heroin, in particular, was being portrayed as a major social evil. The twentieth century has seen laws developed which are designed to limit the availability of drugs in our society and punish those who take part in drug taking which is deemed dangerous to themselves and to society. Contemporary education aims to foster negative attitudes towards drugs in both users and potential users. So what has caused this change in social attitude to both heroin and its users?

In a society where there exists the normalisation of drug use and use is more prevalent than ever before the heroin user serves as a useful image, a negative stereotype of the 'other', in the preservation of an acceptable image of the self. Crawford (1994) described how the identity process works in this way by "protecting or reformulating self boundaries, reinforcing images or reimagening the other – is required of people as they respond to fears of contagion or stigma, as they adopt strategies to protect themselves from implication, that is, symbolic connection to 'infected' others and the negative characteristics ascribed to them" (p. 1348). In this way heroin use is not just a social crisis or a health crisis but a crisis of identity.

Crawford (1994) argued that "the language of health came to signify those middle class persons who were responsible from those who were not, those who were respectable from those who were disreputable, those who were safe from those who were dangerous, and ultimately those who had the right to rule from those who needed supervision, guidance, reform or incarceration" (p. 1349). In this way health is not only a signifier of identity but also a signifier of power.

At the heart of Calvanism lies a fear of disorder (Taylor, 1989). Therefore the social image of the 'hedonistic, unordered' heroin user has Calvanistic roots of thought. One can still see Calvanistic influence in the pursuit of health in today's society which calls for discipline and moderate living. In an age of individualism this responsibility lies with each individual within society. One way to understand the social representation of the heroin user is to understand the representation of the healthy self. The image of heroin addict is at the opposite polarity of what is good

and healthy, in fact it could be seen as a complete negation. Therefore the image of the addict lies in conflict with this ideal image and is its antithesis. The addict is 'the Other', the unhealthy self, the one who breaks the law and doesn't contribute to the economy or society in general. The heroin addict therefore symbolises the complete opposite of what we should aspire to be in modern, middle class society.

Crawford (1994) explored the metaphorical layers of health and their connotations of what it means to be a 'good, respectable and responsible' person. Crawford identified health as the "key organising symbol for the good, moral responsible self" (1994, p. 1347). Other studies have examined the moral components of health (Blaxter, 1997) and identified a new moral phenomenon that is health (Crossley, 2003). In this way identity is sustained by the existence of 'the Other'. As Crawford (1994) states "my point is that stigmatising images of the other are founded in a social self which needs this other" (p. 1348). Therefore an identity of a 'healthy self' is sustained by the existence of an unhealthy other, the image becomes stronger the greater the social distance.

The use of needles amongst a large percentage of heroin users is for some a digression from the 'healthy self' and creates the demarcation between the recreational drug user and 'the Other', namely the heroin addict. One rarely hears someone speak of a heroin user but rather the coined term 'heroin addict' is phrased. This coined term itself reinforces the image of addiction and the negative stereotypes of the heroin user.

1.11 A different perspective of heroin

Pearson (1987) in *The New Heroin Users* attempted to get a true account from heroin users themselves of what the lifestyle entailed. This research introduced a discourse which highlighted the pleasure that can be achieved from using heroin. This is not an aspect of heroin use that is normally studied or reported. Ordinarily one associates heroin and the heroin user with negative images and stereotypes which focus on the negative aspects of this pursuit.

> "It's just the *nicest* drug going, you feel just *great*! Just ... phoo ... blows your mind, like, you start nodding and ...."
>
> (Eddie, 21 years, Merseyside)
>
> **(cited in Pearson, 1987, p. 26)**

Much has been written on the negative features of heroin use and most of the health promotion discourse centres around the stereotype of 'inevitable decline' (Stimson, 1973). Despite this, the number of heroin users in the UK seems to have grown steadily in the last thirty years. This would suggest that there must be some positive features of this lifestyle to attract new recruits (Robertson, 1987). Many researchers have questioned this inevitable decline which is associated with a life of heroin use (Alexander, 1994; Davies, 1992; Robins, Helzer, Heselbrock & Wish, 1980). This decline is attributed mainly to the pharmaceutical properties of heroin itself and the strong hold this drug exerts over the user.

One study by Zinberg (1984) argued the importance of the interaction between drug, set and setting. Zinberg explored the role of personality, situational and social factors in the regulation of heroin use among his cohort of non-treatment

users. Zinbergs' argument was that the psycho-pharmacological effects of any substance, including heroin in this case, occur in conjunction with the set and setting of the individual and one should not be perceived as more influential that another. Blackwell (1983) also investigated controlled heroin use and expounded the importance of personal rules and social norms in the regulation of heroin use.

Shewan and Dalgarno (2005) had two main questions in their research, "(a) that heroin is inevitably addictive, (b) that sufficient exposure to heroin leads ultimately to intensive, prolonged and destructive use characterised by a range of negative health and social outcomes" (p.35). Whilst acknowledging that there is little or no empirical evidence that supports these theories, they conducted a longitudinal study of 126 long-term heroin users. What was significant about this cohort was that they had, at the time of the study, never been in any specialist treatment for their heroin use.

Shewan and Dalgarno's (2005) findings suggest that heroin should not be studied on its pharmacological properties alone and found evidence for controlled heroin use among their sample in Glasgow. The concept of controlled heroin use challenges the pharmacentric model of heroin use, which suggests that the pharmacological effect of the drug will over ride the will of the individual. Some see this as a rhetorical ploy in the demonisation of drugs which are seen "as a form of possession, by an evil substance rather than an evil spirit, with the victim's will mysteriously overpowered by a force outside themselves" (R. Room cited in RSA 2007, p. 33).

In total, what is being questioned here is the level of control the individual has throughout their heroin using careers. Davies (1997) argued that "progress can only be made along this route if the notion of addiction is seen for what it is; namely, a preferred style of explanation whose primary purpose is functional. It removes blame and responsibility in a climate of moral censure" (p. 164). Davies suggested that myths regarding the pharmacological powers of heroin coupled with the legal and moral climate, leads to learned helplessness amongst heroin users and an abdication of control and responsibility. It is a choice between being disliked for your choices or pitied for your plight. Shewan and Dalgarno (2005) argue that "the contribution of psychological factors in addiction is rarely disputed. Regarding these factors as secondary is to neglect what would appear to be a component that is equally as important as drug pharmacology in the addictive process" (p.46).

McSweeney and Turnbull (2007) also explored occasional and controlled heroin use with a cohort of 51 heroin users and a follow-up study of 32 heroin users. They were also interested in exploring the assumption that heroin leads to inevitable dependence and associated problems. They found that their sample contradicted this assumption and identified many factors that enabled their cohorts to avoid total dependence. The cohort identified the "value of being employed, having a partner, focus, direction, support structures and non-heroin-using interests and friends as factors insulating them from the risk of developing problematic or uncontrolled patterns of use" (p. ix).

These findings therefore and those of Shewan and Dalgarno (2005) and Blackwell (1983) would seem to support Zinberg's (1984) arguments about the importance of

the interaction of the drug, the set and the setting. All of these researchers emphasised that they were not disputing the addictive nature of heroin or the devastating effects it has on some peoples lives, they did however posit that their cohorts are a group of heroin users who were previously under researched and discounted.

Shewan and Dalgarno (2005) suggested the term 'unobtrusive heroin use' for the heroin use described by the participants in their study and argue that this should provide the starting base for future research. In fact, McSweeny and Turnbull (2007) argued that "from a policy and practice perspective it is important to examine this subset of users. Understanding how they use heroin can help us to better understand the nature of dependence and it may also identify tactics for helping dependent heroin users gain greater control over their drug use" (p. viii).

The latest government drug policies advocate in favour of drug treatment with the aim of establishing abstinence from all illegal drug use. Harm reduction techniques are encouraged for clients who are not ready to abstain, in an effort to reduce harm to the heroin user and to the public at large. "Funding for drug treatment has increased significantly since 2001 and has received substantial investment in the last five years" (NTA, 2006a). An emphasis has been placed on new initiatives which include 'testing on arrest' for trigger offences. People who test positive for opiate use are encouraged to attend an initial assessment which will steer them into treatment services. For some, this is a further example of the Governments efforts to criminalise the heroin user.

1.12 Treatment options in the UK today

The National Treatment Agency (NTA) is a special health authority, set up in 2001 by the government, and its main focus is to develop the accessibility, capacity and efficacy of treatment for drug misuse in England. The NTA outlines the national strategies for supporting adults with drug addictions (NTA, 2006b) and within this document the national strategies for supporting adults with drugs addictions are set out. Data from the National Drug Treatment Monitoring System (NDTMS) for 2004/05 outlines that 67 per cent of individuals receiving structured drug treatment identified heroin as their primary drug of choice. Some clients reported crack cocaine as their primary drug of choice but 13 per cent of those named heroin as their secondary drug of choice. The document outlines guidelines for best practice in the provision of good quality and effective drug treatment. This is provided through the criminal justice system or the primary care system.

Under the 2005 Drugs Act new practices were introduced which include 'testing on arrest' and 'required assessment' (NTA, 2006b, p.8). Individuals who are arrested for trigger offences will be tested for drugs and offered a drugs assessment which will include treatment choices through the Drug Interventions Programme (DIP). Drug treatment is also offered in prison to inmates who have substance misuse issues. Drug intervention programmes are provided to prison inmates through clinical services, CARAT (counselling, assessment, referral, advice and throughcare services) teams and the provision of rehabilitation programmes. An individual with substance misuse issues can also access support from primary care interventions. Treatment is provided by GPs and primary healthcare teams and

includes practices such as drug screening, provision of general medical services, advice and referral, triage assessments, harm reduction, methadone proscribing and medical monitoring both in the community and in detoxification services and residential rehabilitation (NTA, 2006b).

The NTA works with the local DAAT (Drug and Alcohol Action Teams) to commission appropriate drug services for their boroughs or regions (see Table 1.2). This is based on the four-tier model of commissioning. The national guidelines on Models of care are also based on the four tier model of intervention. A heroin user basically passes through this pathway of intervention if abstinence and a heroin free life is what is desired. What is noticeable in Table 1.2 is the regular use of the term 'specialised' treatments. Heroin users have a problem that needs expert intervention, in this case, medical interventions.

	Definitions
Tier 1	Interventions include provision of drug related information and advice, screening and referral to specialised drug treatment.
Tier 2	Interventions include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.
Tier 3	Interventions include provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialised liaison.
Tier 4	Interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.

Table 1.2 Definitions of Tier 1 to Tier 4 interventions (NTA, 2006, p. 20 – 23).

Many drug treatment services and drug rehabilitation centres in the UK, within the four tier models of care system, adhere to a 12-step drug treatment approach. Alcoholics Anonymous (AA) was the original twelve-stop program and was created by Bill Wilson and Dr. Bob Smith in Ohio, USA in 1935. The twelve-step-program inspired other self help groups such as Overeaters Anonymous (OA) and Narcotics Anonymous (NA) and this approach has become the standard for recovery treatment from an addiction in the USA and increasingly in the UK.

NA stared in 1953 in the USA and the first NA meeting in the UK was held in Chelsea, London in 1980. In the UK there are approximately 770 weekly meetings. These meetings take place in treatment or detox units, young offenders institutes and prisons, hospitals and other venues in the community (NA, 2008). A twelve-step program provides a set of guiding principles that will enable recovery from addiction (See Appendix J). This program has at its core a belief that addiction is a disease and that there is no known medical cure.

1. General hospital psychiatric units
2. Specialist drug misuse inpatient units in hospitals
3. Residential rehabilitation units (as a precursor to the rehabilitation programme).

Table 1.3. The three main settings for inpatient treatment, NTA, 2006, p. 46.

The settings for inpatient treatment for heroin addiction, shown in Table 1.3 and the pathways of support set out in Table 1.2 demonstrate how heroin treatment has become medicalised. Heroin users are 'treated' in 'specialist' settings where they can be 'cured' of their addiction. In the UK treatment for heroin addiction is based

around the fundamental belief that heroin, by nature, is extremely addictive and heroin users have to receive professional treatment in order to be free from their addiction. This belief that the drug is more powerful than human will has seen the creation of a paternalistic approach to the treatment and support offered to heroin users. Their perceived lack of autonomy has led to the belief that heroin users can only be helped through the criminal justice system or 'specialist drug misuse inpatient' services. In this way, heroin users are criminalised and medicalised and these identities are reinforced by the nature of the services that are available to support heroin users.

1.13 Conclusions

It was not my purpose in this thesis to advocate the use of heroin or to decide if using heroin is right or wrong. My aim was to explore the social representations of heroin and heroin users in society. Why has heroin become so distinct from other recreational drugs that are widely used but yet remain illegal? Are heroin users perceived differently from other recreational drug users? How this group are perceived might in some way influence how society deals with this problem. Whilst it would be impossible to ignore that heroin use is a salient legal issue and has serious health connotations also, it would be futile to ignore the social aspects of this issue. "Drugs are a broad social issue, not exclusively a crime issue or a health issue. Just as social exclusion contributes both directly and indirectly to problematic drug use, so problematic drug use is an important component in social exclusion. Drugs should be seen at least partly as an issue for communities to

handle for themselves at the local level. The 'communities' strand of the drug strategy should be revived, rehabilitated and broadened" (RSA, 2007, p. 17).

The corpus of data for this research was sourced from three studies. In chapter three I will present the findings of seven focus groups. The groups were given a social dilemma style task and heroin users were discussed in relation to three other categories, smokers, alcoholics and obesity. In chapter four I present findings from a media analysis. The role of the media's influence in the creation and proliferation of the social representations of heroin will be discussed. Finally, in chapter five I present the findings of semi-structured interviews and the interviewees' reactions to a case study that was designed to challenge the stereotypical image of the heroin user in society today. The social representations in the data and how they emerged will be discussed in chapter six. Finally, the findings and implications of this research will be discussed in chapter seven.

Chapter Two: Heroin use: a matter of common sense

2.1 Introduction

Chapter one introduced the historical background of heroin use in the UK in an attempt to trace the social image of heroin in society today and ascertain how it has become aligned with negative stereotypes. Despite the negative social image of heroin society has seen a proliferation in the number of users and this leaves researchers and health workers asking the question 'why'. Why do an approximate 250, 000 people use heroin in the UK today? Much of the work on attribution theory has concentrated on answering this question 'why'. Why do people behave in certain ways? The aim of this chapter is to explore what attribution theory contributes to our understanding of heroin use and to argue why we need a social representations approach (SRA) to understand heroin use in its wider social and cultural context.

2.2 Attribution theory

The attempts to understand behaviour, our own and the behaviour of others, is reflected in our thoughts and our speech and these are attributions. Attribution theories, therefore, emphasise how people interpret their own and others' actions. Heider (1958) who first put forward this premise, from a social psychological approach, viewed individuals as *naïve scientists* who strive to understand the behaviours of another in order to make the world more predictable. According to attribution theory people seek explanations in their everyday lives, for the behaviours of others, in order to have a greater sense of control over the world.

Central to attribution theory is the causal explanations of lay people although the study of causality did not actually begin in the field of social psychology. Earlier work on this topic can be accredited to Piaget (1930) and his study of the language of causality with children and Michotte (1946) and his studies on perceptual causality through the apparent movement of geometrical shapes. There is a vast amount of social psychological research in the field of Attribution Theory but the main contributors to the concepts and theory are provided by Heider (1958), Jones and Davis (1965) and Kelley (1967). These three theories are the building blocks for theories of causal attribution and shall now be outlined briefly.

Heider's main contribution was to put forward the idea that when a perceiver is evaluating the action of another they make a decision as to whether that action is attributable to something within the person or something outside the person. Heider's (1958) first research on social cognition was concerned with common sense psychology:

> "since common-sense psychology guides our behaviour toward other people, it is an essential part of the phenomena in which we are interested. In everyday life we form ideas about other people and about social situations. We interpret other people's actions and we predict what they will do under certain circumstances. Though these ideas are usually formulated, they often function adequately". (Heider, 1958, p. 5)

Heider was interested in how lay people attribute behaviour and how observable behaviour is often attributed to unobservable causes. Heider's interest in attributions focused mainly on what he called a causal locus. He argued that the result of an action is dependent on two sets of conditions, factors within the person

or factors within the environment. Therefore this process involves making a distinction between 'internal' and 'external' causes for behaviour, which is also known as the person/environment split. Heider also focused on attributions of responsibility which were concerned with who or what was culpable for an action. He posited that people whose actions were seen to be done intentionally were also attributed more personal responsibility for the outcome of those actions. Heider's work also influenced the work of Jones and Davis (1965) and Kelley (1967). His ideas on the analogy between causal analysis and experimental methods greatly influenced Kelley's body of work and Jones and Davis (1965) followed up on his ideas on the importance of intentionality in assessing personal causality.

Jones and Davis (1965) continued Heider's (1958) conception of causality and responsibility attributions by focusing on the importance of intentionality in personal causality. In order to make this judgment the perceiver has to make a decision on the knowledge and ability of the actor. Then once intentionality has been established the observer can make a decision on the personal dispositions of the actor. Therefore the aim of Jones and Davis' (1965) correspondent inference theory was "to construct a theory which systematically accounts for a perceiver's inferences about what an actor was trying to achieve by a particular action" (p.222).

Intrinsic to correspondent inferences are the 'non-common effects', which guide the observer to make their attributions, and also the role of social desirability. The observer takes into account what others would do in the actors' position. All of these factors influence how the observer comes to a decision about the dispositional cause of an intention, that is, was the action intended. One of the primary gains

from a focus on dispositions was an understanding of the importance of intentionality. It was also the work of Jones and Davis (1965) that led to a more systematic analysis of biases in attribution and other social judgments which I will discuss in section 2.4.

Kelley (1967) was interested in how observers arrived at certain causal attributions and in particular what information was used in this process. He drew comparisons with the research methods employed by scientists and thus highlighted the idea of the lay person as 'a lay scientist'. Kelley's theory of covariation stated that "an effect is attributed to a condition that is present when the effect is present, and absent when the effect is absent" (Hewstone, 1983, p. 7). He therefore compared the underlying logic of covariation to the analysis of variance (ANOVA). Studies have found that factors such as consensus, consistency and distinctiveness do affect the way attributions are made (e.g. McArthur, 1972). Consistency refers to whether that person responds in the same way to the same stimulus or similar stimuli at different times. Distinctiveness concerns whether the actor acts in the same way to other, different stimuli, or whether the actor's response distinguishes between different stimuli. Consensus is not a feature across actors in response to the same stimulus, but is a feature of the behaviour of the observed. Consensus asks the question do the observed all respond in the same way to a stimulus or do people vary in their response.

According to Kelley (1972) there are many kinds of causal schemata, ranging from simple to complex, available to lay persons in times when they lack the time or adequate information to make attributions. These schemata are "beliefs concerning

how certain kinds of causes interact to produce a specific kind of effect" (Hewstone, 1983, p. 7). Therefore in the analysis of variance framework these schemata can be conceived as incomplete patterns of data. There are many types of causal schemata available to the lay person, ranging from simple to complex, for example the multiple sufficient cause schema (Kelley, 1972) although Surber (1981) argued that details of how and when schemata are used is unclear.

More recently the work of Weiner (1986, 1995) has contributed further to developments in attribution theory. I am introducing this work as I am interested in the concepts of controllability and its relationship to heroin use. Weiner (1985) established substantial links between attributions and emotions and this influenced his seminal work (Weiner, 1986) in which he made a connection between the ways people infer others' motivations with their subsequent emotional responses to the precipitating event. His second important contribution involved the extension of attribution dimensions. Weiner also identified that locus of causality, whether the cause for an event is assigned to personal agency or to factors in the environment, is an important dimension in attributions of causality (Heider, 1958). But he noted, for example, among the 'internal' causes of attribution that whilst some were stable, others fluctuated.

He identified three dimensions which explained this; stability, controllability and globality. Stability refers to the degree to which a cause is likely to remain constant over time (Jones & Davis, 1965; Kelley, 1967). Controllability is the degree to which a person has the ability to control the cause and is therefore accountable for the outcome and globality is the degree to which the cause underlies a range of

effects or can be generalised across settings. According to Weiner (1986) attributions made along these dimensions lead to future expectations that enable an individual to predict future behaviour.

2.3 Research on attribution theory

There is a wealth of attribution research that is too vast to discuss in any depth in this thesis. Attribution research has made contributions to clinical psychology and mental health research, sport psychology, organisational psychology and the law, to name but a few. Researchers in the field have also focused on such topics as blame and accountability, motivation and leadership. However, as I am interested in heroin and heroin users it is more relevant to focus on research related to addiction. I will therefore briefly discuss the work of Eiser (1986) and Davies (1997)

The most comprehensive work on the attribution of addiction was the contributions of Eiser (1986) who presented valuable research on the reasons smokers gave for smoking. An important conclusion from Eiser's research was that people smoked because they liked to smoke. This motive is rarely given enough consideration in the literature on smoking or in health education. It is notably missing in the literature on heroin use and rarely given any consideration at all by drugs researchers. Eiser offered his own conclusions on the attention health educators need to pay to this feature of smoking:

> "...account must be somehow taken of pleasure smokers derive from smoking itself and of the prime importance of this factor in maintaining their behaviour,

in spite of warnings of dangers to health. Secondly, associating the concept of addiction with cigarette smoking, whatever deterrent effects this may have for the would-be smoker, may well make the existing smoker feel less able to give up…" (cited in Davies, 1997, p.130).

Davies (1997) in his *The Myth of Addiction* argued that current views of addiction are too mechanistic and do not take account of human desires and purposes. He rejects the popular belief that addiction happens to people and is imposed from the outside by the pharmacological properties of the drug. Instead Davies takes the standpoint of functional attributions and puts forward his theory that explanations for drug use are first and foremost, functional. He points out that to argue that a behaviour is within or outside one's control has positive or negative consequences for the individual. These consequences are dependent on the current moral and legal climate of the society concerned. Davies (1997) therefore contends that it makes sense for an individual to argue that the addictive behaviour is outside one's control and therefore avoid negative judgments.

This has great relevance for my research as it suggests that different people will make different attributions depending on whether or not they believe the heroin user is responsible for their heroin abuse. This will also have implications on whether or not a person believes the heroin user is deserving of help. Davies (1997) argued that "the function of the addiction concept, which it holds in common with Jellinek's (1960) definition of alcoholism, is to ensure that something we define as 'bad' is not also seen as done 'on purpose'. This grants permission for us to offer help rather than punishment, but it also recasts the doer of the 'bad' thing in the role of helpless victim" (p. 107). Other research, in the field of

addiction, has focused on the role of control and its affect on judgments of responsibility and therefore judgments of blame (e.g. Haynes & Ayliffe, 1991)

2.4 Biases and other problems in with attribution theory

Despite the wealth of research in the field of attribution theory there are still areas of this theory that remain problematic and have led to more critical research. Firstly there is some question as to how rational the observer is when making causal attributions. Heider (1958) describes man as the 'naïve scientist' and Kelley (1967) posited that the process of making causal attributions was analogous to the ANOVA model. But, as I will discuss in the following paragraphs, there are many studies to show that humans are not like scientists when they make judgments and decisions but are in fact biased and make attribution errors (Hewstone, Stroebe & Stephenson, 1989).

One bias that is researched in this field is the fundamental attribution error (Jones & Harris, 1967) whereby observers seem to attach too much importance to the person being observed and too little to the situation. There are differing views on why this may occur. Rholes and Pryor (1982) posited a 'salience theory', arguing that it depends on the situation and how much of the social circumstances are salient to the observer. Peterson (1980) proposed that there may be a shift in attributions made, after a period of time has passed, whereby the dispositional attributions are stronger than when the attributions were made immediately. Miller (1984) put forward a cultural explanation whilst Semin and Fiedler (1991) drew attention to a

widespread tendency to use abstract language that leads to a bias towards internal dispositions. However, in contrast to these findings, Kulik (1983) found that in certain circumstances people will over attribute a person's behaviour to situational factors when there is an inconsistency with expectations.

Self-serving biases tend to help a person paint themselves in the best light possible. An example would be where a person attributes their success to internal, dispositional factors and failure to external, situational factors. This can serve two purposes, firstly to self enhance by taking credit for success and secondly to self protect by abdicating responsibility for failure. According to Miller and Ross (1975) this self-enhancing bias could be attributed to cognitive factors and therefore be termed a cognitive bias. However, Zuckerman (1979) discussed the need to preserve self-esteem and would therefore be more in favor of calling this a motivational bias. Despite much research there is little consensus on whether or not cognitive or motivational factors play a stronger role in self-serving biases.

From the perspective of a self-serving bias, it is probably better for heroin users to be seen as addicts. It diminishes them of their responsibility and it means they are not bad people and therefore deserving of help. It also means that they have a reason to continue their life-styles as surely they are unable to do anything about it. There is extra pressure from the current trend for the healthy lifestyle. The media and the ever growing health industry are constantly proposing the need for exercise and caffeine free diets and healthy eating options and warning the public how bad smoking and drinking are for you. Everyone needs to be striving to be healthy or needs to justify their lifestyle in some way. Critics have referred to the pro-health

movement as 'health fascism' (Davies, 1991).

2.5 How much information is actively processed?

Critics of attribution research argue that models of common sense attribution, such as the ANOVA model are too complex and lend themselves to errors in social judgment due to the oversimplifying of cognitive heuristics (see Fischoff, 1976; Nisbett & Ross, 1980). One of the major challenges for attribution theory is the question of whether or not humans analyse social cues at all in their day to day social interactions (Harris and Harvey, 1981). Langer (1978) suggests that there is less cognitive processing than attribution theory would suggest and believes that when engaging in everyday activities most humans rely on scripts (Schank & Abelson, 1977) to provide explanations for behaviour.

Other social cognitive researchers prefer to see people as 'cognitive misers' (Taylor, 1981) and argue that attribution theorists have attributed too much mental activity to humans even when they are engaging in mundane activities (Thorngate, 1976, 1979). Therefore the perceiver would take short cuts or use heuristics when making a decision rather than making 'scientific-like' attributions. This can be seen in the 'fundamental attribution error' which is the tendency to give person, rather than situation attributions (Ross, 1977).

2.6 From attribution theory to social representations theory

According to Hewstone (1983) attribution theory is considered the best example in

contemporary social psychology of a Hobbesian approach. This approach views people as rational, though not infallible information processors. Therefore, using a Hobbesian approach, people can make rational decisions and any departures from logic are seen as errors and biases, caused by social and motivational influences. However, there are many researchers who doubt the ability of humans to process social information in an elaborate and accurate manner (See Hewstone, 1983, p.9).

Many critics argue that attribution theory places too much emphasis on what differentiates the actor from other people and neglects shared factors between people and other social factors. Many researchers have been critical that the social beliefs of the observers have been ignored as have the personal investment the observers may have in the experiments (DaGloria & Pages, 1974-75; Deschamps, 1973-74). No attention is paid to an individual's group membership which may influence attributions if they are influenced by group stereotypes. Semin (1980) claimed that the distinction between personal and social causality had led to a disregard for the social context.

If the social beliefs of the observer are ignored then it can be expected that motives for making certain attributions will be ignored also. Hewstone (1983) argued that although there has been a great interest in errors and biases within attribution research, these have been interpreted in cognitive terms and there has been a neglect in most studies of motivational influences. Research in this area might shed light on the possible reasons that observers have for explaining behaviour in a certain way and might show that the objectivity of the attribution process is not as objective as attribution theorist would hope.

Davies (1997) argued that "any satisfactory general theory of attribution has to go beyond the specific semantic content of attributions, since the same attributional explanation can serve different functions in different circumstances; and the same functions can be served by different explanations, again according to circumstance" (p.122-123). One question that needs to be addressed is where do people's attributions come from (Lalljee, 1981). Hewstone (1983) argued that in order to do so, researchers need to look at shared beliefs among people from a wider perspective. I propose that a social representations approach is appropriate for this purpose.

It is necessary to explain why I have chosen social representations theory over attribution theory. Attribution theory has been criticised for being primarily an individualistic theory which has ignored the wider social perspective (Hewstone, 1983). Therefore, Mosovici and Hewstone (1983) posited that social representations provide the fundamental base upon which attributions are built. In other words, whilst an attribution can be limited in specific dimensions of time and context and personal experience, the importance and relevance of the attribution can be derived from a set of wider social belief systems which are influenced by history and culture.

> "A theory of social causality is a theory of our imputations and attributions, associated with a representation ... any causal explanation must be viewed within the context of social representations and is determined thereby"
>
> (Moscovici, 1981, p. 207)

Farr's (1987) discussion of the work of Ichheiser (1949) *Misunderstandings in Human Relations: A study in false social perception* expands Moscovici's arguments further. Farr explained how in this monograph Ichheiser identified with the Durkheimian tradition and explored the collective representation of the individual within chosen Western Cultures. Farr explained that Ichheiser identified a representation of an individual who is responsible for his or her actions. According to Farr (1987) Ichheiser therefore posited that we attribute praise or blame on the basis of the representation of personal responsibility.

Therefore, I was interested only in attributions that were part of the process of the social representations of heroin users in society today. Moscovici (1973) described social representations as "systems of values, ideas and practices with a two-fold function; first, to establish an order which will enable individuals to orientate themselves in their material and social world and to master it; secondly, to enable communication to take place among members of a community by providing them with a code for social exchange ad a code for naming and classifying unambiguously the various aspects of their world and their individual and group history" (p. xiii). I was interested therefore to know the codes for social exchange, the social meanings that society holds for heroin users that allow attributions to be made in the first place.

Although Nisbett and Ross (1980) noted the paucity of research on the social and cultural beliefs in relation to attribution theory, Hewstone (1983) defended the theory by highlighting the attempts made in this field to take interpersonal social contexts into consideration through integrative research (Stryker & Gottlieb, 1981;

Zito & Jacobs, 1979). However, Moscovici and Hewstone (1983) argued that by paying attention to the shared beliefs of people and the role they play in how individuals make causal attributions will "bring attribution theory back to the issue of common-sense psychology and deals with the rather neglected question of *where* attributions come from" (p. 98, italics authors own).

2.7 The social representations approach

A social representations approach (SRA) offers a useful theoretical framework with which to explore the world of heroin use. An SRA approach is concerned with the way members of society construct their social reality and make sense of their world "by anchoring new experiences onto existing knowledge" (Hadley & Stockdale, 1996, p. 233). Many individuals have a 'common sense' view of heroin use that is often influenced by the media, personal prejudice and the culture they belong to (McDermott, 1992). Hadley and Stockdale (1996) argued that "applying a social representations framework to the world of drugs acknowledges the culturally and historically located nature of drugs and drug use, and accepts the importance of everyday ideas about the world in which these exist" (p. 234).

This thesis proposes the need for a social psychological approach that encompasses the participants understanding of heroin in the social environment and also examines the role of the media in the creation of the stereotype of the heroin user in contemporary society. An SRA is adopted and this acknowledges the social context of individuals' experiences and beliefs particularly in relation to local, social, cultural and historical contexts. According to Moscovici (1988) the role of representations is to conventionalise objects, persons and events, to locate them

within a familiar categorical context. Their genesis derives from social communication and fabricates an understanding of the social world, which allows interaction within groups sharing the representation. Social representations range from hegemonic structures that are shared by society to differentiated knowledge structures that are shared by subgroups within a collectivity.

As it stands, social representations theory makes a sharp distinction between science and common sense. Purkhardt (1993) looks at the dominant Cartesian paradigm and opts for the alternative Hegelian paradigm instead, which is applicable to both science and common sense. Descartes, the inventor of the Cartesian approach, established the possibility of acquiring knowledge about the world based on deduction and perception. Therefore in Descartes' system knowledge takes the form of ideas and philosophical investigation of these ideas. Descartes viewed rational knowledge as being "incapable of being destroyed" and his best of example of that is *Cogito ergo sum*, I think therefore I am.

Hegel also took a rationalist approach to knowledge but emphasised the historical character of reason as it unfolds in social, political and cultural contexts. This adds a historical dimension to the ahistorical Cartesian concern for which history was only a *fibula mundi,* a mere story. Hegel set out to reconcile epistemological realism with a socially grounded theory of knowledge. According to Westphal (1989) the Hegelian view of knowledge as a social phenomenon is possible because it is an activity engaged in a naturally structured world. Hegel makes this natural basis clear and therefore avoids subjectivism in the course of developing his social account of empirical knowledge (Westphal, 1989) Markova (1982) outlined the

main distinctions between the Cartesian and Hegelian approach (see Table 2.1)

Cartesian	Hegelian
• Nature of mind is individualistic	• Nature of mind is social
• The mind is static and passive in acquisition of knowledge	• The mind is dynamic and active in the acquisition of knowledge
• Knowledge is acquired through algorithms	• Knowledge is acquired through a circle returning within itself.

Table 2.1 Markova's (1982) Cartesian and Hegelian Frameworks

In this framework Markova (1982) argued that the knower is, for the most part, an isolated individual. Within the Cartesian framework the knower constructs his understanding independently from any social context. His consciousness, therefore, is also separate from the external world, and knowledge comes from intuition and deduction applied to the stimuli which encroach on the rather passive knower from outside. In Markova's (1982) opinion most of these fundamental assumptions of the Cartesian paradigm are misleading.

Markova (1982) posited that these assumptions have placed constraints on psychology, making it unproductive. She believed that a shift of paradigm to a Hegelian framework would be more useful and productive. A shift of this nature would entail recognition of the knower as someone who develops his knowledge inextricably in and with a social context. Within the Hegelian framework the knower's mind is active in the selection and modification of information and in the construction and use of knowledge. Thought can be pragmatic as much as logical and theories can be revised and therefore consciousness can be transformed. Markova (1982) explored the Cartesian notion of fixed universals contrasting this

with the Hegelian view that universals correspond to "concepts that are the product of human evolution" (p. 81) and posited that there are no universal concepts which are ontological entities existing independently of the human mind.

According to social representations theory whilst an objectivist view of reality may be appropriate for the sciences, a different approach is needed for the study of common sense, preferably an approach that discerns the consensual and constructive nature of everyday thought and interaction. Purkhardt (1993) posited that this social perspective is also instrumental in the study of science because like common sense, science is a social activity involving the active participation and collaboration of scientists in their particular cultural and historical contexts. Therefore, Purkhardt's (1993) preference for a Hegelian paradigm over the dominant Cartesian paradigm is relevant to a social representations approach.

It was this very dilemma of what happens when scientific knowledge becomes common knowledge that inspired Moscovici's (1961) study of psychoanalysis and the public's knowledge of it. This study led to the modern study of social representations. Farr (1993) drew a critical distinction between a scientific theory and its corresponding social representation, which relates to the diverging worlds of science and common sense. He posits that a theory is nothing but a representation of reality and when it enters the public domain it becomes a social representation.

Moscovici made the distinction between social representations and science. He aruged that social representations are " a set of concepts and explanations originating in daily life in the course of inter-individual communications. They are

the equivalent, in our society, of the myths and belief systems in traditional societies; they might even be said to be the contemporary version of common sense" (Moscovici, 1981, p.181). Science, in contrast, endeavors to bring to light that which we do not yet know (Farr, 1993). Science can surprise us with discoveries about hidden laws, structures and mechanisms. Social representations lay bare schemas of common sense. They rarely surprise us because they represent a social consensus.

Fahnestock (1986) examined the changes that occur in scientific information as it passes from the scientists to the popularisers of science. Her main interest was what changes actually occur to the information as it travels from one rhetorical situation to the next. This has important implications as it could be argued that media discourse is part of the process by which individuals construct meaning. Indeed, Moscovici saw the media as intermediaries between research scientists and the public (Farr, 1993). If the public are to construct representations of science that are more realistic then it is important that they are informed properly in the first instance.

2.8 Forming social representations

Moscovici (1984) posits that the objective of all representations is to make the unfamiliar, familiar and this is done through two central processes, 'anchoring' and 'objectification'. I shall introduce these processes in this section and discuss them in more detail in chapter six (section 6.11) as they have relevance to understanding how the social representations of heroin and heroin users were formed. 'Anchoring' is a process by which unfamiliar objects are given meaning through

classification and naming by comparing them with existing culturally accessible categories. By making the unfamiliar, familiar in this way we are not only able to recognise it but we are also able to evaluate it, either positively or negatively, and therefore form a social attitude towards it. Moscovici (1984) referred to this classification and naming process as a 'nominalistic tendency' which holds great significance. It is through this process that something new will be located within a society's 'identity matrix' and be subsequently represented.

Objectification' is the process by which abstract concepts are transformed into familiar and concrete images or things through selecting information and integrating it into a coherent structure. Inherent to Moscovici's (1961) research on the diffusion of psychoanalytic concepts throughout sections of French society is the objectification process. Further research (Moscovici & Hewstone, 1983) has examined the proliferation of scientific concepts throughout society paying particular attention to the role of the mass media. Objectification plays an important role enabling laypersons to assimilate scientific knowledge and make it familiar thereby transforming it into an everyday, common sense form of knowledge.

Moscovici and Hewstone (1983) described three ways that new knowledge can be transformed into a social representation; the 'personification of knowledge', 'figuration' and 'ontologising'. The 'personification of knowledge' occurs when an association is formed between a concept or a theory to a particular person, for example, Freud and psychoanalysis, and therefore gives the idea a concrete existence. When an abstract idea is exemplified by a dominant metaphorical image,

thereby making it more accessible or concrete, this is called 'figuration'. A good example of this is when people talk about 'butter mountains' when referring to food surpluses within the European Community. Finally, 'ontologising' is a process whereby conceptual constructs can be given physical properties which can happen with abstract concepts such as the 'mind' or 'neurosis'. Through the use of these three processes, scientific and other highly specialised knowledge can become available to the lay community and become a part of everyday speech or common sense.

Wells (1987) identified two differential theories within Moscovici's work: the 'phenomenal theory' and the 'meta-theory'. As detailed above, the phenomenal theory alludes to the phenomena of social representations that are socially and culturally conditioned ways of understanding everyday reality. This also includes the process that results in these representations, namely anchoring and objectification. The meta-theory drew attention to Moscovici's assertions that there are two distinct and disparate forms of reality: the 'reified' and the 'consensual universes', or alternatively, the world of science and the world of common sense.

Essentially, the 'reified universe' is the world of experts and scientists and reality is scrutinised objectively and subject to experimentation. The 'consensual universe', however, is where lay persons make sense of their everyday life and social representations are constructed in order to enable them to do that. Moscovici ardently believes that it is the consensual universe that should be the concern of the social psychologist:

> "It is readily apparent that the sciences are the means by which we understand the reified universe, while social representations deal with the consensual. The purpose of the first is to establish a chart of the forces, objects and events which are independent of our desires and outside our awareness and to which we must react impartially and submissively. By concealing values and advantages they aim at encouraging intellectual precision and empirical evidence. Representations, on the other hand, restore collective awareness and give it shape, explaining objects and events so that they become accessible to everyone and coincide with our immediate interests".
>
> (Moscovici, 1984; p.22)

It is clear then that for Moscovici there are two contrasting forms of reality. The reified world of science is a world of objective truth and certainty that is indifferent to context and culture and the consensual universe of social representations is a created world of symbolism and meaning dependent on its historical and cultural context (Purkhardt, 1993). On several occasions, Moscovici makes the distinction between the reified universe of science and the consensual universe of social representations (Moscovici, 1984, 1987, 1988). The reified universe is a world of discrete objects that are indifferent to and autonomous from human collective life, devoid of human meaning (Purkhardt, 1993).

In contrast to this, humans are an integral part of the consensual universe in which society is a "visible, continuous creation, permeated with meaning and purpose" (Moscovici, 1984; p. 20). It is in the consensual world that symbolic understanding emerges through communication and interaction and the mind shapes reality and acts upon it. Moscovici and Hewstone (1983) argued that these two universes, the reified world of science and the consensual world of common sense form two different types of reality, each with its own logic and attributes.

According to Moscovici social representations should be perceived as a particular way to understand and communicate what we already know (Farr, 1993). In contrast to this idea then, science is seen as the method for discovering the things we do not yet know. Wagner, Elejabarrieta and Lahnsteiner (1995) explored the difficulties faced by lay people who would try to understand science in its original form. The popularisation of science however has enabled it to become a part of common sense. Purkhardt (1993) argued that social representation theory is not just exclusive to common sense but can be implemented in a practical and useful way in the transformation of science itself.

Habermas (1989) described in detail the emergence of the 'de-traditionalised' public sphere which took the place of the traditional public sphere. Public life and the public sphere were identified by Jovchelovitch (2000) as a particular kind of social space. She argued that public life is the place where social representations are "generated, develop, meet other representations, change, and if the social and historical conditions so determine, die" (p.1). She posits further that a change in societal conditions results in a change in social knowledge. Jovchelovitch (2000) argues that "it is the triangulation between people, ... objects and the work of representations that produces the symbolic register in which we live" (p. 15-16).

She adds that "processes of cultural production, or processes of social construction, are dependent on an outside, objective and natural world, from which they draw the materials without which nothing can be constructed" (Jovchelovitch, 2000, p.16). Jovchelovitch (2000) suggests that it is wrong to believe that our representations are reality, but rather are a symbolic system that represents reality. Reality is much

larger than the representation which is what we socially construct. The scientists are also representing reality, albeit in a mode that is not used by the lay public, using mathematical symbols and a different discourse. It is in the public sphere that representations are formed and become real to a group of people, however, the mass media makes the public sphere almost unnecessary due to its pervasive nature (Jovchelovitch, 1995).

2.9 Social representations and heroin use.

In order to be specific that it is social representations that are being discussed certain criteria are important. Social representations are used by individuals like theories in order to help them make sense of the world around them. They are widely shared in certain milieus although they manifest differently in different groups. Social representations originate in expert knowledge (often scientific) and are transferred into common-sense knowledge, usually through the media. They are shaped through relevant and familiar ideas (anchoring) and by linking abstract concepts with concrete images or symbols (objectification).

Heroin was manufactured by a scientist as a medicine and was originally administered by doctors only (Jay, 2000). It therefore qualifies as originating in expert knowledge. It was not until the eighties that the UK saw the proliferation of heroin users within society and for most of the lay population it was through the media they gained most of their information. Therefore the representations of heroin and heroin users that exist today are in the form of common sense knowledge and manifest differently in different social groups. It is appropriate then to adopt an SRA approach to this thesis.

The role of the media is pertinent to any study of social representations. One possible definition of the role of the media is to inform the public whilst simultaneously entertaining its audience. From an SRA perspective, and Moscovici's idea of the assimilation of new information into the public sphere, if we consider heroin users as they are perceived today, then this started as a small group of people and the problem has now grown. For most of society knowledge of these matters would have been sparse and therefore there is a greater reliance on the media, the government and also public health campaigners.

Social representations theory has always been interested in health and health care settings starting from Herzlich's (1973) first study of mental health in rural France. Heroin use is a health issue that concerns not only those directly involved but also their families and the community in which they live. Social representations are also interested in risk and the 'risky other'. Many people consider the lifestyle of the heroin user poses many risks to their health, and with the fear of AIDS, to the health of others. All of these issues make a social representations approach appropriate for this research.

2.10 Social representations and the media

Farr (1993) outlined the crucial role of the media in the public understanding of science. Indeed, Moscovici, (1976) in his pioneering study of psychoanalysis, studied how scientific information in disseminated throughout society by increasingly efficient means of communication, namely the mass media. Moscovici was able to identify three very different modes of media discourse which typified

the ideology of the paper and its readers (Wagner, Duveen, Farr, Jovchelovitch, Lorenzi-Coldi, Markova & Rose, 1999): the laissez faire approach of the liberal bourgeois, the selective approach of the Catholic press and the propaganda style of the communist papers (Bauer & Gaskell, 1999).

Farr (1995) argued that the media plays a significant role in the generation and proliferation of representations in modern society. This has great significance for health psychologists who wish to analyse the media representations of health versus illness. Although much of the research on heroin users tends to ignore the role of the media, chapter one demonstrated that the media had a key role in the creation of the negative stereotypes that surround heroin users today. Whilst, social representations theory is interested in the interaction between the individual and society it is important to remember that the media may sometimes act as a bridge between the two. Although the media can be a useful tool to inform society it also contributes to the representations that exist within society and it is therefore important to examine their messages and ideology that make up a vital component of our culture.

Moscovici (1976) in his classic study was interested in the role the media played in the conversion of psychoanalysis from the world of science into the discourse of everyday common sense. In reference to the media Moscovici himself said "the media penetrate every home and seek out every individual to change him into a member of a mass ... It is the kind of mass, however, that is seen nowhere because it is everywhere. The millions of people who quietly read their paper and involuntarily talk like their radio are members of the new kind of crowd, which is immaterial, dispersed and domestic ... They all stay at home, but they are all

together, and all seem different, but are similar" (Moscovici, 1985, p. 193).

Stockdale (1995) advocated the examination of representations in the media in an effort to explore their contribution to the beliefs and attitudes that make up social reality. She proposes that the media should be more reflective on their role in portraying certain social issues. The media can often contribute to stereotyping, as we shall see in study two, which can have a strong influence on the social representations that exist within society today. So whilst the media has a role in reflecting society's representations and beliefs, it also plays a crucial role in contributing to them.

2.11 Social representations and health psychology

The SRA is distinct from conventional approaches that concentrate solely on the individual person as the principal focus of the research. There are many models which adopted precisely this focus (e.g. the theory of reasoned action, Azjen, 1985; Azjen & Fishbein, 1980; the health locus of control model, Wallston & Wallston, 1982) which are now considered to be problematic for their failure to see the individual within their social environment. Many researchers are now focusing on the role of social interaction and shared knowledge on local communities and cultures in their health behaviours and beliefs (Campbell, 1997; Crawford, 1994; Jodelet, 1984). Crawford (1994) argued that to focus solely on the individual in isolation from the rest of society is to also make each individual totally responsible for their health and lifestyle. This seriously undermines the role of society, politics, economics and culture as key determinants of health.

Moscovici's theory of social representations seeks to understand the individual within their social and cultural milieu. An SRA views all psychological experience and identity as being mediated by the individual's membership within society. For Moscovici therefore, all thought is socially created and socially communicated and forms a stock of knowledge which people use in the form of common-sense theories about the world. Through these conceptual and pictorial elements, members of a society are able to construct social reality. Health beliefs and behaviours are largely dependent on cultural backgrounds and people carry with them the assumptions, values and knowledge that belong to their communities and give them a social identity (Gervais & Jovchelovitch, 1998). An SRA approach therefore enables the researcher to examine health beliefs and 'choices' against a backdrop of negotiation between the individual and their society, taking into consideration the role played by group norms and cultural traditions.

A classic study of health, that established the relationship between social representation and health or illness, was Herzlich's (1973) *Health and Illness: A Social Psychological analysis.* Herzlich found that health was defined in terms of a vacuum, a reserve or in terms of balance or equilibrium. In her study she showed three types of representations: illness as destruction, illness as liberator and illness as occupation. Herzlich's work showed that people develop different types of social representation of illness and these affect the way that they consequently cope with illness.

Flick (1991) also conducted health research and in his book *Everyday knowledge on health and illness* he argued that conventionally social representations stress the

relationship between the sick individual and society and have focused less on the personal ways people have coping with stress. Flick (1991) focused on how the social representations of illness relate to the interactions between the patient and the professionals and how this influences compliance, confidence and the effectiveness of treatment. Flick therefore highlighted that professional knowledge about illness is only part of the knowledge that is currently circulating in society. He drew attention to lay people and their lay knowledge of illness, particularly if they have personal experience of the illness in question. He argued that lay people would have representations that are just as important and will inevitably influence engagement with the professionals and treatment compliance.

Later work by Flick (2000) conducted research on health and illness with German and Portuguese workers. Although his findings were similar to those of Herzlich (1973) he identified two underlying dimensions which were unique to his study. He identified differences between the two groups; whilst Portuguese workers appeared to have a general lack of awareness about health the German workers felt in some way forced to be healthy. Flick also highlighted that whilst the German workers had greater feelings of individual responsibility for their health the Portuguese workers felt they had little or no control over their health. Flick explored the differing societal contexts of both countries. The Germans were living in an industrial democracy and therefore there was an ideology of individual responsibility which was encouraged in all citizens. Portugal had recently experienced a political repression and therefore there was a general feeling of acquiescence and fatalism amongst the citizens.

Murray, Pullman and Rodgers (2003) explored the social representations of health and illness among baby-boomers in Eastern Canada. Murray et al. examined the role of narratives in the construction of social representations of health and illness and therefore focused on the narrative quality of social representations. This differed from Herzlich's (1973) study, where she focused on the categorical quality of health representations. Murray et al., (2003) found that health was defined in terms of attitude to life, social engagement, reserve, functionality and as a vacuum. However, the dominant view points, in how health was defined, was in terms of lifestyle and personal responsibility. Therefore the participants in this study identified health as something that can be achieved through a certain lifestyle and believed that everyone had a shared moral duty to be healthy and were therefore personally responsible for their health.

Another area of health research that has been the focus of an SRA approach is the study AIDS. Heroin users also became strongly associated with AIDS in the 1980s due to the dangers of sharing a needle to inject. The images of heroin users in the health campaigns of the eighties showed an abject figure with skin problems, underweight, and possibly HIV positive. According to Moscovici (1984) eventually "the image is wholly assimilated and what is *perceived* replaces what is *conceived* .... Thus by a sort of logical imperative, images become elements of reality rather than elements of thought" (p.40, italics authors own).

Early work by Markova, McKee, Power and Modine (1995) focused on HIV/AIDS and the perceptions of risk and risk behaviours. They argued that "throughout history and across many cultures, social representations of illness have been

associated with notions of morality and social transgression" (p. 126). Markova et al., (1995) based their observations on studies of lay representations of HIV/AIDS in prisons. Numerous studies since have explored the social representations of HIV/AIDS and this chapter does not have the scope to discuss them all. Several recent studies include the work of Analysis of AIDS, from a social representations perspective, have paid particular attention to the way different groups protect their individual and group identities by way of group specific representations. This has specific significance for my research and for this reason I will discuss the work of Joffe in more detail.

Joffe's (1996, 1999) early work on AIDS detected an 'identity protective process' at work in lay explanations of AIDS and this was discerned by the association of AIDS with 'the Other'. 'The Other' was identified as foreigners, out-groups and deviant practices. Her later work among Zambian adolescents (Joffe & Bettega, 2003) explored the shared representations of risk. Her findings in this study showed that AIDS was linked to the West, God and teenage girls and was therefore beyond the control of teenage boys and men. Therefore the 'identity protective process' was still active amongst male members of the community but Joffe and Bettega (2003) also showed how social representations can be system justifying.

2.12 Conclusions

Why have I chosen social representations theory as my theoretical framework? My aim was to understand the social representations of heroin in a society that is becoming increasingly obsessed with health and virtue. What does heroin signify in relation to modern day values of healthy living? In contrast to the values of

health and virtue, the use of illicit drugs is more prevalent than ever before. Heroin has a more negative social image than any other recreational drug. Given that heroin was once hailed as a wonder drug and opiates have been used for centuries, as I discussed in chapter one, I am interested in how heroin is depicted within society today and the deviational salience that has become attached to this image. Social representations theory allows me to examine this within a social, historical and cultural context.

The SRA is interested in how knowledge is integrated into everyday common sense, becoming part of our everyday thinking. It is through social interaction that shared representations allow individuals to make sense of their social reality, providing a basis of references with which to guide their relations to the world. Because social representations have their genesis in the public sphere they become deeply embedded in the social and cultural framework. Heroin does not exist in isolation but is a feature of our social world. Therefore, the social representations approach (SRA) forms the theoretical framework of this study.

As we have seen in this chapter, the SRA is concerned with the collective nature of common sense knowledge in contrast to the individualistic nature of the purely positivist approach to psychology. Moscovici does not advocate a particular approach to the methodology but rather encourages a wide range of methodologies to capture the social nature of social representations. Farr (1989) advocates a range of qualitative methods to be employed which are better suited to the SRA than traditional laboratory settings. According to Augoustinos and Walker (1995) "much of the research on social representations explores and describes the content

of people's beliefs, values and knowledge rather than cognitive processes linked to this knowledge" (p. 155). Therefore, the SRA is frequently linked to qualitative methods such as focus groups and interviews (Laszelo, 1997).

Willig (2001) argued that all researchers need to have clear and concise objectives before setting out on their research. She recommended, therefore, that all researchers should adopt their own epistemological position at the start of the research. In this chapter I have argued that a Hegelian paradigm that emphasises the historical character of reason as it unfolds in social, political and cultural contexts is preferential to a Cartesian paradigm which has largely ignored the social significance of knowledge and its relevance to knowing. According to Willig (2001) "social constructionism draws attention to the fact that human experience, including perception, is mediated historically, culturally and linguistically" (p.7). Therefore, a qualitative methodology is appropriate for this thesis as it is congruent with the social constructionist approach and the SRA.

In chapters three, four and five I will describe the methodology of the three studies that were carried out for this research. I will also present the findings of the content and thematic analysis for each study (Joffe & Yardley, 2004). In chapter six I will discuss the social representations of heroin and heroin users.

Chapter Three: heroin use in comparison to other behaviours

3.1 Introduction

This chapter presents the methodology and main themes for my first study. Seven focus groups were conducted and the participants in each focus group were given a social dilemma style task. A discussion was generated from the completion of this task and this formed the data for analysis in this study. I will discuss the methodology for this study and then introduce the main themes that were generated using a content and thematic analysis (Joffe & Yardley, 2004).

3.2 Design and Procedure

Focus groups are complementary to the SRA approach. I was interested in the shared nature of social representations and how these are negotiated in a social experience. It was decided that focus groups were appropriate, therefore, for Study One. The focus groups were designed to evoke negotiations on various topics and elicit data that provided a rich debate on heroin. Through this process it was possible to gain access to a range of perspectives, opinions and stereotypes of heroin users that exist in British society today. Gaskell (2000) supported the view that "the real purpose of qualitative research is not counting opinions or people but rather exploring the range of opinions, the different representations of the issues" (p. 41). The focus group differed from the traditional style of focus groups because participants were given a social dilemma style task to resolve.

Social dilemmas appear in two basic forms; the public goods problem (in which the individual must decide whether to contribute to a common resource) and the

commons dilemma (individuals must decide how much to take from a common resource). For example, many common resource tasks not only pose the social conflict of personal versus collective interest, which is the interest of a social dilemma, but a temporal conflict, between short and long-term interests (Messick & McClelland, 1983). There is research to show that groups composed of people from collectivist cultural traditions would display more co-operative behaviour than groups composed of people from individualistic cultural traditions.

The resource allocation task in this study was therefore an adaptation of a social dilemma task and its purpose was to facilitate a focus group discussion. The task required participants to discuss and compare the four categories represented in the pictures. I was interested in the comparisons the participants made of heroin users in relation to the other three categories. The 'social dilemma' in my study took the form of a money allocation task. Participants were presented with four pictures on a board and four bundles of money. The four pictures were a male smoker (fig. 3.1), a man about to inject his arm (fig. 3.2), an obese man sleeping in a chair (fig. 3.3) and an old man sitting on a bench with two empty bottles of wine at his feet (fig. 3.4). Each picture was representative of a health behaviour common within society today. The pictures will be discussed in more detail in the next section. The four bundles of money represented four million, twelve million, sixteen million and twenty five million pounds respectively. The money bundles were made by hand. They had the same dimensions as a five pound note but varied in thickness according to the amount they represented, i.e. the greater the amount, the thicker the bundle.

The participants had allocate a sum of money for each health behaviour (represented by a picture) that they believed was substantial enough to promote better health behaviours or facilitate change. Each focus group was presented with the same standardised instructions (see Appendix A). The group had to reach a consensus about the amount of money each category received. Each member of the focus group was encouraged to negotiate and justify to the other members how they believed the money should be allocated. The rich data generated from these discussions formed the data for my analysis.

It was decided to use photographs in order to reduce any bias that may be produced by the researcher when discussing the relevant categories that were part of the task. The use of pictures reduced the need for the researcher to discuss the categories at the start of the focus group. There is a long tradition within anthropology and ethnography to use photography as part of the research process (Flick, 2004). Collier (cited in Flick, 2004) posits that "photos have a high iconic quality, which may help to activate people's memories or to stimulate/encourage them to make 'statements about complex processes and situations" (p.154). It was my aim that any thoughts or stereotypes that participants had about the pictures would be theirs and not influenced in any way by my input.

In the initial pilot study eight pictures and eight sums of money were used. In the final design this was reduced to four pictures and four sums of money. I will discuss the four pictures and four sums of money that were omitted from the final design in my discussion of the pilot study (see Appendix D). In the following sections I will present the four pictures that were included in the final design. The

four pictures were of a man smoking a cigarette (fig. 3.1), a man about to inject his arm (fig. 3.2), an obese man sleeping in a chair (fig. 3.3) and an old man sitting on a park bench with two empty wine bottles at his feet (fig. 3.4).

Figure 3.1. A man smoking a cigarette.

This picture (fig. 3.1) was sourced on the internet using Google image. I typed in the word smoker and many images were found. I chose this picture because of its neutrality. There was nothing particularly striking or significant about this man except for the fact that he was clearly smoking a cigarette. Therefore, it was hoped that participants would not be distracted by any other features or characteristics of this man other than his smoking behaviour. It was therefore decided that this picture would adequately represent 'smokers' as the first health behaviour in this study.

It was extremely difficult to find a picture that represented heroin users. Many of

the pictures that were generated on Google image had been used in previous health campaigns and had health warning messages attached to them. It was important to find a picture that had no writing or health warnings on it. This picture (fig. 3.2) was chosen because although the man is clearly about to inject his arm, he has none

Figure 3.2. A picture of a man about to inject his arm.

of the other characteristics of a heroin user that are on government health warning posters. In government health campaigns the heroin user is frequently underweight, has bad skin and looks ill. This picture was neutral in that sense and suitable for my aim of reducing bias amongst participants. I wanted participants to draw on their own representations and knowledge of heroin users and not be unduly influenced by the picture.

I also sourced the picture of the obese man sleeping in a chair (Fig. 3.3) on Google image. I typed the word obesity into the search engine and this was one of the many images that were found. I chose this picture because it was difficult to see the man's face and therefore it was my aim that participants would focus on the

issue of obesity and no other distracting features or characteristics of this man. It was apparent that this man was extremely overweight and I believed that this picture would represent the health behaviour of 'obesity' adequately.

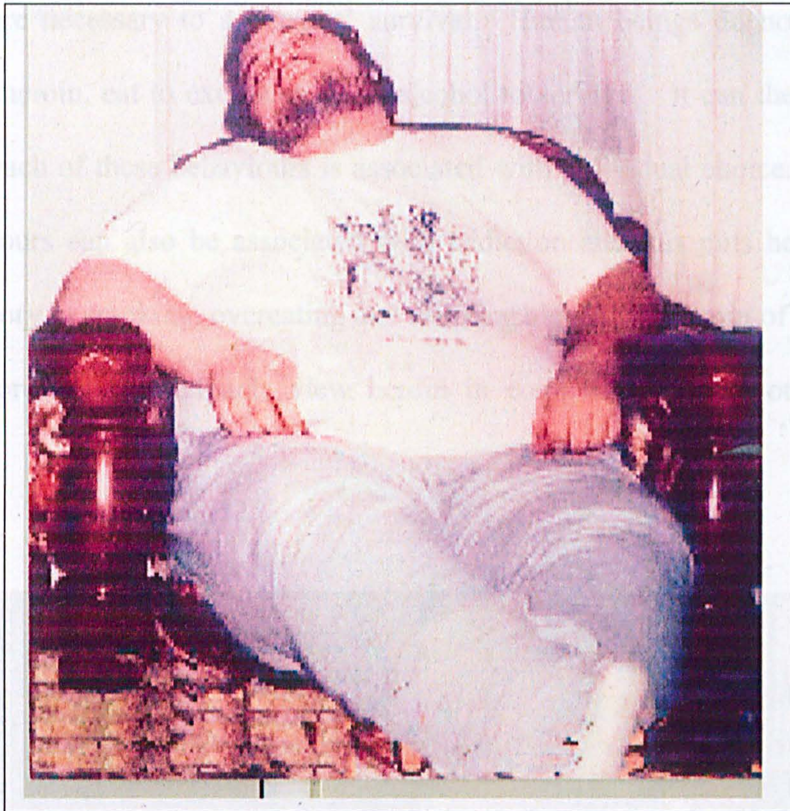


Figure 3.3. An obese man sleeping in a chair.

The picture of the old man on the bench (fig. 3.4) was sourced on the internet using Google image. I typed the word alcoholic into the search engine and many photos and pictures were found. It is a challenge to find a picture that represents the category of 'alcoholics'. The man's unkempt and soiled clothes suggest that he has other priorities in his life and that cleanliness and appearance are not a priority. The two empty bottles at his feet give a clue that his other priority is in fact alcohol. In the pilot study participants correctly identified that this picture represented alcoholism and I decided to keep it in the study.

All four pictures in the final design were chosen to represent a different health behaviour. Although the four pictures all represent a different behaviour but they have some characteristics in common. All of these behaviours could seriously affect a person's health if they are indulged in an extreme manner. None of these behaviours are necessary to a persons' survival. Human beings do not need to smoke, take heroin, eat to excess or drink alcohol to survive. It can therefore be argued that each of these behaviours is associated with individual choice. Each of these behaviours can also be associated with addiction and this puts heroin in a similar category to smoking, overeating and drinking alcohol. The aim of the study was to explore how participants view heroin in comparison to the other three behaviours.

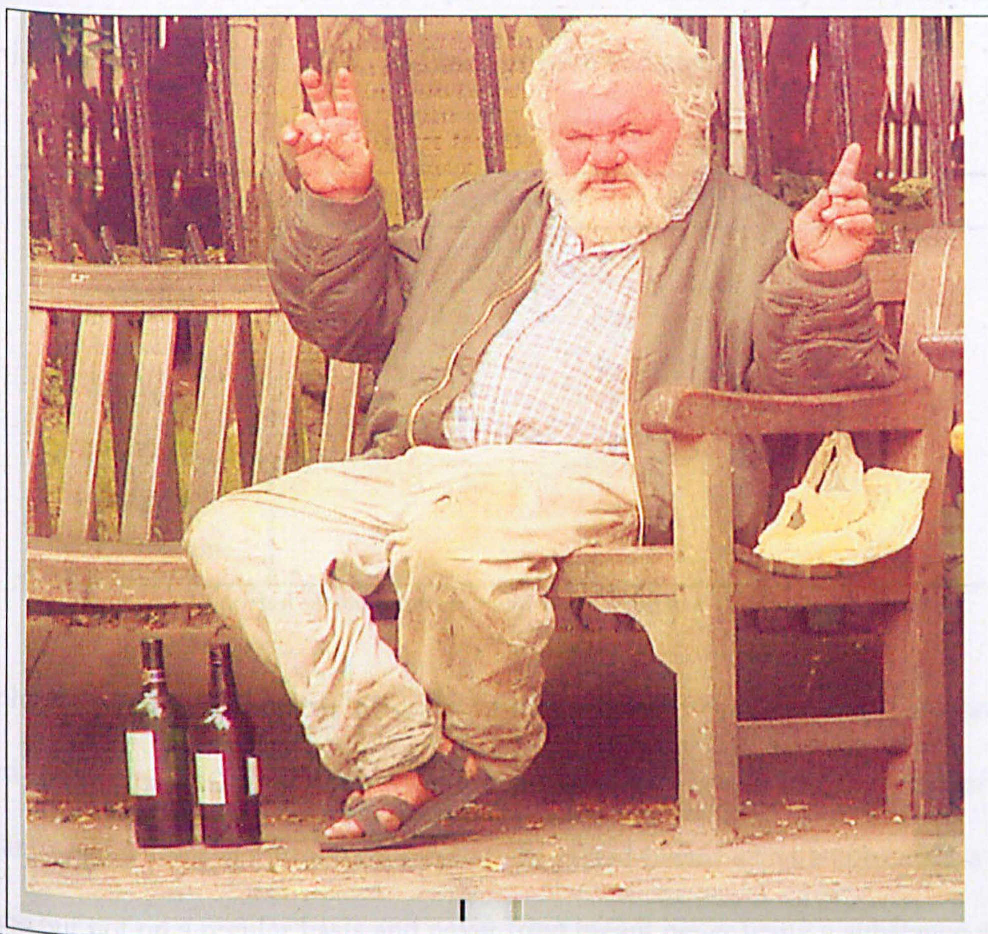


Figure 3.4. An old man sitting on a bench with dirty clothes and two empty bottles of wine.

Sampling

Participants were recruited through City University and through word of mouth. Advertising was placed around the campus inviting students to take part in a focus group discussing health issues. Respondents were encouraged to bring friends or work colleagues who were not connected to City University as I did not want to use university students only. There were no age constraints and no other limitations.

Seven focus groups were conducted with a total of 34 participants, 12 males and 22 females. Each group had a maximum of five participants and minimum of four. The average age was 24, with an age range of 18 to 64. Fifty per cent of participants were white British, fifteen per cent were white European, twenty per cent were black British and fifteen per cent were Asian. Only five per cent of participants knew someone who had tried or been addicted to heroin.

	Current	*Former*	*Tried*	*Never Tried*
Tobacco	8			4
Alcohol	11	1		
Cannabis	5		2	5
Cocaine	2			9
Ecstasy	4		3	5
Heroin				12
Crack Cocaine				12

Table 3.1. Reported alcohol, tobacco and illicit drug use of male participants.

Table 3.1 shows the number of male participants who smoked, drank alcohol or used illicit drugs. Current use meant used in the last week or month. Former use meant regular use but currently no use at all. Tried meant using a substance a few times but not on a regular basis and never tried meant never using a substance at all

(this format will be used for Table 3.2 also). 91.6% of male participants drank alcohol and 66.66% of male participants reported being regular smokers. None of the participants reported ever using heroin or crack cocaine. Other illicit drugs that male participants currently used were cannabis, cocaine and ecstasy.

Table 3.2 shows the number of female participants who smoked drank or used illicit drugs. None of the female participants reported ever having tried or used crack cocaine or heroin which was the same as the male participants. 86.3% of females reported current alcohol use and 63.6% of females were current smokers. 50% of female participants reported current cannabis use which was slightly higher than male participants. There were no notable differences in the reported alcohol, tobacco or illicit drug use across male and female participants.

	Current	*Former*	*Tried*	*Never Tried*
Tobacco	14	1		7
Alcohol	19			3
Cannabis	11		2	9
Cocaine	1		3	18
Ecstasy	5		1	16
Heroin				22
Crack Cocaine				22

Table 3.2. Reported alcohol, tobacco and illicit dug use of female participants.

Procedure

Approval for study one was obtained from the psychology department ethics committee at City University. Participants were recruited and organised randomly into focus groups. These were held in a quiet room of the psychology department. Participants were asked to sign a consent form and were assured of total

confidentiality (see Appendix C). Participants also gave consent for the focus groups to be audio recorded using a mini disk player. The participants were issued with a set of standardised instructions (see Appendix A), the board with four pictures and the four bundles of money. They were advised that they would be debriefed at the end of the task. One member of the focus group was asked to read the instructions out loud to the rest of the group and then each participant was asked to clarify that they knew what the task entailed. Each focus group lasted approximately one hour.

Once the task was completed and the focus group had reached the end of their discussion, they were given an opportunity to discuss how they found the task. Participants were then asked to fill in a brief questionnaire (see Appendix B). Participants were fully debriefed by the researcher and actively encouraged to ask questions. Participants were invited to leave contact details if they wished to receive the data results once they had been analysed. The focus groups were all recorded and transcribed verbatim. To ensure confidentiality no names were included in the transcripts. Participants were given numbers as identifiers.

Researcher objectivity

My career development has run parallel with the completion of this thesis, as discussed in the preface (p. xiii – xv), and I have made genuine efforts to keep the two aspects of my life separate and not to loose my academic objectivity. However, as Gergen (1973) posited, "it is rare social psychologists whose values do not influence the subject of his research, his methods of observation, or the terms of

descriptions" (p. 311). Whilst acknowledging this I am confident that throughout the data collection I made great efforts not to allow my own personal attitudes, verbal or non-verbal, to influence the participants. The use of pictures and standardised instructions in study one supported this effort. I did not wish to influence the participants' views of heroin use in any way and I wanted participants to have the space and confidence to speak openly and honestly, thereby sharing their personal beliefs.

Ethical considerations

The use of recreational drugs in the UK is illegal and carries the risk of a criminal record. I was sensitive to the fact that participants may in the course of the discussion disclose some information about themselves, or people they knew, who use recreational drugs. For this reason it was necessary to assure participants of confidentiality. In addition to this, the transcriptions contained no information that could identify any of the participants and the recordings were stored in a secure location that was also locked. In this way no other person could gain access to the recordings.

3.3 Method of data analysis

A large corpus of data was produced by the seven focus groups. Content analysis is an accepted method that allows the researcher to order a vast amount of data and provide a systematic overview of the most frequent categories. Any text can be analysed in many different ways according to the predisposition and aims of the

researcher. One definition of a content analysis states that it is "any technique for making inferences by objectively and systematically identifying specified characteristics of messages" (Holsti, 1969, p.14). It is precisely this element of objectivity which allow the researcher to make inferences from the data set, that are valid and reliable, and pertinent to the research question. However critics such as Silverman (1993) argue the relevance and interest value of results which count units of text. Bauer (2000) argued that content analysis "can neither assess the beauty, nor explore the subtleties, of a particular text" (p. 133).

According to Joffe and Yardley (2004) this is precisely where a content and thematic analysis can counter such problems. "Ideally it is able to offer the systematic element characteristic of content analysis, but also permits the researcher to combine analysis of the frequency of codes with analysis of their meaning *in context*, thus adding the advantages of the subtlety and complexity of a truly qualitative analysis" (p. 57, italics authors own). It was for this reason that a content and thematic analysis (Joffe & Yardley, 2004) was used to analyse the focus group data.

Content and thematic analysis are congruent as they share many of the same principles and processes. Themes refer to an established pattern that is recurring throughout the data and according to Boyatzis (1998) 'themes' and 'codes' are exchangeable terms. It varies from one researcher to another whether or not they use deductive or inductive coding. The research question itself and also the theoretical background of the field of interest will influence how the researcher approaches the data. Hadley and Stockdale (1996) explored children's

representations of the world of drugs. They focused on drugs as a generic term and made no real distinction between specific drugs. The social representations of heroin and heroin users have not been previously explored. For this reason, I employed inductive coding and remained open to the themes that emerge from the data.

Procedure for Coding

The first stage in the process of coding the focus groups was to create the coding frame. As this study was exploratory in nature and I was using inductive coding it was important to sustain flexibility in the coding process. In order to get a sense of the data, each transcript was read thoroughly. According to Tesch (1990) it is important to distinguish between topic and content and in order to achieve this it is more beneficial to pay attention to what it is 'about' rather than what is 'said'. Adopting this approach I read the transcript thoroughly several times and on each reading a list of topics was assembled and similar topics were clustered. I was coding the data to explore the main themes of heroin use. I did this by noting patterns in the data from the similar topics and these patterns were then labelled with codes. This allowed me to organise the data into categories of themes.

Bauer (2000) pointed out that the coding frame emerges from the questions the researcher poses to the data set. This is also bound within the aims of the research project. The initial coding frame is made up of a list of codes which is further developed by means of linking and splicing (Dey, 1993). Splicing is a process whereby sets of codes are merged to form an overall category. In other words, different codes become subsumed under an overall theme to form a new code.

Another option is to link codes together and create a higher order of themes without loosing the particularities of the finer coding.

Code Name	Description	Examples
Impact – on heroin user	More immediate risk of death	"I think I would give the more money to 2, 3, and 4 because I think they have much more of a chance of dying younger through what they are doing, whereas smoking in most people is gradual killing" (Focus Group 6)
Impact – on others	Spread of AIDS	"But then you have the problem of people giving AIDS whereas with alcoholism you can't pass it on, do you know what I mean" (Focus Group 2)
Impact – on families	Effect of heroin use on families and society at large	"It has social implications, it affects their families, their relationships" (Focus Group 2)
Impact – wider community	Risk of associated crime in community	"And there is also the links with crime. Robberies isnt it?" (Focus Group 2)
Impact – wider community	Risk of a breakdown in society	"...but where as 2 and 4 yeah, like the social field will be breaking down if they restart..." (Focus Group 4)

Table 3.3. An example of a coding frame for the theme of impact from study one.

I developed a coding frame that contained the code name, a description of each code and examples of text that fitted into this code. Some text related to each of the four pictures and was therefore coded in each relevant coding frame as it had relevance to each of the pictures. I did a separate coding frame for each of the pictures but the code names were the same. It allowed me to look at the text for

each of the pictures separately and also collectively. Differences and similarities between each of the four pictures were then explored and a greater understanding of the themes of heroin in relation to smoking, obesity and alcoholism was achieved.

Obesity, smoking alcohol and heroin are all types of behaviour that pose a risk to an individuals' health. Table 3.4 shows the annual deaths associated with all four categories in study one. I was unable to get statistics for heroin alone and so the estimated annual deaths attributed to heroin and morphine for England and Wales in 2005 were 842. As these statistics show the death rates associated with the other three categories, obesity, alcohol and tobacco, are much higher than those associated with heroin and morphine.

	Annual no. of deaths	**Source**
Obesity	30,000	Tackling Obesity in England, 2001.
Alcohol	6,627	Office of National Statistics, 2005
Tobacco	86, 500	Office of National Statistics, 2005
Heroin and Morphine	842	Office of National Statistics, 2005

Table 3.4. Estimated number of deaths per year from obesity, alcohol, tobacco and heroin and morphine.

Obesity figures show that the number of deaths associated with obesity is 35 times greater than those associated with heroin and morphine. Similarly, the number of deaths associated with tobacco is 102 times greater than those associated with heroin and morphine. These are interesting statistics but would these ratios be represented in the data?

Despite what the statistics in Table 3.4 show the participants in study one identified heroin as the biggest threat to health and life of all four health behaviours. Heroin therefore was perceived to have the greatest association with health problems and death. Table 3.5 shows the distribution of money by each of the seven groups following the group discussions. Group one chose to add the money together and split it equally in four as they could not decide who should be the most deserving or the least deserving. Group five had a dilemma about who to give the two largest amounts of money to and they resolved this problem by adding the top two amounts and dividing it in two thereby administering £20.5 million pounds to two groups. Groups two, three, four and six allocated the 4 amounts differentially to the 4 categories of people.

	Smoker	**Person injecting**	**Obese person**	**Homeless/ Alcoholic**
Group 1	£14.25	£14.25	£14.25	£14.25
Group 2	£16	£12	£25	£4
Group 3	£4	£25	£12	£16
Group 4	£4	£25	£16	£12
Group 5	£12	£20.5	£4	£20.5
Group 6	£4	£25	£16	£12
Group 7	£16	£4	£12	£25
Average	£10.035	£17.964	£14.178	£14.178

Table 3.5. Distribution of money (in millions) for health benefits allocated to four categories from Study One.

It can be seen in Table 3.5 that on average the greatest amount of money was allocated to heroin users. The health behaviours, obesity and alcohol problems, were allocated the same final amounts and the health behaviour, smoking was

allocated the least amount of money. It was interesting that although Table 4.4 showed that the number of deaths associated with tobacco is 102 times greater than those associated with heroin and morphine, participants still perceived heroin as the most life threatening substance and associated heroin with death more than the other three health behaviours.

3.4 The main themes of heroin and heroin users

I will now present the findings of the analysis of the focus group data. A social representation refers to a widely held common sense and the thoughts and images that surround it. Therefore, in this study I am interested in the common sense view of heroin and the thoughts and images that surround this view. In this study heroin was discussed in terms of the following themes: impact, control and perceptions of heroin users. Participants focused on the impact that heroin has on the heroin user, families and society at large. Participants focused on the addictive qualities of heroin in relation to the loss of control the heroin user has over their lives and the choices they make. Finally participants discussed their perceptions of heroin users and heroin's place in society. Heroin was deemed to be less prevalent within society than smoking, obesity and alcoholism and this would suggest that heroin use was in some way confined within certain social parameters.

3.4.1 The impact of heroin

One of the main themes to emerge from the data was the impact of heroin on the heroin user and on society at large. Participants also focused on the impact of smoking, obesity and alcoholism and therefore it was possible to make comparisons across the data.

When participants were discussing the smoking group they were very conscious of passive smoking which has been prominent in the media in the past few years due to the proposed smoking bans:

> "I'm just saying out of all the four of them the one that would affect others the most would be the smoker, like you know all the people around are second hand smokers and that would be the most important one to get help because you are hurting more people than just the smoker" (Focus Group 7)

The use of the phrase 'hurting more people' emphasised the perceived impact on others, namely, the threat of cancer. This threat is to non-smokers, people who do not themselves smoke but in some way are affected by the smoking activities of those who do. This process is called "passive smoking" and this not only suggests that non-smokers are inactive themselves in smoking a cigarette but are also resigned to, and at times suffering from, the activity of the cigarette smoker. However, Table 4.1 showed that smoking, as a health behaviour was only recommended for the £25 million by group seven and even then there was no consensus within the group. The impact of passive smoking was not enough to persuade participants to allocate the larger sums of money to picture one. In Table 4.2 , which shows the distribution of money, we can see that on average smokers were allocated the smallest sum of money. Smokers were also recommend for the smallest sum of money, four million pounds, by three out of seven of the focus groups. The impact of smoking on non-smokers was given attention by focus group 2 also:

"Alcoholism doesn't affect other people".

"It s the lung cancer that is affecting ... alcoholism doesn't affect as much other people, ..., it is passive smoking (...)". (Focus Group, 2)

This was the perceived impact of smoking in comparison to someone with an alcohol dependency. Alcoholism was not considered by the participants to be contagious or to impact greatly on the wider community but passive smoking, it was argued, can cause lung cancer and this can kill you.

In the following extract the perceived differences in the impact made by heroin and alcohol on the wider community were also highlighted

"But then you have the problem of people giving AIDS whereas with alcoholism you cant pass it on, do you know what I mean?"

"There is always that worry about AIDS within the community, it's a massive thing isn't it?" (Focus Group 2)

AIDS was discussed here in relation to heroin use. It was argued that alcohol dependency cannot be passed from one person to the next and therefore was not perceived to make such an impact on other members of the community as heroin did with its associations with HIV/AIDS. It is interesting to note the phrase 'within the community'. This highlights a latent theme of contagion and the potential threat to the populous at large. This concept of the threat to life emerged in relation to all four pictures in the initial stages of the decision making process:

"But you are talking about serious in the sense that you are more likely to die, I assume?"

"Yeah". (Focus Group 4)

The threat to life would be an example of an extreme impact on the individual or society at large. This concept was explored in other groups also and it was a discussion about which behaviour would cause one to die the quickest:

> "I think I would give the more money to 2, 3, and 4 because I think they have much more of a chance of dying younger through what they are doing, whereas smoking in most people is a gradual killing". (Focus Group 6)

The impact in this extract was an example of a direct threat to life and therefore the participants decision-making in this context tended to focus on saving lives, particularly young people's lives, who are threatened by drugs, food and alcohol or homelessness. In this extract the consequences of the behaviour were for the individual and not society. Some focus groups had different ideas about how each activity could kill you and which could kill you the quickest:

> "With the obese person I think its, hmmm, because there are so many problems that can kind of occur with obesity like blood pressure, heart disease, diabetes, coronary heart disease, strokes, lots of things, that can come about if you are like that and it's the number one killer, kind of thing in this country anyway and its rising, definitely in the last 20 years anyway and we need to stop it". (Focus Group 2)

In this extract the participant argued that the main impact of obesity was on the individual and the threat to the individuals' life due to associated health problems. Other threats were identified in relation to heroin and focused on the impact on society:

"It has social implications, it affects their families, their relationships".

"And also there are the links with crime".

"Robberies isn't it?" (Focus Group 2)

The mention of 'families' and 'relationships' touched on the theme of the fabric of society and the strands that hold community together. Bearing in mind that children are part of a family, then it could be argued that heroin impacts also on future generations to come. Crime is something that can also affect anyone, particularly perhaps someone who is affluent and therefore has assets that are worth stealing. Therefore, in this extract, the impact of heroin was on society and not just the individual. The impact on society and social cohesion was also touched on by Group 4:

> "If you consider perhaps the argument that between 1 and 3 and 2 and 4, 1 and 3 have something from 2 and 4. 1 and 3 have abuses that are like totally individualistic, so if the person goes back to that life and abuses such as smoking or eating it is totally from an individualistic point of view but where as 2 and 4 yeah, like the social field will be breaking down if they restart, considering family and friends or whatever, yeah, and so I think to cure 2 and 4 is more important than to cure 1 and 3". (Focus Group 4)

This participant posited that smoking and eating too much food mainly affects mainly the individual concerned but argued that heroin use, alcohol use and possibly homelessness actually affect the 'social field' which will start 'breaking down'. This highlights the difference between doing something that will harm yourself or something that will harm society. Heroin, was seen in the data as posing the greatest threat to society and, therefore, was perceived to have the most consequences for others:

"What it is with that is AIDS which is the worst"

"Yeah, that's true and then it can affect other people".

"Yeah, hepatitis and children, you sell to younger kids". (Focus Group 2)

Here the impact was seen as two fold, the threat of AIDS is there only if you associate with a heroin user. However the threat to children is there and is more acute because it is implied that the heroin user will actively seek out your child and sell heroin to them. As seen in previous dialogue also, the heroin user will also seek out your house and steal your belongings. Therefore, heroin users were perceived to pose an *active threat* to others. Alcohol was also seen to pose threats of its own:

" There is also so much violence, there is not as much violence in drugs as in alcohol". (Focus Group 2)

Although this participant believed that alcohol could lead to a serious threat of violence it was never made clear to whom this violence would necessarily be directed. Because this image (picture 4) was also strongly associated with homelessness a majority of participants believed that this group did not pose a threat to the community at large, as the following extract demonstrated:

"Yes, they more or less row among themselves actually as it happens, eh, I've been to places where you sign on the dole and what have you and these guys more or less recognise each other and that's I mean they do". (Focus Group 6)

This extract suggested that this category, represented by picture 4, is almost like a little family or club of its own and hence they were assumed to 'recognise each

other'. The suggestion that they 'more or less row among themselves' made them sound relatively unthreatening and this was later reiterated further:

> "... but basically they do keep to their own community and don't really interfere with the populous at large, they sort of keep as a separate part of society".
>
> (Focus Group 6)

By virtue of the fact that they can 'keep to their own community' and not interfere with others, the threat is removed and therefore the potential detrimental consequences are only harm to themselves. This was in sharp contrast to the perceived effects that heroin users have on the community:

> "Well I would tend to think 2 (Heroin users), sorry, because they can be very disruptive locally, they cause a lot of havoc, stealing and you know, to sustain their habit of drug taking and its very expensive and very disruptive".
>
> (Focus Group 6)

In comparison to a homeless person with an alcohol problem heroin users were depicted here as people who destabilise communities and 'disrupt the lives of others'. The consequences for others were seen as 'disruptive' and potentially threatening. This was a moot point, the distinction made by participants between heroin use and alcohol addiction. In reality, there is a considerable amount of devastation and disruption in the families of alcoholics but this was not referred to in this extract.

3.4.2 Control

This theme was discussed by all the focus groups and greatly informed the decision making process in the allocation of money to each category. The debate on

addiction featured the concept of control. Some of the participants saw addiction as 'a loss of control'. Other participants maintained that a person has the ability to choose to smoke, to drink alcohol, to eat too much food or to take heroin and therefore despite the power to control their behaviours still make rational choices to indulge in certain behaviours. An example of this is evident in the following extract:

> "I think smoking is something people choose whether they become addicted or not ... whereas obesity you may have a biological predisposition and homelessness you don't choose either." (Focus Group 3)

In this extract the participant compared smoking to homelessness and obesity. The latter, homelessness and obesity, were seen as something that happens to people. This reinforced the belief that smokers make the decision to take up smoking regardless of all the warnings about the damage it can do to a person's health. Although the consequences may be that the end result is addiction, some participants believed that smokers make the rational choice to start smoking in the first instance. The nature of making a choice involves alternatives, as in order to make a choice a person makes a decision amongst two or more options. In this extract the smoker had the choice to smoke or not to smoke whereas the obese person or homeless person did not have those choices. Although another participant in group 4 saw it differently:

> "Yes but what about mental functioning as well? I don't think being obese affects your capacity to make decisions and function as a human being but I do think being an alcoholic does". (Focus Group 4)

In this extract the participant could not see any reason why a person's ability to choose how much to eat should be impaired. In this extract choice, that is being able or unable to choose, is seen to play a role in obesity in comparison to the alcoholic who does not have the ability to make rational choices due to their alcohol consumption. Throughout the data there was no consensus as to which category was capable of making rational choices or not but rather this argument was used by participants as a persuasive tool to influence decision making. This was seen clearly in a discussion about homeless persons:

> "Yes but this is only a case of finding a home".
>
> "Yes, but if we agree he is only homeless, most homeless people don't want to find a home, did you know that?"
>
> "Why?"
>
> "I read it somewhere that most of them don't want to, ..., most of them have council flats from the government and then they take money and then they take alcohol and such". (Focus Group 3)

This participant maintained that many homeless people are homeless by choice, that they have somewhere to live but that they choose to let someone else live in their flat so they can have the money from illegal rent for 'alcohol and such'. Why was this argument about choice such an important part of the decision making process? As mentioned before, if a person has choice then they also have alternatives to choose from. Therefore if their choices lead to bad health or the need for public spending there has to be some sort of accountability:

> "I don't think its their fault that they are homeless but I think it is their fault that they drink". (Focus Group 5)

If a person or group is at fault then one can attribute blame. If it can be shown that a person is to blame for the state of their health then it can be argued that another category are more deserving of the larger amounts of money and therefore support. This rhetoric served a purpose in the group task as it enabled participants to show preference for one category over another. The desired outcome of this line of argument was to justify who was the most deserving of the money and support. If it could be shown that a person is blameless in their plight, rather than the victim of their own rational choices, then they would be in pole position for acquiring the larger sums of money. The converse argument is also true:

> "I would give the two less amounts to these two people (smokers and heroin users) because it is their choice". (Focus Group 3)

This participant argued that people are liable for the consequences of their choices. Therefore, if a person chooses to smoke or to use heroin, they would not merit the same level of support as someone who suffered or who needed help through no fault of their own. This was echoed by a participant in another focus group:

> "For me I guess I agree with Lily that we give the tiniest amount of money to number two (heroin addicts). I think its because I was told if you are on heroin, even if you quit for a while, you will still go back to it, like nine times out of ten, so trying so hard may not always work, so like most of them are going to be happy to go back on it anyway so like why waste your money, yeah?" (Focus Group 7)

The use of the term 'happy to go back on it' suggested that heroin users make a rational decision to re-engage with heroin use. This participant was therefore

suggesting that the majority of heroin users willingly choose to use heroin as happily go back to it after periods of abstinence. This was reinforced by the suggestion that any investment in a heroin users' welfare would be a 'waste of money'. Perhaps the participant saw it as a lack of self control and a lack of self discipline. One could then argue that the choice being made is actually not to exercise self-discipline or to govern oneself in a way that conforms to rational behaviour as preferred by normative society.

The theme of 'addiction' featured strongly here and in relation to the four health behaviours in this study, those who were seen to be addicted were deemed to have lost control. Some participants adopted a pharmaceutical model of addiction whereby the substance 'took control' of the individual. Others adopted a biomedical approach and argued that those with addictions were in need of a cure, which is suggestive that addiction is an illness. Addiction was seen as something very powerful and the addicted person had little or no control over their behaviours:

> "Yeah but have you even asked someone, they all know it can kill them but they still do it and maybe that is because it is addictive, they know it is addictive". (Focus Group 5)

In this extract the participant was discussing the addictive nature of cigarettes. The cigarettes are deemed to be so addictive that a person will carry on smoking regardless of the knowledge that cigarette smoking can kill them. Participants distinguished between the ability to make choices and the point where a person is addicted:

> "For some people eating is a drug, some people they eat and eat like some people need a cigarette or alcohol or what so ever, I mean, from this point of view look how fat he is, I mean he cant even move, I'm sorry, like but that is the point where food is an addiction, he needs the Big Mac and the Whopper and the fries and the ....."
>
> "KFC, everything, lunch for breakfast!!" (Focus Group 4)

In this extract the participant argued that when being over weight gets to the point of obesity then it means, in their opinion, that the person is addicted to food. Participants argued that once a bad habit becomes an addiction the person is no longer in control and therefore no longer able to make rational choices. This theme emerged in the discussion around alcohol also, the distinction between binge drinking and being addicted to alcohol:

> "There are a lot more people drinking now, ad campaigns for alcopops".
>
> "Are we talking hardcore alcoholics?"
>
> "Yeah, are we talking about alcoholics though or people who just go out and binge and go to football matches and that?" (Focus Group 2)

Here again a distinction was made between choosing to over indulge and being addicted to something. The concept of over indulging suggests that a person has choice and can stop at any time or at least choose when they will over indulge. The suggestion here was that people who are addicted no longer have the ability to choose when and where they use but want to indulge all the time.

Participants also discussed varying degrees of addiction with some substances being seen as 'more addictive' than others:

> "Well I think the most should go to number two (heroin addicts) cause that is the hardest one to give up. (Focus Group 7)

In this sense, addiction was seen to exist along a continuum and heroin was seen by the majority of participants as the most addictive substance out of the four. It was argued that a person addicted to heroin was 'more addicted' than a person addicted to cigarettes, alcohol or food:

> "Yeah, like, for heroin it is more difficult than for alcohol to stop the addiction, much harder than for alcoholics to stop the addiction, for smoking its probably very easy, I don't know". (Focus Group 4)

This extract appeared to suggest that the power of the addiction lies within the substance itself rather than with the individual concerned. This was evidence of the use of the pharmaceutical model of addiction. Heroin was seen as more addictive than cigarettes and therefore a person who uses heroin is more addicted than a person who smokes. This argument was seen again in a comparison between smokers and obese people:

> "No if like everybody made an effort, like, smoking could be reduced much more than like obesity, like the person who is obese, it is much harder for him". (Focus Group 4)

Participants argued that some addictions were easier than others to overcome. The suggestion here that smoking could be reduced if 'everybody made an effort' would suggest that smoking was not viewed as very addictive by this participant. There was an inference here that giving up smoking is a matter of choice and effort whereas obesity is not.

This posed an ambiguity in the argument. On the one hand it was argued that once a person was addicted they were no longer able to make rational choices and at this point had lost control. But another argument was that addiction can occur in different intensities and with some of the 'easier' addictions it is just a matter of making a concerted effort, as with the suggestion above on smoking. This would suggest that some addictions could be overcome by making the rational choice to make more effort. Heroin however was not seen in this way. Heroin was seen as so addictive that a person may have to take it for the 'rest of their lives':

> "How do you see it as a bigger problem?"
>
> " Cause heroin is like such a big drug its so hard to stop, there's nothing like, I know there is stuff out there but there is like not enough, I think people who like smoke heroin think it is like so addictive that they have to do it for the rest of their lives and there is like no way to stop and there are not enough programs out there to help people". (Focus Group 5)

Addiction in this sense was seen through a biomedical lens and it would seem the heroin user was seen in this extract to have no choice about stopping his heroin use unless he gets help. The participants also introduced the concept of 'curing':

> "I mean like heroin addicts if you treat them are the going to go back onto heroin or are they going to get addicted to the .... something else, I mean are you really going to cure them?" (Focus Group 4)

The term 'cure' suggests that heroin is an illness and the fact that heroin was seen as the most addictive drug it was therefore deemed the hardest illness to remedy. This had two effects on the participants' dilemma of where to place the money. Some participants suggested that heroin addicts need the most help and therefore

the most money but other participants suggested that it would in fact be a waste of money because heroin is 'too addictive' to remedy:

> "I would give it (the most money) to the heroin people".
>
> "I just worry about putting all that money in and then they just go back to their life again and then they start again". (Focus Group 4)

The participants in this study, consciously or unconsciously, were looking for value for money. It would seem the best value for money in this instance would be if their financial investments produced reformed characters as the end product. This would be the ultimate justification for the investment of large amounts of money in these four areas within the health sector. Investment in cure could also be seen as an investment in conformity. This was particularly prominent in the discussions on heroin users. Heroin use was perceived as something that only a small percentage of the population take part in. Giving up the addiction could be seen as conforming also to the behaviours of the rest of society.

> "I would personally put number one for the least money because with obesity you definitely need help to get it down and so you would need the same, ... counselling or dieticians or weight people, ehmm, like a drug addict or an alcoholic, ... ,whereas smoking is something the most people do by themselves, they don't go to counselling for it or they don't go to somebody else for help so I think the first one would have the least money". (Focus Group 6)

This extract again suggested that there were varying degrees of addiction and whilst heroin addiction was seen as something that is extremely difficult to break, smoking here was seen was something that can be overcome on your own without specialist intervention. This again reiterates the concept of choice. In some

instances it was perceived that there is the ability to make rational choices and in other circumstances the addiction was considered to remove the capacity to do just that.

3.4.3 Perceptions of heroin users

Participants spoke of heroin use and the other three behaviours in terms of lifestyle choices throughout the data also. Participants had their own views on what behaviours were considered acceptable and which ones were not. There were moral tones within this also regarding how a person should behave within society today. Society was perceived to influence what is and what is not acceptable:

> "Its become so acceptable now, like heroin is less acceptable than cigarettes.
>
> "Like society is built around having a cigarette".
>
> "Everyone knows, like, when you are doing heroin you have a problem, cigarettes are more, like, casual but they still cause more people to die every year". (Focus Group 5)

In this dialogue not only was acceptability discussed but also the different meanings and different associations that certain behaviours have. Heroin was seen as a quite extreme behaviour, something would only do it if you had a problem, whereas smoking was perceived as 'casual'. This could relate to the fact that there are a greater number of reported smokers than heroin users. If a small percentage of the population are partaking in a behaviour it is easier to judge this as an out-group behaviour and members of this out-group can therefore be distinguished from the in-group. Smoking has traditionally been pervasive among society and is not

limited in any way by class or gender. In the data it was also seen to serve a type of social function as 'society is built around having a cigarette'. This argument was put forward, in a different context, by another group:

> "There are so many illnesses involved with that (obesity) whereas an addict you can actively treat (heroin addict) that is much harder because its people and their habits.
>
> "Its their way of living, it's a living style"
>
> "Yeah, sedentary lifestyle". (Focus Group 2)

In this extract it was argued that obesity is due to modern living habits and often a product of a lazy way of life. The heroin addict again was seen as different in some way. The addict can be 'treated' and again the use of medical language draws parallels with the concept of disease. This was further compounded by the implication that heroin use is in some way abnormal, it is not just 'people and their habits'. In contrast, the participant made reference to obesity being 'harder' in relation to the normality of overeating and laziness. Due to its normality and the fact that it is a lifestyle choice it is harder to address. Heroin use was not seen in this context but was seen as something outside the norm. Heroin use, therefore, was not seen as a lifestyle choice.

> "A fat person definitely is not acceptable but a person who smokes and a person who drinks is acceptable.
>
> Number 3 (obesity) is acceptable too, you wont think they are bad just because they are fat, you may think they are undisciplined or whatever I mean like ... I would look at the drug addict and might think oh this person is like a thief or whatever, you are thinking many negative things associated whereas for the fat person they are just

fat and that is their sin but you don't think they are into bad things (...)".(Focus Group 6)

In this extract the argument focused on how lifestyle choices impact on how a person could be perceived within society. Heroin use was seen here as the least acceptable behaviour amongst the four categories. There was some controversy over whether or not obesity is acceptable. It became a question of whether or not lack of discipline is bad thing. There is a moral relevance here that is related to discipline and it is a theme that underlies a lot of the discussion through all of the focus groups. There was no debate about whether smoking and drinking are acceptable behaviours within our society today. It would seem what made heroin use an 'unacceptable' behaviour was the negative association with deviant traits. None of the other three categories were perceived to have those associations to such an extent.

There were other suggestions put forward as to why heroin use is not a common lifestyle choice in today's society and one big factor was class:

"(...) cause you know alcoholics covers a whole spectrum of people whereas heroin addicts I tend to associate with people that are living in poverty, you know, have a lot less". (Focus Group 4)

Heroin use was associated with poverty and as a result it was deemed to be a very unpopular lifestyle choice for most people. This would suggest two reasons why heroin use was unacceptable, the heroin use itself and the association with being poor. Other associations had an impact on why heroin use was seen to be an unpopular or impractical lifestyle choice:

> "This (heroin use) is like a particular age group and can like try to confine it and try to deal with it in your own way whereas this (obesity) is like an epidemic among more people and age groups as well".

> "These are like ... that's like a specific problem (heroin use) whereas this is like normal everyday (obesity), ..., its becoming normal and therefore its quite dangerous because of the normality of it". (Focus Group 2)

Again, in this extract heroin was seen as something outside the norm of everyday lifestyle choices. Obesity, in this extract, was described as a part of today's society and perhaps that is why it was perceived as 'quite dangerous'. This is an interesting concept that normality makes something 'dangerous' because it makes it acceptable. If heroin use is not seen as normal then it cannot be perceived as acceptable. It is not clear what age group the participant meant when discussing heroin use but it would possibly be safe to assume they meant young people as a lot of drug use is commonly associated with young people.

3.5 Looking at heroin, comparatively

Participants in study one were required to allocate four different quantities of money for health promotion or to promote change in four health behaviours, namely, smoking, heroin use, obesity and alcoholism. Three main themes emerged from the data set: impact, control and perceptions. Each theme will be discussed across each of the four health behaviours.

Impact

The first theme, impact, was concerned with the consequences of each behaviour for the individual, their families and for society in general. Participants paid the

least attention to smoking in terms of the consequences of their behaviour. It was discussed that passive smoking would impact on others due to the cancer risks associated with passive smoking. But otherwise smoking was seen as something that mainly had consequences for the individual in terms of their health and cancer risks. Participants did not believe that smoking posed any threat to social cohesion. Participants saw alcohol as something that may cause a person to be violent but on the whole they believed that there were more consequences for the individual alcoholic than other members of society. In some of the data it was suggested that violence would only manifest amongst the groups of drinkers themselves and in that way they would not be a threat to the rest of society. Alcohol was seen however as something that could threaten social cohesion and also something that could cause a person to die prematurely.

Obesity was something that was seen as a threat for society in terms of an epidemic. In terms of consequences, however, participants argued that this would impact only on the individuals' concerned, in terms of ill health and premature death. Obesity was not regarded as a threat to social cohesion in any way. The threat was seen more in terms of a warning of what could happen if people don't change their ways. Heroin use was discussed as the behaviour that could potentially impact on society at large and not just the individual concerned. Heroin use, it was argued, posed direct threats to others through the spread of AIDS, the links to crime and the potential distribution of drugs to young people. It was acknowledged that there was a perceived threat to the individual heroin user of premature death but participants mainly focused their attention on the consequences for others. Heroin use was also deemed to pose a threat to social cohesion and therefore the impact of heroin use

was seen as an indirect affect. Although it was seen as the greatest threat in terms of consequences for others it was not seen as something that could directly affect large numbers of people in the way that smoking or obesity could. Heroin use was therefore perceived to have a big impact on a small group of people.

Control

The second theme in this study, control, pertained to the amount of control a person would have in relation to the four behaviours. Participants showed more tolerance for behaviours that they deemed to be out of the persons' control. In contrast, participants showed less empathy for behaviours where they believed that there was still an element of choice and control in the decision-making. In this way, there was a notable tone of morality in the theme of control.

In the data set smoking emerged as the behaviour that was deemed to be the least addictive. The general attitude of the participants was that people who smoked could stop if they made more effort to do so. It was seen to require the least professional intervention or support and whilst it was acknowledged to be addictive it was not believed to be as addictive as any of the other three categories. Participants showed the least amount of tolerance towards smoking as it was believed that this behaviour could be controlled.

The majority of participants viewed alcoholism as a choice. A distinction was drawn between binge drinking and alcoholism. The latter was seen as an addiction whereas the former was seen as something people chose to do. Those who associated alcoholism with homelessness did not see this as something an individual would have any choice over. Alcoholism and homeless were believed to

need professional intervention unlike smoking. Many participants believed a smoker could easily stop if they put their mind to it.

Obesity was seen more in terms of an addiction or something that had a biological cause. The majority of participants did not see obesity in terms of a choice and considered a food addiction more difficult to address than smoking. Participants also believed that professional help and support was necessary to combat obesity. There was a mixed reaction from participants in terms of tolerance and blame but on the whole it was mainly tolerance that was demonstrated for this category. Most participants felt that if a person reached the point of obesity then there had to be an underlying addiction to food and therefore the individual had no sense of control over their eating.

Whilst some participants argued that heroin use was a choice, the majority saw it as the 'biggest' addiction of them all. Participants who spoke about heroin use in terms of addiction spoke about it as the most addictive drug there is. This had two effects on the decision-making process. Some participants thought heroin use needed the most money as it was the behaviour that needed the most help and support. Other participants spoke about their concerns of wasting money and argued that if heroin was so addictive then it was not something that could be 'cured'. This demonstrated varying degrees of tolerance from the participants despite heroin use being seen as the most addictive behaviour amongst the four categories.

Perceptions

The third theme, perceptions, was concerned with the perception of the four behaviours within society. Within this theme was a latent theme of lifestyle and this incorporated the concept of 'acceptability'. None of the categories were deemed to be acceptable in terms of health. Each one was seen as a threat to good health and the risks of premature death were discussed. Therefore, participants spoke about acceptability in terms of the number of people who were affected by it and society's tolerance for the behaviour.

Smoking was perceived as the most acceptable lifestyle choice in terms of the number of people who smoke. Participants did not pass any moral judgement on smoking in this context but rather accepted smoking as something that people do. Smoking, it was argued, had an almost social function within society today. Alcohol was also deemed to be an acceptable lifestyle choice, again due to the fact that so many people use alcohol within society today. A person who drinks alcohol was viewed by the majority of participants as an acceptable person. It was acknowledged that alcohol problems could affect anyone within society, regardless of gender or class, and perhaps this was why alcoholism did not carry the same stigma as heroin use in the data.

Obesity was regarded as a bad lifestyle choice in terms of the consequences for the individual themselves. Obese people were deemed to be acceptable albeit undisciplined in their habits. Obesity was considered to be almost too acceptable within society and therefore considered dangerous in terms of a potential epidemic.

Some participants suggested that it was because it had become acceptable that it was on the increase.

Heroin use was seen to be a totally unacceptable lifestyle choice. As a way of life it was believed to be abnormal in comparison to the other three categories. It was insinuated that the heroin user themselves was also not acceptable as a person in comparison to the other three categories. Heroin use was not seen as something that could affect anybody within society but rather it was confined to a certain age group or a certain class, namely, the lower class or those living in poverty.

3.6 Conclusions

Participants drew on three themes to discuss the four categories of health behaviours, impact, control and perceptions. The findings in this chapter, however, demonstrated that there were discernible differences between heroin users and the other three health behaviours. It was notable also, that on average, the greatest amount of money was allocated to heroin users (see Table 3.5). Heroin use was believed to have the greatest impact on the individual and society in general and this influenced many participants' final decisions in the allocation of money.

Alcohol and heroin were associated with a threat to social cohesion. Participants argued that heroin had the greatest impact on society at large but also had a profound impact on the individual heroin users themselves. For some participants it was an association with addiction that led them to conclude that spending money on helping and supporting heroin users was a waste of time. Participants focused

on the lack of control associated with addictions and argued that smoking was the only behaviour associated with the ability to choose. This was also reflected in the fact that obesity, alcoholism and heroin use were all deemed to need professional intervention.

	Obesity	Smoking	Alcohol	Heroin
Matter of choice		√		
Addiction	√		√	√
Tolerable	√			
Blameworthy		√	√	√
Socially acceptable	√	√	√	
Socially unacceptable				√
Threat to social cohesion			√	√
Professional Help needed	√		√	√

Table 3.6. Summary of attributions for all four categories in study one.

In table 3.6 I show the attributions and judgements that participants made aobut the four health behaviours. Participants attributed blame and tolerance in proportion to the amount of control they believed an individual could have in relation to the behaviours. None of the participants attributed blame to the case of obesity. Discussions that focused on smoking, alcohol and heroin, however, attributed varying degrees of blame. The discussion on heroin users had an underlying theme of morality and blame and this was interlinked with the perceived addictiveness of heroin. Heroin was seen to be the most addictive of the four health behviours and participants believed this moderated how much control a heroin addict could have

over their behaviour. The lack of control lessened the attribution of blame for heroin users. Similarly, smoking was perceived as an individual's choice and the participants attributed blame to smokers for their choice of behaviour.

In terms of perceptions, the four health behaviours were discussed in terms of lifestyle choices and acceptable behaviours. Heroin use was seen to be the least socially acceptable in comparison to the other three health behaviours. Smoking, obesity and alcoholism were not perceived as more socially desirable but rather were considered more acceptable only due to the numbers of people who engage in these behaviours. Smoking, eating and consuming alcohol are also legal pursuits whereas the consumption of heroin is illegal. Heroin users were perceived to have negative characteristics and traits that were not associated with the other three categories.

Although the participants identified the potential for addiction in all four categories it was heroin that was associated with the most negative aspects. Heroin use was seen as the least acceptable behaviour of the four whereas the other three were seen to be perfectly acceptable within society albeit not desirable. In this way heroin use was seen as the least socially desirable behaviour of the four health behaviours.

Chapter 4: Media analysis of heroin.

4.1 Introduction

The media are a primary influence on social representations (Farr, 1993). Moscovici's (1961/1976) classic study of psychoanalysis addressed how different social groups in France adopted and interpreted Freud's psychoanalysis. He was interested in how they transform it into something linked to their everyday practices, personal knowledge of the world and emotional investments. Moscovici (1976) chose three different social groups (the Catholic, the communist and the urban liberal milieus) and studied their reception of psychoanalytic ideas. He identified that each milieu cultivated different forms of communication (propagation, propaganda and diffusion) and this led to varied representations of psychoanalysis. This study is not a replication of Moscovici's (1976) original study, however, the three sources of written text were dictated by an attempt to examine three different milieus of contemporary society. This was one of the implications for research discussed by Bauer and Gaskell (1999).

4.2 The media sources

In the course of my review of the history and cultural background of heroin I noticed that there were strong associations between heroin and crime. There is much debate about the cause and reasons of crime but it was this link that led me to choose Police Review as one of my sources of data. The media has an important role in lay persons knowledge as information is offered to the public, on a daily basis, in the form of words and images. It is often through this medium that the lay person gains knowledge and organises his attitudes and opinions through a process of anchoring. Joffe (2003) argued that this process occurs by drawing on

metaphors and iconic images that already exist in a person's cultural and personal environment.

Police Review represents a law enforcement milieu which should be highly resistant to any type of recreational drug-taking. The predominant approach of a law enforcement milieu is *zero tolerance.* Police Review describes itself as the 'leading independent journal of the UK police force' and outlines its journal as 'intended for UK police officers and staff, police associations, government and all those interested in policing issues' (www.policereview.com). This journal is published by Jane whose vision is 'to be the leading Open Source Intelligence provider' and whose mission is 'to help our clients make the right decisions' (www.janes.com). My sample consisted of forty articles, 24 were small features and news stories, 7 were large feature stories spreading over two pages and there were 9 editorials.

Heroin users also seek out and are referred for treatment and support through primary care routes ad GP involvement is necessary if a heroin user is to obtain a methadone script. There is a strong argument that heroin addiction is a medical problem and not just a legal problem. Marks (1996) argued that "the powerbase and organisation of health-care systems lie in the hands of those who control the use of resources, that is, medical doctors and surgeons" (p. 11). I chose the British Medical Journal (BMJ) because it represents a doctor oriented approach of the medical milieu. The principal concern of this milieu is with the medical treatment of members of society and the predominant position of this milieu is *harm reduction.*

The BMJ is published by BMJ Publishing Group Ltd. which is a wholly owned subsidiary of the British Medical Association. Its vision is 'to be the world's most influential and widely read medical journal' and its mission is 'to lead the debate on health, and to engage, inform, and stimulate doctors, researchers and other health professionals in ways that will improve outcomes for patients' (www.bmj.com). Again my sample consisted of forty articles, 8 research papers, 6 editorials, 1 article entitled 'educate and debate and 24 news articles.

The final text source, newspapers, represents a milieu of mass communication which contributes greatly to the information which is circulating in society and its predominant position therefore is *informing*. Its importance is amplified by the fact that it not only plays an important role in determining the form of a social representation but it influences its distribution also (Farr, 1995). I chose four national newspapers for this study, The Times, The Independent, The Mirror and The Daily Mail. The four newspapers can be sub-divided into the broadsheets (The Times and The Independent) and the tabloids (The Mirror and The Daily Mail).

Although these terms originally referred to the size of the publications, the broadsheets being bigger in size than the smaller tabloids, they also carry extra connotations in the British media. The broadsheets are considered by many to be more intellectual in their approach to the news and the stories that they cover. One reason for this is their greater size allows them to cover stories in greater depth than the smaller tabloids. However, the tabloids have become associated with a sensationalist approach to media stories and often take a more extreme political position than their broadsheet counterparts. For this reason it was decided to chose

two broadsheets and two tabloids to have a balanced representation of the different styles of journalism. I did not pay attention to the political affiliations of any of the newspapers and they were chosen randomly. Again I chose forty articles, 5 editorials, 6 letters from the readership, 7 big feature stories and 22 small news articles.

The articles were dated from January 2001 to December 2003. All articles that discussed or made reference to heroin, in this time frame, were obtained for the study. This produced a large corpus of data so I randomly chose forty articles for each milieu giving me a total of 120 articles for the study. I obtained the BMJ articles and the newspaper articles from the internet as they are all available online. I travelled to Cambridge and visited the Cambridge university library in order to source the Police Review articles. The articles were sourced on the library's internal electronic system and all the articles were photocopied manually. (For details of each of the 120 articles please see Appendices D-F)

4.3 Method of data analysis

I chose to use a content and thematic analysis (Joffe & Yardley, 2004) to analyse the data. As I argued in chapter three this allows me to order a vast amount of data and to provide an overview of the most frequent categories. Once again I employed inductive coding in order to remain open to the themes that emerge from the data. There were three sources of data in study two: Police Review, the BMJ and the newspaper articles. They were analysed separately and at the end of this chapter, in section 4.7, I will discuss the similarities and differences across the three sources of data.

Procedure for coding

The first stage in the process of coding the media data was to create the coding frame. I used inductive coding and at this stage of the analysis it was important to sustain flexibility in the coding process. I paid attention to content rather than topic and therefore paid attention to what the data was about (Tesch, 1990). There were 40 articles for each media source and I analysed the Police Review data first. I read through all the 40 articles several times and then listed the themes that emerged. In this way similar themes were clustered until I had discovered the dominant themes in the data set. This process was repeated for the BMJ articles and the newspaper articles.

Code Name	Description	Examples
Crime	Crime is fuelled by heroin addiction	"Heroin does not make you commit crime; it gets you addicted. If you could get free of heroin you wouldn't commit crime". (1 Feb. 2002)
Crime	Heroin dealers are associated with violent crimes	"PC Maloney has noted the rise in kidnappings and serious assaults on the county's local 'players', which, he is convinced, are a hallmark of the Yardie gangs' attempt to gain control of the local market". (5 July 2002)
Crime	Less obvious crimes fuelled by heroin addiction	"...it is right to remind ourselves it is not only the use of these drugs that is of concern but also drug abusers who will often have to drive to find their 'hit' ". (21 Dec. 2001)

Table 4.1 An example of a coding frame for the theme of Crime from the Police Review articles.

A coding frame (see Table 4.1) was developed that contained the code name, a description of each code and examples of text that fitted into this code, as

recommended by Joffe and Yardley (2004). I did a separate coding frame for Police Review, the BMJ and the newspaper articles (see Appendices I, J & K). In the next three sections I will present the main themes that emerged from the data sets. Finally I will discuss similarities and differences across the data set.

4.4. Police Review

Forty Police Review articles were analysed. I initially analysed the forty articles separately using a content and thematic analysis (Joffe & Yardley, 2004). The coding frames for the analysis of the Police Review articles can be seen in Appendix I. The data from the Police Review produced four main themes associated with heroin and heroin users: crime, demand reduction, the legalisation debate and the heroin arena.

4.4.1. Crime

The most common theme in the Police Review was the link between heroin and crime. This was discussed from the perspective of the heroin addict and also the heroin dealer, and it was presented as an inarguable fact that there was an established link between heroin and crime. The following extract was a typical example of how the link between heroin addiction and crime was depicted:

> "We can go out everyday and arrest offenders, but in the end they will just come back out of prison and re-offend because of their drug habits. They just return to their former lifestyles. They consider heroin to be the dirty drug. The effects of heroin are physical whereas crack is a mental addiction, says Superintendent Tunks. Robbery, street crime and prostitution were all used as methods of obtaining money to feed their addiction, says Mr Luke". (Police Review, 25 Oct. 2002, p. 18)

This extract suggested that the crime is inextricably linked with drug addiction and therefore crime is fuelled predominantly by a desire for the drug. This did not create the sense of a deliberate criminal but more the sense of a person desperate enough to commit a crime because they are addicted to heroin. This theme was prominent in other extracts where it was argued that it is the need for heroin and not the desire to commit a crime that drives criminal activity:

> "Heroin does not make you commit crime; it gets you addicted. If you could get free of heroin you wouldn't commit crime. We know that a third of all crime is committed by people to get money to support their drug habit. In theory, at least, if we gave away heroin to those people who needed it they should not need to commit crime and crime should go down. Why are we allowing these people to become criminals?" (Police Review, 1 Feb. 2002, p. 21)

By asking the final question, in this extract, 'why are we allowing these people to become criminals?' there was an implication that it is in some way not their fault and they are in fact driven to their actions. The crime was attributed more to the heroin than the heroin user and this goes some way to admonishing them of responsibility. Other arguments in the Police Review echoed this sentiment that offenders who test positive for heroin should not have to wait for treatment but should be offered helped straight away. The argument was based on beliefs that heroin addicts are not able to take control of their criminal activities due to their drug addiction. This line of argument put the onus back on certain governing bodies within society to step in and help the helpless addict. Drug dealers were described differently throughout the data and were associated with more serious crimes:

> "So they [the dealers] have seen an opportunity and know they can fill the market. The gangs' tactic for breaking into a new market is not to introduce crack cocaine immediately, PC Maloney explains. Rather, the gangs flood the area with cut-price heroin in order to undercut local dealers and establish a customer base. Only then is crack gradually fed into the market". (Police Review, 5 July 2002, p. 18)

There was a notable change in the style of language here and it heavily implied more deliberate action. This was in contrast to the depiction of heroin addicts who were perceived as motivated primarily by the addiction to heroin itself. Obviously drug dealers are also motivated by heroin but their main motive is to sell it and make money from it. They were depicted as being in control of their actions and their behaviour was represented as deliberate and volitional:

> "PC Maloney has noted the rise in kidnappings and serious assaults on the county's local 'players', which, he is convinced, are a hallmark of the Yardie gangs' attempt to gain control of the local market. 'We have had enforcement attacks with axes and machetes', he says. 'One local dealer had his face slashed with an axe. One was kidnapped, beaten up, and left semi-naked on the hard shoulder of the M4'". (Police Review, 5 July 2002, p. 19)

In this extract the crime associated with drug dealers appeared to be more deliberate and more violent than that associated with heroin users. In the data from Police Review the perceived threat associated with heroin seemed to be mainly linked with the heroin dealers. Heroin addicts were depicted as individuals who need help because they mainly commit crimes to support their heroin habits. There is always a threat to the public when someone commits a crime but in Police Review the heroin addicts' need for treatment was a bigger focus than the crimes they committed. A different type of threat was discussed in relation to heroin users in this extract:

> "Driving a motor vehicle while impaired through drugs is a problem that has been growing and is, I believe, almost unnoticed. ....it is right to remind ourselves it is not only the use of these drugs that is of concern but also drug abusers who will often have to drive to find their 'hit'. It is not until the drug abuser takes his or her habit onto the road that we consider the effects of these substances on their ability to drive safely". (Police Review, 21 Dec. 2001, p. 22)

In this extract it was clear that a crime was being committed by driving under the influence of heroin. Again, there was a suggestion that the impetus behind this action appeared to be coming from the need for heroin as opposed to any deliberate wish to commit a crime. Nevertheless, this reinforces the association between heroin and crime.

4.4.2 Demand reduction

The "war on drugs" was discussed throughout all the articles in the Police Review sample. The use of this terminology was no surprise in a publication that is aimed at law enforcers. The 'war' metaphor creates an image of the police fighting a war and suggests that something is being done about heroin. The war metaphor also creates a sense of heroin as an 'enemy'. A treatment approach was believed to be one way to fight the war against heroin:

> "A huge part of gun crime in the UK is fuelled by drugs somewhere along the line. Theft would fade to a shadow of itself without habits to feed". (Police Review, 24 Oct. 2003 p. 18)

The argument put forward in this extract takes the focus off the heroin user as the enemy and puts forward the idea of the heroin user as the casualty of war instead.

The drug dealer was seen in a different light and was depicted as a more calculating and violent player in the war. The drug dealer was perceived therefore as one of the enemies in the war on drugs:

> "I am particularly pleased that the drugs that do most harm to society, such as crack and heroin, are being stopped in greater quantities. .... Despite these success stories, the debate continues about whether breaking up middle-market and small-market dealer networks actually helps to cut down on the amount of drugs on the street. Critics of the Governments' 'get-tough' approach on dealers say a better way of dealing in the drugs trade is to tackle demand so dealers have no market to sell". (Police Review, 11 July 2003, p. 20)

The language that was used here to describe the heroin dealer was the language of business and this reinforced the image of the dealer as a calculating businessman. It was strongly suggested in this extract that the heroin dealer is driven by profit and not by an addiction. Their motives, therefore, were considered to be different to that of the heroin user and they were presented as having more control over their behaviours than a heroin addict would. However, it is addiction that creates the demand for their product, the heroin, and again it was suggested that heroin addicts, above all else, need treatment and support. It was suggested that this would be the most effective way to fight this war against heroin dealers and the heroin they supply:

> "Detective Superintendent Roberts argues that the drugs fight needs to start with the reduction of users through health and education initiatives, saying the priority has been to keep a lid on a situation that threatened to get out of control. ... 'We know we can never fully eradicate the drugs problem – the solution is more complex than kicking in a few doors and arresting people". (Police Review, 18 Oct. 2002, p. 27)

There was no sense, in this extract or any of the data, of wanting to 'fight' heroin users. In fact it was strongly suggested that heroin addicts need education, treatment and health intervention. Again there was a suggestion in the data that drug use within society will always exist and it was suggested that the optimum approach would be to reduce the number of people who want to use or who need to use. This softened the concept of 'war' and the 'fight' that was being proposed to be the most useful fight is the effort to engage with and educate people.

A large quantity of articles from Police Review discussed the importance of treatment and education. Concern was shown in some of these articles that 'gateway drugs' could lead to a lifetime of heroin addiction and crime. The articles therefore focused on the ability to change attitudes towards drugs use and therefore reduce the demand for drug:

> "Most addicts do not seek out treatment, they have to be persuaded or directed to it. It is only through a combination of thorough education at all levels of society, including parents and professionals, appropriate enforcement and adequate and sustained treatment that we can hope to achieve a reduction in the demand for drugs". (Police Review, 2 Nov. 2001, p. 19)

A strong theme in many of the articles in the Police Review sample was that treatment could be more effective than punishment. A punitive approach was seen merely as an interruption to the heroin lifestyle:

> "He believes we should be following Portugal's lead and transferring our focus onto treatment, rather than enforcement. Portugal's new drugs laws maintain the status of illegality for all drugs, however, the punishment has changed and anyone now caught in possession of a 'modest quantity' of drugs for personal use will have the

drugs seized and the case will be transferred to a local commission made up of a lawyer, a doctor and a social worker. The drug user is then put on a course of treatment." (Police Review, 1 Feb. 2002, p. 20)

The heroin user was described in this extract as a person who would benefit more from help and support rather than punishment. This was similar to the theme of the links with crime that depicted the heroin user as someone driven to crime to feed their habit rather than someone deliberately carrying out criminal acts. This emphasis on the need for treatment shifted the focus from the image of the criminal to the image of the patient:

> "The unit went on to suggest treating heroin users as patients, who would be prescribed pure amounts of the drug, free from drain cleaner and brick dust it is frequently cut with". (Police Review, 1 Feb. 2002, p. 20)

In this extract the heroin user was seen as vulnerable and in need of help from the appropriate professionals. There was a suggestion in this extract of an element of helplessness whereby the heroin addict needs some professional intervention as they are no longer able to help themselves. In this extract the health of the heroin user was perceived as vulnerable to the harm of street drugs. Street drugs are mixed with 'drain cleaner and brick dust' and it was argued that this poses great health risks for the heroin users body. This reminds the reader of the negative side of the heroin dealer and the threat they pose to the heroin user. There is wilfulness in this action of mixing these dangerous agents with heroin. It was argued that health and education campaigns may be one effective way to fight the war on drugs but only if the message is honest:

> "It would appear that campaigns aimed at 'frightening' young people do not work; they simply do not believe the message. Perhaps we can learn from more successful campaigns to discourage drink/driving and tobacco smoking, both of which have been significantly reduced in recent years. We have not achieved this by banning the use of alcohol and tobacco, or by targeting and arresting adults who use them responsibly, but through honest education campaigns". (Police Review, 19 July 2002, p. 23)

This extract showed strong support for treatment as opposed to punishment and highlighted how previous campaigns were not successful by employing punitive approaches. Treatment in this sense, then, would suggest an approach that is collaborative and honest. There was a subtle hint again in this data of the need to accept the desire of people to use illicit drugs recreationally. This extract suggested that there has been a reduction in the use of alcohol and tobacco without having to ban them or arrest someone who uses them responsibly. The argument therefore drew attention to a correlation between alcohol, tobacco and drugs and encouraged the reader to think in a similar way about drugs.

4.4.3 The legalisation debate

There was a subtle tension in the articles from Police Review between those arguments in favour of legalising drugs and those against. The main argument in the data was for the legalisation of cannabis and no articles indicated any support for the legalisation of heroin. Those who were reticent to see cannabis legalised argued that it could be a 'gateway' drug that leads to heroin use and subsequent addiction:

> "Nor should it be a question of 'look at all of us who smoked cannabis, we're not heroin addicts'. Just show me the heroin addict who did not start with cannabis". (Police Review, 9 Nov. 2001, p. 27)

This argument suggested that there is a relationship between the use of cannabis and the eventual use of heroin. It was proposed that one drug leads to another and there was nothing in this argument to suggest that the drug user exercises' much choice or uses rational decision making in this progression. Advocates for the legalisation of cannabis did not see it as a springboard to a life of crime:

> "While most heroin users have used cannabis, the reverse is certainly not true. As for encouraging offending, an average criminal user commits far less crime to fund drugs than to pay for tobacco or alcohol". (Police Review, 9 Nov. 2001, p. 26)

In this article, the drug users were seen to exhibit choice and rational decision-making in their behaviours. It also drew attention to a point that was recurrent in much of the Police Review data, that alcohol and tobacco are legal and yet seen to cause many problems in society. This line of reasoning fuelled much of the debate surrounding the legalisation of drugs:

> "Let us make something very clear, all drugs are dangerous and that includes alcohol and tobacco. If abused, prescribed drugs can kill and harm. As police officers, we all know the problems colleagues face every day from alcohol-related offences". (Police Review, 19 July 2002, p. 23)

This extract suggested that it is not the legal or illegal status of drugs that matters. Alcohol is legal within British society and yet it is acknowledged that it still causes problems of a criminal nature. It was acknowledged throughout the Police Review data that there is a demand within society for substances, such as alcohol, tobacco and drugs, and it is only the abuse of a substance that can cause problems for the

user. Within the Police Review articles there was an acknowledgement that individuals can exercise their ability to decide whether or not to use illicit drugs:

> "There are a variety of reasons people take drugs – whether it be to socialise, relieve stress, gain acceptance, or for psychological reasons. The reason for this is that a large proportion of society wants to take these drugs – whatever the beliefs of the rest of us, they are successfully doing so and will continue to do so". (Police Review, 6 Sept. 2002, p. 17)

This article clearly highlighted the point that people decide for themselves to use or not to use drugs and are not led by the supply market. Despite this none of the articles argued in favour of legalising heroin. However, it was acknowledged that heroin use leads to crime and leaves the users vulnerable to the drug dealers. A clear argument was put forward in favour of making heroin available on prescription and the introduction of shooting galleries:

> "The committee recommends that the law regarding certain banned substances should be relaxed and calls for a renewed emphasis on education, treatment, and harm reduction measures targeting the country's 250, 000 'problematic drug users'. ... The report stated: 'We accept there is a strong case for bringing heroin use above ground, so that those who do not wish to be helped can at least indulge their habit at minimum risk to their own health and that of the public'". (Police Review, 31 May 2002, p. 10)

The motivation for this argument appeared to stem from the inherent risks that are involved with taking recreational drugs. This argument also encompassed many of the principles of 'harm reduction' which acknowledges that some people may not be ready to stop using heroin and therefore the best solution is to reduce the risks involved. A harm reduction approach lies somewhere between the legalisation of drugs and zero tolerance. It supports the sentiment of many of the articles in the

Police Review which called for a supportive approach towards heroin users in the form of treatment and education. Yet in some articles it was apparent that the harm reduction approach did not sit easily with the perceived role of the police force:

> "...said he did not believe that supplying needles to drug addicts was a job for the police. 'It might be necessary from a social point of view but its not a proper thing for the police to be involved in. Some of our members will see it as condoning offending behaviour". (Police Review, 16 Nov. 2001, p. 10)

The reader was reminded here that heroin use is illegal and the supply of needles might be seen as 'condoning offending behaviour'. It was acknowledged that harm reduction is necessary but not something that the police should support as their main concern is upholding the law.

4.4.4 The heroin users' environment

In the Police Review articles heroin was depicted as something that was associated with poor housing estates as opposed to mainstream society. This theme created a link between heroin and poverty:

> "Much of Middlesborough is taken up by deprived, sprawling housing estates on which drug dealing, particularly in heroin, is rife. Another major problem, according to the force, is the strong link between the town's prostitutes and drugs. The result is that Middlesborough's heroin is among the cheapest in the country". (Police Review, 4 Jan. 2002, p. 18)

This extract depicted a strong link between heroin and a deprived area of Middlesbrough which has many social and economic problems. Crime, drug dealing and prostitution are not desirable behaviours within today's society but in

this article it described them as bound up in the 'sprawling housing estate'. This distinction between drug use among the poor and the middle class was also seen clearly in the following article:

> "It is not the leafy suburbs occupied by affluent white liberals fondly rediscovering their 1960's youthfulness that suffer from the crimes prompted by the incessant need for these addicts to 'score'. It is the decaying inner-cities and dump estates. It is the poor and deprived ethnic minorities who suffer the resulting burglaries and robberies. It is not the parents who live in affluent suburbs who must live with the fear that their children will be drawn into this web. It is those who struggle to escape poverty and deprivation who see their children scrambling their brains". (Police Review, 28 June 2002, p. 15)

In this extract it was argued that drugs and crime are not a middle class problem, rather they are the scourge of the poor and deprived. There was also a suggestion in the text that young middle class people don't take heroin and therefore their parents don't need to fear it. Heroin use was seen as a method of escaping poverty and deprived lives. In another article a police officer told the story of how he coped when he discovered his son was a heroin addict:

> "He told his father he had started to take drugs at the funeral of a friend who had committed suicide. His habit got slowly worse and he found himself struggling to hold down jobs and desperate to raise enough money to pay for drugs. He told his father he didn't resort to crime to pay for drugs".
>
> (Police Review, 30 Aug. 2002, p. 16)

This article was a good example of the clear demarcation that was evident between the lifestyle of heroin addicts from run down housing estates and that of the son of a police officer. In this extract although the police officers son was addicted to heroin he allegedly did not steal to support his habit. It as also argued that this

heroin addict was drawn into heroin addiction by the harrowing loss of his friend. There was no mention anywhere in this article about where this young boy got the money to buy his heroin. These arguments have the potential to create a 'them and us' situation, drawing a clear line between those who take heroin and the rest of society. In terms of class, this was reinforced further in the Police Review data by the suggestion that heroin addiction and drug crime only happen in deprived parts of the UK. Other articles suggested that heroin was present in all parts of society:

> "Mr Howard says the war metaphor suggests that something is being done when there is, in fact, confusion and inaction. But when it finally comes down to it, he adds, drug usage is now embedded in our society. We can't wage war against our own citizens, friends and neighbours'". (Police Review, 1 Feb. 2002, p. 21)

The resistance to wage war against 'our own citizens, friends and neighbours' reminded the reader that drugs are ubiquitous within society today. This would suggest the heroin users' environment is not just associated with poverty and deprivation but reaches into all parts of society.

4.5. British Medical Journal

Forty articles were analysed from the British Medical Journal. I initially analysed the forty articles separately using a content and thematic analysis (Joffe & Yardley, 2004). The coding frames for the analysis of the BMJ can be seen in Appendix J. In the British Medical Journal (BMJ) three main themes were identified and these were: death, perceptions and impact.

4.5.1 Death

The most common theme in the BMJ was the effect that heroin could have on the health of the heroin user, particularly those who inject the drug. Within this theme there was a focus on the rising number of fatalities due to heroin use:

> "The recent 'heroin epidemic' has led to a dramatic increase in the incidence of fatal and non-fatal heroin over-dose in many countries. ...... Every year about 2% of people who inject heroin die, which is six to twenty times the rate expected in peer controls who do not use drugs. This epidemic of deaths among injecting heroin users has led many organisations to develop strategies other than simple abstinence to prevent this tragedy". (BMJ, 22 Feb. 2003, p. 442)

This extract discussed, in a factual manner, the realities of heroin use and the possibility of death. The risks of heroin use were highlighted and the heroin user's vulnerability to the risk of death. This article took a pragmatic approach to the problem and strategies other than abstinence were considered in order to prevent these deaths from occurring. This was a reference to harm minimisation approaches that are focused on reducing the risks associated with drug use. Although the tone of the article was factual, it was possible to see the emerging vulnerability of the heroin user:

> "Heroin related deaths occur at a steady rate and are not caused by sudden changes in the purity of heroin. Research from Australia has shown that most of these deaths occur in the company of other people and that medical help is not sought or is sought too late. Instant death does not seem common and in most fatal cases death is estimated to have occurred one to three hours after injection. Only a minority of heroin related deaths (17%) occur among new users". (BMJ, 22 Feb. 2003, p. 442)

This article highlighted that heroin users are vulnerable to death every time they use heroin. This may be a result of a lifetime of bad health or just bad luck. It was pointed out that although most of the deaths occur in the company of others help is not always at hand. There are many possible explanations for this. In some instances the other people present may also be using heroin and therefore incapable of calling for help. There is also the possibility that the persons present fear calling for help due to the legal implications of being caught using heroin. The articles of the BMJ took a pragmatic approach to this problem and saw it as a challenge to be met:

> "The challenge is to continue developing accessible and effective services, thereby reducing the risks of all opiate related deaths, balanced against measures to reduce treatment related individual and community risks. For example 'Reducing Drug Related Deaths' implicates methadone diversion as an important factor in accidental overdoses and recommends witnessed consumption. This would help ensure treatment compliance, reduce the potential for naïve users to obtain methadone, and reassure professionals and communities". (BMJ, 31 March 2001, p. 749)

The overall focus of these articles was to meet the challenges of the health risks of heroin use, particularly the risks from injecting the drug. In general the approach was one of 'harm minimisation' in particular with relation to the risk of death due to heroin use. The article recommended 'witnessed consumption' and asserted that this would ensure compliance and, amongst other things, 'reassure professionals and communities'. The tone of this proposal implied that strong intervention from the medical profession would be effective for all concerned. Another focus was on effective work practices that lead to better health for those involved:

> "Outreach and case management techniques can improve the standards of daily living for homeless people. Young people who misuse drugs are difficult to help and programmes should be especially developed to ensure that this group receives psychiatric treatment, detoxification treatment, medical treatment, social advice and accommodation. The prevention of social exclusion should start early in life". (BMJ, 12 July 2003, p. 81)

It was pointed out in this extract that another risk facing the heroin user is that of social exclusion due to homelessness. It was a reminder of what the heroin user could lose because of their drug use. It was believed that this challenge could be met by encouraging assertive techniques to help and support heroin users. Proposed techniques were professional interventions and these stressed the health aspects of heroin use but also the social implications too:

> "All controlled drugs are harmful and will remain illegal, he said. The misery caused by the use of drugs and hard drugs that kill cannot be underestimated. It damages the health and life chances of individuals; it undermines family life, tears apart communities and turns law abiding citizens into thieves".
>
> (BMJ, 7 Dec. 2002, p. 1321)

This article outlined the effects of heroin on the life of the heroin user and their family. There was a sense of loss for everyone in this extract but particularly the heroin user who risks his/her health and also their 'chances in life'. This resonated with the previous article that posited that drug use leads to social exclusion which also highlighted the risks involved with heroin use and what the heroin user could lose. In this article heroin was seen to be the motivation for the crime committed by otherwise 'law abiding citizens'.

One proposed solution for the reduction of the risk of death associated with heroin use was the availability of heroin on prescription:

> "Heroin users should, in certain circumstances, be able to get the drug on prescription from their GP, a Home Office strategy on tackling drug misuse has recommended. The move recognises that not all users find that methadone, the commonly prescribed substitute, works. For some users, it may be better, initially at least, to prescribe heroin, but then gradually move on to methadone". (BMJ, 7 Dec. 2002, p. 1321)

In this article it was argued that, from a practical point of view, heroin should be available on prescription. This argument embodied the tenet that if something is not working then it is better to find a solution that does work. The desired outcome in this line of argument appeared to be the desire for better health for the drug user and the reduction of associated health risks and risk of death:

> "Heroin prescribing was welcomed by the drugs charity Turning Point. Richard Kramer, head of policy, said it might reduce the risk of over dose and could suit entrenched users. 'But it is just one approach' he said. 'What we are pleased about is they have got a new focus on harm reduction and working with GPs in reducing the risks with drug abuse'. But he said GPs needed incentives to get involved in such work: 'It is not enough to rely on the good will of GPs, real training is needed". (BMJ, 7 Dec. 2002, p. 1321)

Harm reduction was the main theme of this extract and a sense of wanting to take care of the vulnerable heroin user who is at risk from the drug, their own addiction and their chaotic lifestyle is evident. The heroin user was depicted as someone in need of health care and there was no focus on any other elements of their lifestyle, such as criminal activity:

> "The combined prescribing of heroin and methadone on medical grounds to long term users of heroin is safe and manageable and has health benefits over ordinary methadone programmes, two large randomised controlled trials in the Netherlands have concluded ... Patients who were prescribed heroin and methadone experienced 23 – 25% more 'clinically relevant improvements' in their physical, mental, or social condition than patients taking methadone alone. The improvements included better social contacts, less criminality, and less use of cocaine". (BMJ, 16 Feb. 2002, p. 385)

In this article the heroin user was referred to as a patient and this created a strong association between heroin addiction and illness. There was no mention of the legal aspects of illicit drug use or any associated criminal activity. The use of the term 'patient' depicted the heroin user as someone who is ill and vulnerable and needs medical support to 'get better'. Death can be avoided with medical intervention and patient compliance with treatment.

4.5.2 Perceptions

In the BMJ the heroin user was perceived in two different ways, a citizen with rights and a difficult and challenging patient. BMJ focused on the rights of the heroin addict with minimum regard for the legal status of the drug:

> "The United States Supreme Court has ruled that hospital workers cannot test pregnant women for use of illegal drugs without their informed consent or a valid warrant if the purpose is to alert the police to a potential crime. ... The Supreme Court ruled that the facts of the women's pregnancy and of possible danger to their foetuses through use of illegal drugs did not change their basic constitutional rights". (BMJ, 31 March 2001, p. 753)

This extract took into account that the heroin user has similar rights to anyone who does not take illegal drugs. There was tentative evidence here of an existing tension between the medical system and the judicial system. The tension between the heroin user as patient and the heroin user as criminal could be seen more clearly in the following extract:

> "In most EU countries, medical care in prisons is the responsibility of the ministry of justice. But in France, Italy, and England and Wales responsibility has been transferred to health ministries. The report maintains that inmates who misuse drugs hardly ever receive the same level of health care that they would enjoy outside in the wider community despite the United Nations principle that prisoners, though deprived of their liberty, retain all other rights". (BMJ, 22 Sept. 2001, p. 654)

There was a strong sense in this extract that the medical needs of a heroin user should take priority above all else. Throughout the BMJ articles there was very little commentary on the criminal activities associated with heroin use. Instead attention was focused primarily on the health and well being of the heroin user and their entitlement to good healthcare. The following extract again demonstrated that health and welfare were the top priorities:

> "Mainline Lady, a lifestyle magazine offering information and advice on drugs, health and women's issues, has been launched in the Netherlands. ... Modelled on other women's fashion publications, it hopes to challenge the 'junkie' image, arguing that many of its readers will be middle aged, married mothers, wives and girlfriends. It does not campaign for abstinence but, by offering a positive image of women, hopes to empower its readers and increase their sense of responsibility. Senior editor Karin Kloostra wrote: 'Caring for the body and looking after yourself is the theme which runs through this Mainline Lady". (BMJ, 28 July 2001, p. 184)

In this extract the heroin user was not seen in a negative sense and there was no discussion as to how to stop the heroin user from taking drugs. Rather the focus was on harm minimisation and the health of the female and the body. The legal status of heroin was not considered in the extract. However, another perception of heroin users in the same data highlighted the reluctance of some GPs to work with heroin users and incorporated GPs perceptions of this client group:

> "Britain's doctors are not doing enough to care for drug misusers, according to a House of Commons committee report published last week. ..... The report cited 'disturbing evidence that a large, albeit decreasing, proportion of GPs appears to be unwilling to treat drug users'. Using statistics from the 1980s, Dr Clare Gerada of the Royal College of General Practitioners told the committee that 5% of GPs were treating 50% of Britain's drug users". (BMJ, 1 June 2002, p. 1295)

This extract presented an alternative perception of heroin users from that of a citizen with human rights. Within the theme of death the heroin user was depicted as a patient who was in need of medical support and assistance. This article, however, suggested that most GPs do not want to work with drug users including heroin users:

> "Dr Vivienne Nathanson, head of science and ethics at the BMA, responded: 'Prescribing to drug mis-users is complex and time consuming. They need regular health assessments as well as specialised assessments regarding the correct dosage and frequency. Many are also 'difficult' and disruptive, associated with their drug uses and the effect that has on their neurochemistry and personality, so there are issues about safety and about other patients". (BMJ, 1 June 2002, p. 1295)

In this extract it was clearer how the heroin user as a patient is perceived by many GPs. There was an implication in this extract that heroin users are high

maintenance and perhaps a little dangerous or unpredictable. This was emphasised by the concern shown for the safety of staff and the other patients. The following extract discussed 'non-violent' drug offenders:

> "A pilot court scheme offering supervision and treatment rather than incarceration for non-violent drug offenders is under way in Dublin, but without the co-operation of GPs in the area who dispense methadone to heroin addicts. It is expected that as many as 100 offenders could be offered an integrated programme of rehabilitation, counselling, training and education under the scheme, which began this week". (BMJ, 13 Jan. 2001, p. 70)

It was notable that in this article there was an emphasis on offering treatment rather than punishment to heroin users and yet this appeared to be happening without the involvement of the GPs. The extract did not suggest why the GPs were not giving their co operation in this instance.

4.5.3 Impact

The British Medical Journal drew attention to the fact that all drugs are potentially harmful for the user. In this way heroin use was perceived in a similar way to alcohol and tobacco. By adopting this approach the legal status of alcohol and tobacco versus the illegal status of heroin was largely ignored. Instead alcohol, tobacco and heroin were all implicated in health problems for the user and were not distinguished by their legal status:

> "The financial impact of tobacco and alcohol far outweigh the impact of illicit drugs, with smoking costing the community almost three times as much as any other category of drug, according to a study on the social costs of drug use in Australia. ... Drug agencies said that they had been aware that tobacco and alcohol were

> responsible for more problems than were illicit drugs, but they added that the report would show the general public how legal drugs had more impact". (BMJ, 1 Feb. 2003, p. 242)

This extract focused more on the health and social implications of a substance than its legal status. In this extract it was suggested that the impact of heroin was not as great as that for tobacco and alcohol. Alcohol and tobacco were also alleged to cause 'more problems' than other illicit drugs but what those problems were was not specified. This resistance to categorise drugs from a legal perspective was seen again in the following extract:

> "The BMA has called on the UK government to develop a campaign to highlight that taking drugs – whether prescribed, over the counter, or illegal – can impair driving capacity in a similar way to alcohol". (BMJ, 16 March, 2002, p. 632)

Again in this article little concern was shown for the legal status of the drug but rather it was the effects of the drug on drivers that was the primary concern. Again, all drugs were seen in a similar vein to alcohol, both were considered deleterious to driving.

4.6 The Newspapers

Forty articles were analysed from the newspaper data. I initially analysed the forty articles separately using a content and thematic analysis (Joffe & Yardley, 2004). The coding frames for the analysis of the newspaper articles can be seen in Appendix K. Two main themes of heroin were identified in the newspaper articles and these were perceptions and the legislation debate. Within the theme of

perceptions, heroin users were depicted in three ways, naïve and passive, a dangerous aggressor and a patient with an addiction.

4.6.1 Perceptions

Heroin users were depicted as naïve and innocent in many of the newspaper articles. The heroin user and the heroin dealer were described in a significantly different way:

> "It was the worst decision of her life. She was too naïve to realise the nightclub was a well known haven for drug dealers. Within a matter of days, they tempted her with free pot and then ecstasy in return for free drinks. 'He was two years older than me and I looked up to him', she says: I wanted to impress him so I lied and told him I'd already tried heroin". (The Mirror, 17 Sept. 2002, p.23)

In this extract the young girl was described as younger and naïve than the people providing the heroin who were described as older and more in control of their actions. Their actions were described as deliberate and there was a suggestion that 'they' set out to encourage this young girl to take drugs with the intention of introducing her to heroin:

> "They smoked their first fix together in a friend's flat, 'chasing the dragon' by inhaling the liquid on a spoon heated underneath with a cigarette lighter. 'It was a bit sordid, but it felt amazing', recalls Michelle, who moved in with Wayne against her parents' wishes. 'I just floated off into another world'. She believes it took less than four fixes before she was fully addicted to heroin. 'The dealers are very clever', she says. 'They sell a quarter of a gram to you for practically nothing, then raise the price as soon as you become dependent". (The Mirror, 17 Sept. 2002, p. 23)

In this extract again it was the drug dealers who were clever, in contrast to the naïve young girl. She was not deemed to be culpable for what happened to her, but rather it was her boyfriend and the drug dealers who drew her into a world of heroin addiction. The drug dealers were displaying signs of bad intent in their actions whereas the young girl was depicted as passive in her actions. In the following article a father described how his sons became heroin addicts and it was a similar story:

> "Mine got into drugs with their pals. It was that time in the eighties when the kids here were easy prey for dealers. It was Thatcher who put the kibosh on this city. There was that much unemployment and no feeling that there was any future. When someone said to the youngsters 'have some of this, you'll feel great', they did. It wasnae like in my day when you had a drop of whiskey and hated the taste of it. They got their hit first time". (The Mirror, 27 Oct. 2003, p. 26)

The use of the term 'prey' drew attention to the intentional behaviour of the drug dealers in this extract also. It conjured the imagery of a hunter and the term 'prey' suggested that the young people were weaker or susceptible in some way. This could possibly have been due to the lack of a sense of future due to rising unemployment as perceived by the father. There was a reference here to the fact that heroin would make someone feel great. However, the majority of the data concentrated more on the addictive nature of heroin:

> "At the age of 15 Charlene is adrift and alone among the scum of the underworld. Her parents are at their wits end and powerless to help. And all because she has become a slave to heroin. She is aware that the craving is killing her and that it has robbed her life of all meaning". (The Mirror, 18 Feb. 2002, p. 6)

This extract described heroin dealers as 'the scum of the underworld'. This description may also have been referring to other heroin users she may have encountered. It was not fully clear to the reader. The use of the term 'underworld' drew the reader's attention to the fact that heroin use does not happen in mainstream society but was in fact far removed. The young girl, Charlene, had become 'a slave' to heroin. The imagery here was strong and it reinforced the addictive qualities of heroin. It also inferred that once a person becomes addicted to heroin they lose all else in their life. The next extract demonstrated this clearly:

> "Drugs are the scourge of this country. They are taken by millions – and not just the young. ... Rachael was one who couldn't cope. Although she had ten GCSE's, two A-levels and was on her way to university, a boyfriend introduced her to heroin. From then on she was sucked into a spiral of despair and addiction. Her parents did what they could. But even the most devoted parents cannot compete with the hold drugs exert". (The Mirror, 1 March 2002, p.6)

In this extract this young girl was again 'introduced' to heroin by a boyfriend and again there was a suggestion of passivity on her part. Rachael was someone who achieved well at school and was eligible for university. Once she began taking heroin she was 'sucked into a spiral of despair and addiction'. The use of the verb 'sucked' suggested the powerful nature of heroin and this descent seemed to happen against her will. Again the parents of this girl were helpless and there was a sense in the data that heroin addiction is powerful and all encompassing. There was a strong sense, overall in these extracts, that those who became addicted to heroin did so unwittingly and all the intent lay with the dealers:

> "No one benefits from heroin apart from the dealers who sell it. The addict is helpless and the family of the addict is helpless. The police are ineffectual and the then the NHS picks up the bill". (The Independent 9 Nov. 2002, p. 21)

The heroin addict and their families were depicted as 'helpless'. The dealer was depicted, in this extract, as the real winner. It was argued that everyone else, including the taxpayer, suffered in some way including financially. The mention of the police and the NHS was a reminder of the dual aspects of heroin use, that is, crime and health. The newspaper articles also depicted heroin users in a negative way focusing on dangerous behaviours in terms of the threat to individuals and the impact on society:

> "A heroin addict was ordered to spend a minimum of 16 years in jail yesterday for the murder of a two-year old boy who suffered weeks of starvation and beatings at his hands. ... In the final week of his life he was beaten for asking for a glass of water. He was then left alone for two days and nights without food while his mother and Connelly indulged their heroin habits". (The Times 5 April 2002, p. 8)

In this extract the heroin addict was described as extremely dangerous and threatening. The use of the verb 'indulged' also suggested a sense of selfishness and pleasure. A young boy was tortured and eventually murdered yet the child's mother and her partner were still enjoying heroin. The cost to society here seemed to be the genuine care of a child. Other articles demonstrated different dangers and threats:

> "The case, the first of its kind in England and Wales, echoes a conviction in Scotland two years ago. In February 2001, heroin addict Stephen Kelly was convicted of 'culpable and reckless conduct' after he had unprotected sex with girlfriend Anne Craig for six months after being told that he was HIV positive. Kelly was jailed for five years". (The Daily Mail 15 Oct. 2003, p. 1)

This extract highlighted the association between heroin use and HIV. It was not clear if the girlfriend contracted the virus from this heroin user but there was a possibility that she did. The threat associated with heroin, as depicted in this extract is associated with the use of syringes:

> "Junkies are inserting their filthy syringes into lemons and oranges in an attempt to clean them, the Mirror can reveal. Drug users are 'juicing' their contaminated needles in small shops in Dublin's south inner city. The addicts repeatedly stab the needles into the fruit in the belief it will sterilise them. There's virtually no trace and some unfortunate goes and buys the fruit which could have traces of blood which may be contaminated with AIDS or hepatitis". (The Mirror, 29 Sept. 2003, p. 19)

In this article the impact on society was the health of the innocent public. The heroin users in this extract were accused of the possibility of 'contaminating' other people with their blood which may contain the AIDS virus or a hepatitis virus. The action of cleaning a syringe in the fruit is selfish and thoughtless at best, deliberate and dangerous at worst. There was a deliberateness of intent apparent in the term 'repeatedly stab'. Other perceptions of heroin users were highlighted in the data:

> "Most of us don't have the luxury of deciding to pump our veins full of drugs and lie around all day – we are driven by the need to pay mortgages, bring up our families and look after our relatives. Our self-esteem does not allow us to pester other people to fund our lifestyles for free". (The Independent 24 Aug. 2003, p. 24)

A clear distinction was drawn between people who pay mortgages and take care of their families and those who take heroin in this extract. The implication in the extract was that the life of a heroin user is quite luxurious and relaxing. The use of

the term 'pester' was negative and depicted an action that is unwelcome but persistent. The following extract looked also at the costs to society:

> "Who suffers from heroin addiction? Certainly addicts loose their self-respect, health and friends. Users become disinhibited about what they will do to support their habit; prostitution, theft, lies, manipulation. Children of a user suffer emotional and physical neglect. Daily, a child hears the message, 'I love you but I love my habit more'. The whole community suffers from the huge volume of crime necessary to pay for the gear". (The Independent 18 Nov. 2001, p. 31)

It was clear in this extract that there is a cost to the whole of society from heroin use. It was argued that it impacts on everyone but most importantly the children of heroin users. Crime affects everyone and there was a strong assumption that it accompanies heroin use in the majority of cases. The heroin user was seen in a pitiful light with no self-respect, bad health and no friends. They were described as people who love their children but not as much as their heroin.

Within the theme of Perceptions the heroin addict was also depicted as a patient as opposed to a criminal. This theme incorporated the issues of how best to deal with the problem of heroin use within society today:

> "The cost of crime to fuel addicts' habits runs to billions. A £300-a-week habit is responsible for £3000-worth of crime. The war against drugs is lost and costing more every year. Yet no sensible strategy has been produced to curb it. At the very least, heroin users could be treated as patients, as they used to be, rather than criminals. They wouldn't rob and steal if they no longer needed to". (The Mirror, 12 July 2002, p. 4)

This extract presented the heroin user as a sick person in need of medical treatment rather than punishment. This was supported by the belief that heroin users only steal because they have to, not because they want to. Addiction was seen in many

of the articles as very powerful and something that has to be 'fuelled' or in other words, fed. Other articles echoed this theme but drew attention to the fact that help was not always available for heroin addicts:

> "In Caernarfon, a heroin addict has to wait for up to nine months for an appointment with a drugs counsellor, and many more months for proper treatment. The only way of by passing the waiting list is to break the law: in prison, an addict can expect to be sent to a detox-wing on admittance". (The Independent, 26 May 2002, p. 27)

In this article, the heroin addict was presented as helpless in this situation. It was argued that if a heroin addict wants medical help or support it was not available and therefore they were forced to break the law to get help. Once again the heroin addict was depicted as not being responsible for the intent of their criminal behaviours but rather acted out of desperation for money or for help. Most of the articles were in agreement that heroin addiction should be seen as a medical matter rather than a criminal one. Many suggestions were made for how to address this problem within society:

> "We will never end the supply unless we run the supply ourselves. David Blunkett is an honourable member of a government I trust. This is not a political point – scoring exercise – this is a matter of life and death. The dealers out of the equation, bring drugs under government control and then we'll win the war on drugs because we will, at least, have a say in the matter". (The Independent, 9 Nov. 2002, p. 21)

The author was suggesting that heroin should be brought under government control which would go some way towards legalising heroin. The drug dealers were seen here as the undesirable part of this equation. The heroin user was not described, however, there was a reference to the risk heroin posed to their lives so there was a reference to their vulnerability. The author was suggesting that under government

control heroin could be given to heroin addicts in a safe and controlled way. In many articles this was seen as the only solution to the problem and the answer to many of the challenges:

> "The decision to allow doctors to prescribe heroin is to be welcomed. When addicts are provided with a safe regulated supply they will not be forced to turn to crime to satisfy their cravings and will not need to contribute to the earnings of the pushers. The use of clean needles will help to reduce HIV and hepatitis. There is even the prospect that some addicts may be cured of their addiction". (The Independent, 7 Dec. 2002, p. 19)

Clearly this author saw this as the solution to a majority of the problems associated with heroin addiction. There was a consistent theme that drug dealers should be taken out of the equation because they were perceived to benefit from the misery of the addicts. It was argued that drug dealers could be removed from the life of heroin addicts if GPs could prescribe heroin to them in treatment programs. The use of the word 'cured' again reiterated the association between the heroin user and a patient with an illness. In this data sample there were no articles that argued against the proposal that heroin should be available on prescription for heroin users.

4.6.2 The legalisation debate

The following theme focused on the illegal status of heroin in the UK and the perceived impact this had:

> "It has become obvious that our drug laws are not working. The Independent has long argued for a free-minded debate on the issue of drugs and, in particular, the need to differentiate between addictive narcotics and those milder substances where much of the problem is caused by their illegality. There was always something odd

about cannabis being treated in the same way as opiates". (The Independent, 22 Nov. 2001, p. 3)

This article called for an open debate on the existing drug laws in the UK and argued that it is the illegal status of drugs that causes many of the associated problems. The author was not questioning the illegal status of heroin but instead questioned that of cannabis which was not believed to be so addictive. Other articles addressed similar issues:

> "I have said on numerous occasions that in relation to alcohol we all need to be responsible, and that includes everybody – the individual, the parent, the retailer, the drinks industry. Parents often feel alcohol is the least of their worries but the fact is that it causes much more damage to society than heroin and all the other illegal drugs put together". (The Mirror, 5 Sept. 2003, p. 6)

In this extract, heroin was seen as the lesser of two evils and in fact it was argued that alcohol is a more destructive drug. The author suggested that everyone needs to show responsibility around alcohol and this would suggest that alcohol is a substance that an individual can use in a safe controlled way. The following article echoed a similar theme:

> "The hysteria and self-delusion continue. Nine-year-olds are now to be shown a video nasty about the horrors of heroin addiction. The crusade against the evils of 'drugs' will move into a new phase. What hypocrisy. Alcohol and tobacco cause far more devastation to society in terms of murders, road deaths, crime and disruption to families, workplaces, lives, careers and education. ... Children aren't stupid. They understand the ambiguity and insincerity of the underlying message: 'Drugs are bad, but only the ones we don't like. The ones we take are fine. If you like the drugs that we don't like, you are deviant and a threat and we will punish you".
>
> (The Independent, 22 May 2002, p. 17)

This article argued that the hypocrisy surrounding the messages on drugs undermine what the campaign is trying to do. The author believed that it is the illegality of heroin alongside the legality of alcohol that causes ambiguity in drug warning messages to young people. Alcohol and tobacco were depicted as substances that cause far more problems than heroin or other drugs. The comment at the end, 'if you like the drugs that we don't like, you are deviant and a threat and we will punish you' demonstrated how heroin users were perceived in this way. Within the legalisation debate was a reminder of the normality of drug use within contemporary society:

> "Ecstasy, cocaine and 'speed' are increasingly used by young people who take cocktails of 'stimulant' drugs every weekend. In the 1980's, heroin users lived on the margins of society. But now, regular drug users are just as likely to be employed, have close relationships and be settled down".
>
> (The Daily Mail, 24 Oct. 2003, p. 15)

The article referred to the alleged increase in the use of 'weekend' drugs such as ecstasy, cocaine and speed. In this extract was the image of the heroin user as someone who is 'excluded' in some way. It was not clear if the author was referring in the last statement to ecstasy, cocaine and speed or if in fact heroin users were included in the statement. The normality of drug use in today's society was referred to in other extracts:

> "The trouble with anti-drug propaganda from a succession of governments is that it seems to be produced by old, out of touch people. The latest commercials – urging young people to talk frankly about drugs – are no different. Having a chat and laugh about heroin is as pointless as telling youngsters to 'just say no'. What the drugs crisis needs is for politicians to listen to young people and accept the reality of their

lives. If they don't do that, drug use will go on increasing. No matter how many glossy campaigns there are". (The Mirror, 24 May 2003, p. 6).

This extract demanded for politicians to 'listen to young people and accept the reality of their lives'. It was possible that the author was alluding to the normality of drug use in the lives of young people. It was also possible that this was a reference to how complicated young people's lives are today and this infers why they might resort to using heroin or other illegal drugs. The suggestion here was that young people use heroin in some way to assist them with other problems or situations in their lives. In this sense heroin use would not just be for the sensation of the heroin itself but to help the user cope in some way with another situation.

4.7 Similarities and differences in the themes from Police Review, BMJ and the newspaper data

In the last three sections I presented the main themes that emerged from the Police Review, the BMJ and the newspaper articles. Each of these three data sources were analysed individually to explore the main themes in each one. It is important to note the similarities and differences across the data sets. An SRA is interested in shared meanings and therefore I was interested in the commonalities and differences between the three sources of data.

4.7.1 Perceptions of heroin users and the heroin users' environment

The BMJ and the newspaper articles both had themes of the perceptions of heroin users. Both sources portrayed differing perceptions of heroin users within the data samples. The BMJ articles focused on the rights of the heroin user and also on

associated behaviours that were construed as difficult and challenging. The theme of perceptions in the newspaper data contained three differing perspectives; the naïve and passive heroin user, the dangerous aggressor and the patient with a controlling addiction. The Police Review data did not focus on perceptions of heroin users directly but paid more attention to the heroin users' environment. This theme encompassed poverty and other associations with the use of heroin and people who use heroin.

The newspaper articles focused on many negative behaviours of the heroin addict. Heroin addicts were depicted in many articles as being 'culpable' and 'reckless'. They were associated with spreading HIV through unprotected sex, causing the death of a two-year-old child and stabbing fruit with dirty needles with no regard for the public. Heroin addiction was seen as the main motivation behind these behaviours but heroin addicts were described as having no self-respect and showing no concern for the impact their actions had on others. It was argued that their only motivation was the acquirement of heroin. The BMJ articles also made reference to the negative behaviours of heroin addicts but perhaps to a much lesser extent. In the BMJ, heroin addicts were described as 'difficult' and 'disruptive' and the safety of staff and other patients was brought into question.

There was ambiguity in the newspaper data, however, because the heroin addict was also depicted as 'naïve', 'easy prey', 'a slave', 'helpless', 'a patient' and 'curable'. These terms were more descriptive of a state of being and therefore there was a passivity that was not associated with the negative behaviours described above. Similarly, the BMJ articles also perceived the heroin addict as a citizen with

human and medical rights which was in contrast with the perceptions of the heroin user as challenging and difficult. The BMJ articles referred to heroin addicts through the use of medical terms. The BMJ articles discussed 'injecting heroin users', 'heroin related deaths', 'treatment compliance' and naïve users. In this data, therefore, the heroin addict was perceived predominantly as a patient. There was also a reference to the impact of heroin and how it 'turns law abiding citizens into thieves'. This echoed the sentiments of the Police Review. In the newspaper articles the heroin addict was also perceived as a patient in relation to the prescribing debate. Some of the newspaper articles posited that the heroin addict should be perceived as a patient and not a criminal.

The newspaper articles and some of the BMJ articles focused on the behaviours of the heroin addict whereas other newspaper articles and the Police Review described how the heroin user was and there was a sense of passivity in this as in the patient or the slave. Finally, the BMJ articles described the heroin addict in medical terms which created a sense of anonymity.

The heroin users' environment was a prominent theme in the Police Review and was much less so in the BMJ and the newspaper articles. In the Police Review articles heroin was associated with 'deprivation' and 'sprawling housing estates'. A clear distinction was drawn between 'leafy suburbs' and the 'decaying inner cities and dump estates'. In the BMJ heroin addiction was associated with homelessness and social exclusion. These are also linked to poverty and deprivation. In the media articles the link between heroin and poverty was

established in a subtle way. There were references to the 'scum of the underworld' and periods of great unemployment in the UK.

4.7.2 Distinctions between the heroin user and the dealer

This theme featured in the Police Review and the newspaper articles but did not feature in the BMJ. There was a distinction in the Police Review articles between the crimes associated with heroin addicts and the crimes associated with heroin dealers. Heroin addicts were associated with robberies, street crime and prostitution. However, their crimes were explained in terms of their addiction. The Police Review data argued that the main motivation behind these crimes was the addiction to heroin itself. This was evident in the theme, crime (see section 4.4.1). Heroin addicts were portrayed as victims of their own circumstances, "If you could get free of heroin you wouldn't commit crime". Heroin dealers however were associated with kidnappings and serious assaults, such as 'enforcement attacks with axes and machetes'. Their actions were deemed to be more deliberate, more calculated.

The Police Review data suggested that the main motivation for these more serious crimes was to sell drugs and make a profit. Terms like 'tactics' and 'gain control' were used in the Police Review articles. The newspaper articles also, in some articles, depicted heroin addicts as vulnerable to heroin dealers. Heroin addicts were described as young and naïve and quickly hooked on heroin once they were introduced to it. Heroin dealers were seen instead to be 'clever' and it was argued

that they were the main beneficiaries of the heroin problem in society. This was evident in the theme, perceptions (see section 4.6.1).

4.7.3 Prescribing and demand reduction

These themes were found in all three sources of data and overlapped in theme content. Demand reduction was a theme in the Police Review and this theme incorporated the topic of prescribing. In the BMJ, methadone prescribing was discussed in the theme, death, and in the newspaper articles, prescribing was discussed in the theme, legalisation. Whilst the Police Review and the newspaper articles argued that treatment was a better option than punishment, the BMJ did not focus on punishment but focused on the positive outcomes of methadone prescribing and highlighted the rights of the heroin user. Although the Police Review is part of a law enforcement milieu, the majority of articles advocated for a treatment approach as a way of reducing the problem of heroin use. Heroin addicts were described as helpless due to their addiction and the associated crime was accredited to their need for the drug. There were striking similarities between the Police Review and the newspaper articles. The latter argued that heroin addicts were sick people or patients as opposed to criminals and therefore they should receive treatment rather than punishment for their behaviours. The newspaper articles also advocated in favour of the benefits of methadone prescribing as a form of treatment and this echoed the themes of BMJ.

4.7.4 The Legalisation debate

This theme featured in all three sources of data and the main focus was the legal status of alcohol in comparison to the illegal status of other drugs. It was argued that alcohol and tobacco cause more harm in society than heroin or other recreational drugs. In the newspaper articles questions were raised about the hypocrisy of warning young people about heroin whilst alcohol and tobacco remain legal. There was no suggestion in the Police Review, BMJ or the newspaper articles that heroin should be legalised. The illegal status of cannabis, however, was questioned, mainly in the Police Review and the newspaper articles as it placed it in the same league as heroin.

4.8 Conclusions

Three different milieu were chosen for the media analysis in study two. Each source was analysed for themes and then I explored the similarities and differences between the three sources. Police Review focused predominantly on crime issues but advocated strongly for treatment options for heroin users. Heroin addiction was seen predominantly as a health issue and the associated crime was believed to be in relation to the addiction only. The BMJ focused on health and medical issues and the best ways to manage the health of the heroin user. The newspaper articles focused predominantly on perceptions of heroin users and therefore were concerned with the character of the heroin user.

Many negative attributions were made about heroin users. The newspaper articles contained the most negative attributions in some of the articles. There was a strong moral, judgemental tone in many of the newspaper articles. This was less obvious in the BMJ and Police Review articles. The attributions were related to addiction and the ability of the heroin user to control their behaviours. This was similar to my findings in Study one. Participants made positive or negative attributions about heroin users according to the amount of control they were perceived to have over their heroin use.

Chapter Five: Individual perceptions of heroin users

5.1 Introduction

In the third study I interviewed twenty participants and asked them their views about heroin and heroin users using semi-structured interviews. This study differed from study one. In study one participants were asked to discuss heroin in relation to three other behaviours, smoking, obesity and alcoholism. They also had a social dilemma style task which was designed to promote discussion and debate. In this study I wished to interview participants individually to enable them to speak openly and I also wanted them to focus on heroin and heroin users only. When the initial part of the interview was completed I presented them with a vignette about a heroin user named *Billy*. The purpose and construction of the vignette will be discussed in this section. In this chapter I will present the main themes that emerged from the data created by the semi-structured interviews and then I will present the main themes from the discussion of the vignette - *Billy*.

5.2 Design and Procedure

I opened the interview discussion by asking interviewees to tell me what their thoughts were when they were asked to discuss heroin or a person who used heroin. The objective of this question was to focus the participants' mind on this topic and to allow them to tap into their own perceptions and beliefs about heroin, unhindered by the researcher. The participants were free to discuss anything they wished to discuss, relating to the topic of heroin. The participants were asked questions by

the researcher only if a point needed to be clarified. Participants were also asked to recall their memories of any drugs education they may have received in school. (see Appendix L for the interview schedule).

5.2.1 The Vignette – *Billy*

Vignettes are frequently used in survey research as tools to facilitate discussion during individual interviews or group discussions. Finch (1987) argues that they provide concrete examples of people and their behaviour on which participants can offer comment and opinion. This is particularly useful if the people and behaviours in question, i.e. heroin use and heroin users, are not well known to the participants. The researcher can then facilitate a discussion around the opinions expressed or particular terms used in the participants' comments. This vignette was used to describe *Billy* and his behaviours to participants. *Billy* was created based on the findings of Shewan and Dalgarno (2005) and his behaviours in this vignette were not the 'usual' behaviours that a person using heroin might display.

"Billy is 29 years old. He lives with his girlfriend in a flat in Clapham Common. She works in Toni and Guy. Billy works in the local garage as a car mechanic. He works 5 days a week and has every weekend off. Billy has been injecting heroin for 7 years. He mainly uses at the weekend but does not use every weekend. Billy enjoys using heroin. He likes the way it makes him feel. Only Billy's girlfriend and very close friends know he uses heroin. He has not told his family".

Table 5.1. The vignette of *Billy* that was presented to interviewees in study three.

The research of Shewan and Dalgarno (2005), which was introduced in chapter one, raised questions about the inevitable addictive nature of heroin. They questioned

the expected outcome of heroin use which is associated with negativity and the ultimate destruction of the life of the heroin user. The vignette for this study was created using the findings from their research. Some of the important and interesting features of Shewan and Dalgarno's research will be presented here in order to show how the vignette was constructed.

Shewan and Dalgarno (2005) conducted a longitudinal study with 126 participants (94 male, 32 female) who had never required any specialist treatment for any drug use. Data were collected using two semi-structured interviews. Two phases of data collection took place and eighty-five participants (67%) were re-recruited for phase two of the study. Their main research aim was to "assess whether this 'hidden' population resembled heroin users identified with drug treatment agencies, or alternatively, to test whether heroin could indeed by used in a controlled, non-intrusive fashion for an extended period of time" (p.33).

The majority of participants in this study reported good health and were found to have "levels of occupational status and educational achievement comparable to that of the UK population, and considerably higher than typically found in heroin research" (p.33). Negative outcomes were not evident for the best part of the sample and the researchers reported that the majority of participants were in relationships, had children and had varying types of settled accommodation (17% owning their own home, 50% were renting from a private landlord and 21% were renting from the local authorities). Shewan and Dalgarno (2005) posited that the participants' frequency of heroin use was "predicted by attributional items,

indicating the importance of psychological factors in drug use and addiction" (p. 33).

The findings from their study challenge traditional stereotypes of heroin use. The expected negative outcomes associated with heroin use were not evident amongst this sample. Their participants also demonstrated certain levels of control over their heroin use which is not normally associated with heroin, due to its reputation as highly addictive. As discussed in chapter one (section 1.12) many researchers have questioned the inevitable decline which is associated with a life of heroin use (Alexander, 1994; Robins et al., 1980). The research of McSweeney and Turnbull (2007) also challenge the assumption of dependence that is associated with heroin use.

Therefore I wished to create a character, *Billy*, in the vignette that had many of the characteristics of the participants in Shewan and Dalgarno's (2005) study and therefore challenged the traditional stereotypes of heroin use. In order to demonstrate that *Billy* had some control over his drug use certain features were added to the vignette to demonstrate this. It was included that he had been 'injecting heroin for seven years' and also that he 'does not use every weekend'. These characteristics of *Billy* challenge the beliefs that heroin is addictive in a way that the heroin user has to use every day. Other characteristics were employed to challenge the stereotypes further. *Billy* has a job, a girlfriend and a place to live in this vignette. This also challenges the assumption that a heroin user will inevitably loose everything due to their heroin addiction.

Vagueness in the information provided about *Billy* was an important aspect in the construction of this vignette in order to allow participants to draw on their own beliefs and opinions of heroin and heroin users to 'fill in the blanks'. Certain information was not made clear in this vignette. There were no details given about *Billy's* girlfriend or what her employment at Toni and Guy consisted of. (Toni and Guy is a well known chain of hairdressing salons in the UK). It was not clear if the couple owned the property in Clapham Common or if in fact it was a privately rented or Council rented property. There was no information about whom *Billy* used heroin with or if he used it alone. It was also not disclosed how much heroin *Billy* used at the weekend or if in fact he used other illicit drugs and/or alcohol.

The vignette was designed to challenge 'typical' beliefs about the inevitable decline which is associated with heroin use. I was eager to see if participants could accept *Billy*'s situation as real or if they would reject this portrayal of a heroin user in favour of the typical portrayal of a heroin user. Therefore, the details that were vague or omitted from this vignette were just as important as those that were present. Although I did not do an attributional analysis in this study I paid attention to the salient attributions that emerged from my data. In the previous two studies the negative attributions made about heroin users was in direct relation to the amount of perceived control they had over their heroin use. I was interested to see how *Billy's* apparent control would influence the participants and the attributions they made.

Sampling

Interviewees were chosen by recruitment through casual acquaintances who were not familiar with my research. Each casual acquaintance was asked to recruit one or two people who would be willing to do an interview. Twenty interviews were carried out in total and then I made the decision to stop interviewing when I had reached data saturation and nothing new was emerging in the interviews (Flick, 1998). Bauer and Gaskell (2000) recommend an upper limit of between 15 and 20 interviews for the single researcher if they are "to go beyond the superficial selection of a number of illustrative quotations" (p. 43).

Male	Female
1. Local Councillor, 30, WB	2. Primary School Teacher, 29, AB
3. Ex- Policeman, 63, WI	6. Corporate relationship manager, 28, WE
4. Taxi Driver, 54, WI	7. Social Researcher, 30, AB
5. Journalist, 32, WB	9. Client Liaison Executive, 30, WB
8. Catholic Priest, 67, WI	13. Policy Co-ordinator, 28, WE
10. Journalist, 46, WB	14. Housing Support Officer, 23, WB
11. HR Officer, 33, WB	16. Occupational Psychologist, 25, BB
12. Postman, 20, BB	17. Librarian, 38, WI
15. Local council officer, 35, WB	18. Primary School Teacher, 29, AB.
19. Skills Development, 26, WB	
20. Business Consultant, 32, WB	

Table 5.2. Demographic details of interviewees by occupation, age and ethnic origin. WB = White British; WI – White Irish; BB = Black British; AB = Asian British; WE = White European.

Table 5.2 shows a breakdown of the participants in study three. 11 males and 9 females were interviewed with an average of 34.9 years. 75% of participants were white (including British, Irish and European), 10% were Black British and 15% were Asian British.

Table 5.3 shows the alcohol, tobacco and illicit drug use of female interviewees. All the females reported current use of alcohol but only one participant smoked tobacco. None of the participants reported ever trying heroin or crack cocaine. Two female participants reported currently using cannabis, cocaine and ecstasy.

	Current	*Former*	*Tried*	*Never Tried*
Tobacco	1	2		6
Alcohol	9			
Cannabis	2		2	5
Cocaine	2			7
Ecstasy	2			7
Heroin				9
Crack Cocaine				9

Table 5.3. Reported alcohol, tobacco and illicit drug use of female interviewees.

Table 5.4 shows the alcohol, tobacco and illicit drug use of the male interviewees. The majority of male participants drank alcohol and about half of them smoked tobacco. One male participant reported current heroin use by smoking and he also reported that he had tried crack cocaine also. None of the other male participants reported trying heroin or crack cocaine. Other illicit drug use in this sample included cannabis and cocaine. Three male interviewees reported former ecstasy use.

	Current	*Former*	*Tried*	*Never Tried*
Tobacco	5	1		5
Alcohol	9	1		1
Cannabis	3	3	2	3
Cocaine	1	3		7
Ecstasy		3		8
Heroin	1			10
Crack Cocaine			1	10

Table 5.4. Reported alcohol, tobacco and illicit drug use of male interviewees.

Procedure for the Semi-structured interviews and discussion of the vignette

Approval for study three was obtained from the City University psychology department ethics committee. After participants were recruited I arranged to meet them in their homes where the interviews could take place in private. Some of the interviews were conducted in a private room at City University. Participants were asked to sign a consent form and they were assured of total confidentiality (see Appendix N). They were also informed that the discussion would be recorded using a mini disk recording device. It was explained to interviewees that there would be some discussion at the start of the interview and then at some point they would be given a small vignette to read and they would be asked to give their comments and feedback on what they read. The interviews lasted between sixty and ninety minutes.

At the end of the interviews the participants were given an opportunity to ask questions about the research. Many participants wanted to know if *Billy* was a real person, someone that I knew. I explained that I had created the character from a piece of research and I briefly explained the findings of Shewan and Dalgarno (2005). Participants were then asked to fill out a brief questionnaire that recorded their demographic details and their own personal experiences with illicit drugs (see Appendix M). Participants were then debriefed on the nature of this study. Participants were thanked for their time and invited to leave contact details if they wished to receive further information regarding this study.

Ethical considerations

The use of recreational drugs in the UK is illegal and carries the risk of a criminal record. The consequences for the use of illegal drugs varies according to a classifications system that classes drugs as class A, class B or class C. The greatest penalties are incurred for the use or supply of class A drugs. I was sensitive to the fact that participants were discussing heroin, which is a class A drug, and may in the course of the discussion have disclosed some information about themselves, or people they knew, who use heroin. For this reason it was necessary to assure participants of confidentiality. In addition to this, the transcriptions contained no information that could identify any of the participants and the recordings were stored in a secure location that was also locked. In this way no other person could gain access to the recordings.

5.3 Method of data analysis

I chose to use a content and thematic analysis (Joffe & Yardley, 2004) to analyse the data as I had done in the previous two studies. As I argued in chapter three this allows me to order a vast amount of data and to provide an overview of the most frequent categories. Once again I employed inductive coding in order to remain open to the themes that emerge from the data. The interviewees did a semi-structured interview and this was followed by a discussion of the vignette – *Billy*. I analysed the initial discussion and the discussion of the vignette separately. I did this to explore the main themes and to ascertain if new themes emerged in relation to the vignette.

Procedure for coding

The first stage in the process of coding the media data was to create the coding frame. I used inductive coding and at this stage of the analysis it was important to sustain flexibility in the coding process. I paid attention to content rather than topic and therefore paid attention to what the data was about (Tesch, 1990). I divided the interview data into two parts: the initial discussion about heroin and heroin users in society today and the participants' discussion in relation to the vignette – *Billy*. Similar themes were clustered until I had discovered the dominant themes in the data set.

A coding frame (see Table 5.5) was developed that contained the code name, a description of each code and examples of text that fitted into this code, as recommended by Joffe and Yardley (2004). I did a separate coding frame for the initial semi-structured interviews and the subsequent discussion of the vignette and these can be seen in full in Appendices O & P . In the coming sections I will present the main themes that emerged from the data sets, discussing the initial interviews first and then participants discussion about *Billy*.

Code Name	Description	Examples
Death	Addiction/needles/risk/weight loss	".....you know (laughs) wasting away, ehhh, living in a squat, ehhh, ... withdrawing and not eating and becoming sick, sharing needles and that sort of malarkey and stuff". (Intv. 5)
Death	Weight loss/	"Images come to my head, like pictures in the newspapers of this woman when she was not taking heroin and then when she was taking heroin and just her face and her whole physical appearance and this woman becoming like a skeleton, so yeah". (Intv. 2)
Death	Scary/injections	"I don't know much about heroin but from the little I do know then I think it is definitely one of the scarier drugs, you know, just the way it is prepared and injected, you know, oh, its horrible". (Intv. 18)
Death	Addictive/overdose risks (death)/AIDS	"I suppose that its just really highly addictive and ehmmm tht its easy to OD I think that's the message you took from it, I mean they are really linked to the AIDS messages of the same time ......". (Intv. 9)
Death	Overdose and risk of death	"I guess I would imagine that they are people who were sort of at a high risk of death, ... I've got a feeling that there is quite a high risk of overdose and death". (Intv. 14)
Death	Addiction/death/not reality	"People who have just lost touch with reality, hmm, people who are on the slippery slope and who are going to continue on the slippery slope and if they are not lucky and get checked or get somebody to pull them out of it, they are on the road to death". (Intv. 3)

Table 5.5. An example of a coding frame from the analysis of the semi-structured interviews.

5.4 The semi-structured interviews

Throughout the course of their interview participants were asked to take part in a discussion about heroin and heroin users. This was following by a discussion of the vignette (see Table 5.1). The following sections describe the four main themes that emerged from the interview data. These were death, control, stigma and a heroin

users' environment. The analysis of the discussion of the vignette will be presented in a later section.

5.4.1 Death

Heroin was closely associated with death or being close to death in this theme. There was also a very strong sense in the data that heroin users were in some way lost to the world:

> "Well I guess I have quite a stereotypical image in my mind of, you know (laughs) wasting away, ehhh, living in a squat, ehhh, ..., withdrawing, and not eating and becoming sick, sharing needles and that sort of malarkey and stuff". (Interviewee 5)

Heroin users were frequently associated with being underweight and participants interpreted this in a negative way. The use of the term 'wasting away' created the link to the possibility of death. It was a recurring description throughout the data:

> "Images come to my head, like pictures in the newspapers of this woman when she was not taking heroin and then when she was taking heroin and just her face and her whole physical appearance and this woman becoming like a skeleton, so yeah". (Interviewee 2)

The physical appearance of the heroin user produced strong imagery throughout the interviews and most participants visualised the heroin user as very unhealthy and undernourished with a 'hollow look'. In this extract the heroin user was compared to a skeleton, an image that is, again, strongly associated with death. Another strong association with heroin use was the needle and the majority of participants mentioned needles somewhere in their interview:

"I don't know much about heroin but from the little I do know then I think it is definitely one of the scarier drugs, you know, just the way it is prepared and injected, you know, oh, its horrible". (Interviewee 18)

The image of needles was very distasteful to most participants and many cited this as one of the main reasons that they personally would not use heroin. Needles also drew associations between heroin and AIDS and in this way the link with death was maintained:

"I suppose that its just really highly addictive and ehmm that its easy to OD I think that's the message you took from it, I mean they are really linked to the AIDS messages of the same time and they were both like 'don't you dare share a needle cause you might get AIDS and don't you dare inject heroin because you might OD and you might get AIDS and it was all images of death". (Interviewee 9)

The use of needles, for many participants, evoked a strong association with the risk of AIDS and the concept of AIDS brought up 'images of death'. This could explain why the use of needles for many participants was considered to be 'dirty'. Other participants saw heroin itself as the risk and the use of needles and the possibility of overdosing associated heroin use with the risk of death:

"I guess I would imagine that they are people who were sort of at a high risk of death, maybe heroin users, from what I know, my limited knowledge, I don't know how long you can use heroin before it gets the better of you, but I've got a feeling, if its correct, I've got a feeling that there is quite a high risk of overdose and death". (Interviewee 14)

Many participants mentioned the 'slippery slope' to indicate the eventual demise of the heroin user. Participants had strong convictions that heroin use could only end in a very negative way and the only way to avoid that was to give it up:

> "People who have just lost touch with reality, hmm, people who are on the slippery slope and who are going to continue on the slippery slope and if they are not lucky and get checked or get somebody to pull them out of it, they are on the road to death". (Interviewee 3)

In this extract it was suggested that heroin users are not totally in this world but have 'lost touch with reality'. This was emphasised further by describing heroin users 'on the road to death' and getting somebody to 'pull them out of it'. This created the sense of heroin users being somewhere outside of day to day life, outside of reality.

5.4.2 Control

Here in this extract the concept of 'a zombie' was strongly associated with the behaviours of a heroin addict. Traditionally, in films and popular entertainment folklore, zombies are associated with the underworld and are not considered to be fully human but are the 'living dead'. This imagery created a sense that the heroin user has lost their humanity and is living closer to death.

> "A zombie is the first one, whether it is in the early stages or the late stages I think that I have an image of an unstable type of person, very unstable, a person who needs help very, very badly and cant get it, crying out for help sometimes and cant always get it, so that's that". (Interviewee 8)

Participants showed great interest in the notion of control. This was a prominent theme throughout the data and the participants were speaking about their attitudes to people who are already using heroin. The majority of interviewees believed that people who are using heroin have no control over the situation and this stemmed from the belief that heroin was extremely addictive:

> "You might find a couple of youngsters who are on heroin and they cant do nothing about it because once they are hooked, they are hooked and that is it". (Interviewee 8)

Participants believed that once you took heroin, once or at least a couple of times, then you were in the grip of addiction and this was seen as a negative thing:

> "Whatever the addiction is it doesn't matter, it's the addiction itself that would worry me, it's the addiction itself that is the destructive thing, yeah". (Interviewee 19)

Participants associated heroin with addiction and they associated addiction with loss of control. This would explain why they perceived heroin addiction as 'the destructive thing'. Participants believed that an addiction to heroin meant a person no longer had any control over their behaviours:

> "No drug addict has control, I think once they are on it, it is compulsive after that, and unfortunately it is on the increase and not on the decrease, so now". (Interviewee 8)

The majority of participants saw this as a definite fact, as opposed to a possibility, and firmly stated that heroin addicts no longer had any control over their lives. In this way heroin was seen to be the master of the user:

> "It seems to be the drug that takes you over a lot more, like, it doesn't seem to be like other drugs where people can retain a little bit of themselves, heroin, it seems to be you can just get taken over". (Interviewee 14)

In this extract the participant compared heroin to other illegal drugs and saw a clear distinction between the effects of heroin and other drugs. It was their opinion that a heroin user loses themselves completely and in this way heroin has the control and

not the person using the heroin. This was not considered to be the case with other illegal drugs. This created a sense of heroin as a powerful agent that takes total control of its host. In this way the heroin user was perceived to be lost to their own self and their own lives:

> "I think about junkies and stuff like that and its about the junkie, they are just like this zombie walking around and he is ready to take or do anything just to feed the habit". (Interviewee 19)

As mentioned previously, the use of the term 'zombie' conjured up images of people who have lost their human nature. Zombies are fictional characters who come from and exist in anther world. This term was used by many participants to describe how they imagine the behaviours of a heroin addict once they start using heroin. This argument suggested that heroin becomes more important than anything else in the users lives and it also has the ability to dictate their behaviours:

> "I completely don't understand the dependence to the point where you throw everything in your life away, that's the part that is really scary". (Interviewee 16)

Many participants expressed fear at the thought of a substance, in this case heroin, that could take a person over in such a strong and forceful way. It was clear from the data that the participants believed that once a person began using heroin they had lost all control of their lives. Heroin was also seen to be responsible for making people 'willing to do anything':

> "I mean that is a really extreme thing to do, to want something or to need something so badly that you'll jump out of a window to get it, I wouldn't want to reach that state, that would really scare me I think". (Interviewee 9)

This participant was describing a documentary they had seen about a man trying to come off heroin but who had jumped out of a window to go out to buy drugs. Many participants alluded to their fear of this image of the 'desperate' heroin addict. Participants believed that it was this level of desperation that could compel addicts to behave in extreme ways and that was what scared participants the most.

> "They have to have their fix, ehh, even if they are able to hold down a job their habit will get so expensive they still wont earn enough money and the only way they can get the money is crime, and I mean they are so badly in need of their fix that they don't care what they do, they'll go and get the money for their fix one way or the other". (Interviewee 3)

In this extract the phrase 'they don't care what they do' highlighted the participants' apprehensions and fears of heroin users. The notion that they will do anything for heroin poses a threat to the rest of society. It would suggest that heroin users would be willing to break some of the social rules of behaviour that govern how we live. This unpredictability could be perceived as threatening to other members of society. Participants spoke about their own apprehensions of not having control over their behaviours and this was seen as a possible control measure against the use of heroin:

> "Control was very important to him so I don't think he would have got addicted to it, I don't think he would have abused it, and in that kind of situation you are not going to become a burden on anyone else and you are not going to lose control". (Interviewee 7)

This participant was discussing a friend's boyfriend who had allegedly tried heroin a few times. It was their opinion that this person did not become a heroin addict because they did not like to be out of control. This was the part of heroin addiction

that the majority of participants expressed the greatest fear towards and many participants alluded that they would not like to be addicted to any substance, as they saw it as being out of control. This was seen as something that was very unappealing and to most participants quite scary. One participant however who claimed he recently smoked heroin spoke about the rules he used to help him control his use:

> "I refer to as using rules ... it enables me to control when and where I access heroin, so if it was something that I was easily able to discuss, ..., what I am saying in a sense really is that the stigma actually allows me to set conditions of use". (Interviewee 20)

This participant's depiction of their own heroin use demonstrated that control is an important factor in his behaviours. This participant argued that he uses the stigmatised image of heroin as one of the methods of controlling his own use. The fact that this person had created using rules however and used them consciously suggested that he believed he also could lose control and succumb to a greater level of heroin use than he currently engages in. He commented further:

> "I think my degree of self control is unique to me, I think that my circumstances, my upbringing, my responsibilities, my viewpoint, my own feelings about it". (Interviewee 20)

This participant did not advocate that heroin is a safe drug to use. Instead he accredited the level of control he exercises over his own personal heroin use to his own personal make up and warned that perhaps not all users of heroin would be that self disciplined. He showed awareness, like all the other participants, that one would expect heroin use to lead to addiction and subsequently a loss of control of your life.

5.4.3 Stigma

Participants focused on the stigma attached to heroin use. A stigma has traditionally been a demarcation of some type that distinguishes one person or group of people from another. Participants believed that the stigma of heroin use meant it was not something that a person could openly admit to:

> "Oh, my social life, I think its difficult, I think what you have to understand is heroin use for me is very, what is the word I should use? I have a very clandestine heroin habit". (Interviewee 20)

The participant explained that his heroin use was kept quite secret and throughout the data this was associated with the perceived stigma that he attached to this activity.

> "I've never entered into this with anybody, I've never used heroin with anybody, with the exception of once or twice and that was with complete strangers, i.e. the person who provided me with the heroin, ehmm, yeah, I think they'd be very concerned, cause there's that stigma attached, you know, it's a slippery slope, the first step on the slippery slope". (Interviewee 20)

In this extract he discussed his own beliefs about the stigma of heroin and how his behaviours had evoked concern in those who care for him. He described it as the 'first step on the slippery slope' and this echoed the previous theme that focused on the 'road to death' and the total loss of control in a person's life due to addiction. It was this expected outcome that was a cause of concern for participants. In the interview data the main stigma which marked heroin users out was the use of needles or the idea that a person was prepared to use a needle:

> "I think when you are prepared to fuck with the laws of nature like that, you know, going that one step further doesn't seem like such a big deal maybe, it just seems there is a big stigma around injecting, I think, or being prepared to inject". (Interviewee 15)

Many participants found the idea of injecting your own body abhorrent. The idea of deliberately injecting oneself on a constant basis elicited a negative response from the interviewees. Another participant spoke about the wider effects of stigmatising heroin users:

> "If either of my parents had ever OD (overdosed) I know for a fact what the views of the hospitals are on people going in after od-ing, they are treated like shit basically, 'Ah, here comes another junkie' and I do worry about stuff like that, that someone wouldn't receive the same level of treatment just because they are known to use heroin, well, I mean, it's the stigma attached". (Interviewee 19)

This participant also saw the associated stigma as something that could impact on the care a heroin user. In this extract he was concerned that people like his parents, might not receive adequate treatment in a medical setting. The participant was therefore suggesting that the stigma of heroin might also influence the behaviours of others. The topic of stigma was also discussed by one participant who described it as hypocritical:

> "Is it fair that I should be singled out socially from my social circle as being a pariah because I, because my choice of substance is different from, you know, the main stream, then yeah, I think it is unfair". (Interviewee 20)

In this extract the participant saw himself as being excluded from his social circle and he believed he is seen as a 'pariah'. Again, in this extract there was some

evidence that participants believed that the stigma associated with heroin can influence the behaviour of others.

5.4.4 The heroin users' environment

Participants associated heroin use predominantly with poverty and the lower classes. It was not associated with the middle class or anyone who was doing well in life:

> "...that's cause I've had a nice middle class upbringing and I wouldn't know where to buy heroin". (Interviewee 7)

Participants associated heroin use with parts of society that were poor or less advantaged. In this extract a participant discussed some of his encounters with heroin when he previously worked as a policeman:

> "Not a lot, you see I worked in the good part of the city, you know, I worked in the posh end with my own class of people (laughter), ah, no, you would come across them but not as much as if you worked on the drug squad or in certain parts of the city, the parts of the city I worked in there was drugs used but it wasn't as prevalent as other parts of the city". (Interviewee 3)

Although the participant was being light hearted he made a clear distinction between poor parts of the city and other areas that may have more economic advantages. It was strongly suggested that heroin is more prevalent in the parts of the city that are not the 'good part'. This was the general consensus amongst the interviewees, that heroin belonged to a different part of society, one that did not have great economic status:

"I know that during the eighties Edinburgh was like the heroin capital of Europe and Edinburgh itself was quite depressed and had a huge population that was poor, people felt trapped and were in low income housing and led sort of shitty lives and so I imagine some of it must have been like a form of escapism". (Interviewee 5)

In his description of heroin use in Edinburgh in the eighties this participant highlighted the fact that the city was economically disadvantaged and he believed this to be the reason for people having 'shitty lives'. It was suggested in the previous extract that heroin is more prevalent in the parts of the city that are not the 'good part'. This was the general consensus amongst the interviewees that heroin belonged to a different part of society, one that did not have great economic status. Participants believed that even if you were not poor when you started taking heroin then you would eventually end up losing everything anyway:

"You are captive both from an economical point and a health point because your health is just going to deteriorate, your social status is just going to go through the floor ... and often you know you will end up becoming homeless and ehmm, that's it, you know, you've fallen out of the social net and I know this may not be strictly true but that is my own impression". (Interviewee 10)

This participant saw a heroin user as someone who inevitably loses everything and who falls out of the social net. Therefore there were two co-existing themes emerging from the data, the first, that heroin is mainly associated with poorer parts of cities and towns and secondly, that if you use heroin you will end up with nothing and no longer be a part of a social network or class system. The participants used poverty as a theme to explain why people use heroin:

"We've got a society that is very unequal and it is very easy to fall out at the bottom, yeah, and to need something to cope". (Interviewee 7)

Participants focused on poverty and described heroin use as a tool for coping with deprived lives. The theme of escape was common and many participants saw heroin use as a way to step out of life temporarily:

> "I think everybody knows its something you only take when you are at rock bottom and when you cant deal with your problems and you really cant face life and that kind of thing". (Interviewee 6)

Heroin use in this sense was described a last resort and participants argued that it was something that people turn to because life is so terrible and it is the only solace left. Some participants spoke about escape as the reason they had never used heroin themselves:

> "No, I've never had, or felt the need or felt at such a loss from myself to escape from anything and maybe it was in terms of how I was raised". (Interviewee 16)

In this extract the participant was describing why they had never needed to use heroin. They believe that nothing in their life has ever been so bad that they needed to use heroin. In this extract heroin was depicted in a 'medicinal' way, that is, as a coping device for an extreme situation. Another participant described 'escape' in terms of a sense of adventure:

> "I can often sit in the park for two hours, waiting for him, I sit in the pub and pop out to the park and you know, cause I'm just socially drinking anyway myself, escaping the stresses of both my home life and my work, and it's a bit about adventure for me". (Interviewee 20)

The image created in this extract was more positive, that of a person stepping out of his own reality momentarily as one does when one goes shopping or to an

adventure park for the day. There was no sense in this extract of social ills or personal traumas but more a sense of temporary escape from the day to day realities of life. However, in the following extract heroin is mainly associated with certain types of people:

> "They approach you with an offer of soft drugs and they are very surprised when I turn around and say no but I would really like it if you could get me some of this (heroin), they look surprised and then I normally get frisked or get told to fuck off because I look like a policeman, ehmm, which mean again it is very difficult for me to get". (Interviewee 20)

As this extract demonstrated, participants had an expectation of who heroin users are and what they should look like. In his business suit this participant explained that he did not fit the correct criteria of what a heroin user should look like. He recounted how his more affluent look gave the impression that he might be a policeman. Associating heroin with poverty and the need to escape allowed the participants to understand why someone might use heroin. Heroin use among poor people was deemed to be more acceptable to the majority of interviewees:

> "So I would see someone from a poorer background or a background that's been troublesome, or abused or had other difficulties in their life, I could understand more why they would want that escape, and I would honestly be more sympathetic than someone who's from a posh background, mucking around because they want to have some fun". (Interviewee 13)

Poverty was seen as a valid reason for heroin use throughout the data. It was valid as a tool for escape. Heroin use was not seen as acceptable by someone who just wanted to have fun. The pleasure of the drug itself, or the experience of its effects, was not seen as legitimate reasons for taking heroin.

5.6 Summary of interview findings

There were four main themes identified from the participant interviews: death, control, stigma and the heroin users' environment. Addiction was strongly associated with a lack of control. Heroin was seen to be the driving force in a heroin users' life. This association elicited fear in many participants as they believed that heroin users were capable of anything in order to fulfil their need for the drug. Within this rose the possibility that heroin users would not follow normal social rules and this was perceived to be threatening.

Participants also discussed the stigma attached to heroin use. The main focus was on injecting behaviour which was considered taboo practice due to its associations with AIDS. It was believed that this heroin would elicit a response in others that would cause heroin users to be treated differently. One participant spoke about feeling like a 'pariah'. Participants made a strong association between heroin use and poverty. Within this representation was the theme of escape. In some ways, participants used this notion of escaping a destitute life as a way of understanding heroin use itself. It was not considered acceptable that someone should use heroin just for enjoyment.

The findings showed that participants had negative representations of heroin and heroin users. Heroin was depicted as scary and highly addictive. The perceived addictive qualities of heroin were believed to be stronger than human will and heroin users were therefore described as 'zombies' who were on a 'slippery slope' or on 'the road to death'. Participants mainly focused on the negative aspects of heroin

use, paying little attention to any positive aspects that may be associated with heroin.

5.7 *Billy* – A Vignette

Interviewees were offered a 'case study' to read, at the end of their interview that described a car mechanic called *Billy* who injected heroin on the weekends, but not every weekend. The case study was deliberately vague in an attempt to enable participants to fill in 'the blanks' with their own views and perceptions. The 'case study' avoided any of the negative stereotypical images or behaviours of heroin use. Five themes emerged from the data and these were invisibility, control, death, stigma and perceptions.

5.7.1 Invisibility

The participants' reactions to this vignette were varied but the one common theme was that of surprise. The majority of participants reported not thinking that heroin could be used casually and many participants questioned whether or not *Billy* was a real person:

> "It sounds too much like a fairy tale, I wouldn't say he is typical because you hear an awful lot of negative things about it and people say don't do it, I did it and it was disastrous and ruined my life and I am only getting my life back now, so it seems a little bit weird, you know". (Interviewee 17)

The use of the term 'fairytale' stressed the fact that there is no negative imagery in the vignette and as this participant noted, this is not normally the case with stories

of heroin use. In this extract there was a clear assertion that *Billy* is not 'typical' of the average heroin user.

> "Well, I guess he is definitely an exception to my stereotype, ehmm, but I don't know if he is an exception to the norm as I guess I don't know enough heroin users to be able to sort of tell but yeah, he is definitely an exception to my stereotype of what a heroin user is, I mean there seems to be no sign of criminality here at all". (Interviewee 5)

Billy's job gave him the economic means to buy the heroin on weekends and as a result none of the participants inferred that *Billy* was involved in crime. In fact, many commented that he was probably not involved in crime in any way and therefore he was not causing any harm at all to the rest of society. This was seen to be a positive thing and many excused his behaviour for this very reason. There was no consensus in the data about whether or not there were more people like *Billy* in the community. Other participants thought that there might be lots more people like *Billy* using heroin on the weekends only:

> "I could imagine that there are a lot of Billy's and we wouldn't know about them because its not a very dramatic story I guess, it doesn't hit the papers, I wouldn't know, I'd just say, I wouldn't know". (Interviewee 14)

Many participants struggled to believe that it was possible to use heroin occasionally and in a recreational way whereas others believed that there may be many people like *Billy* who use heroin recreationally but who are unknown:

> "Hmm, I would say that there are probably lots of Billy's that we don't know about, that's probably what I've learnt as I've become a little bit older and a little bit less naïve". (Interviewee 12)

One participant, who smoked heroin himself, talked about the 'urban myth' and how he saw himself as a part of that:

> "I'm part of the urban myth as well, I know there are more people like me as well, I cant be certain but the very fact that the person I have asked to score for me has never been surprised, you know, and presumably he makes a lot of money off people just like me who are doing exactly the same thing". (Interviewee 20)

This participant spoke about 'people just like me' in this extract. He was referring to the fact that he himself has a job and his 'uniform' is a business suit. He acknowledged that this is not the typical image of a heroin user in society today. It was his opinion that there may be more persons 'like him' buying heroin from his supplier and this allowed him to surmise that there are more people using heroin in a recreational manner who are part of the 'urban myth'.

5.7.2 Control

One challenge that participants faced with this vignette was the lack of evidence that *Billy* was in any way addicted to heroin. The fact that he only used at weekends, and sometimes not every weekend, did not fit with their existing knowledge of heroin use:

> "Well what is different about Billy is that, if such a man exists, like he just hasn't been, ... he's not addicted to it, he enjoys using it and to me that sounds like someone who decides sure I'll go out and have a drink and he's not addicted but he's using it". (Interviewee 3)

In this extract a comparison was drawn between *Billy's* heroin using habits and casual alcohol use. As discussed in the previous chapter participants drew a clear

line between heroin use and all other illicit substances and alcohol. Heroin was singled out for its perceived addictive qualities. This vignette challenged the participants' beliefs so much that he questioned whether or not 'such a man exists'. The lack of apparent addiction did not seem credible in any way.

> "But I think Billy is fairly addicted in that he is coming close to it, he is at a dangerous point although he is probably not addicted, no, but then I wouldn't be sure, but I would say he cant go a weekend without it so he is somewhere close to being addicted, so I would say to him get away from it, give it up, you are going nowhere with this thing and you are definitely heading for addiction".
> (Interviewee 4)

This participant reconciled the lack of information regarding addiction by surmising that *Billy* was in fact 'close to being addicted'. This participant displayed genuine confusion as he struggled with his own knowledge of heroin use and what was presented to him in this vignette. In order to conciliate the two opposing ideas he finally decided that *Billy* is 'definitely heading for addiction'.

> "If Billy suddenly had some kind of life changing situation in which he falls into some kind of heroin trap (laughs) he is going to cause social problems and you know there is no doubt about it that heroin use does cause social problems for other people, other than the users, you know so but, so long as it stays like that, its ok, but it's a precarious situation to be in". (Interviewee 10)

This extract also placed *Billy* in a 'precarious situation'. This interviewee was also challenged by his existing knowledge of heroin use and what was presented to him in this vignette. He believed that most heroin users cause 'social problems' for other people. Unable to understand why *Billy* did not appear addicted this participant argued that if *Billy* did have some 'kind of life changing situation' then he would fall into 'some kind of heroin trap'. In the participant's mind *Billy* was

still capable of fitting into the existing stereotype and, although there are no facts in the vignette to suggest he is there, it was argued that it would take very little for him to fall into that role. Other participants pointed out that he may already be there:

> "I think Billy is in trouble, well, he is a heroin user and he is keeping that secret and he is not even seeking help and maybe he has told someone, I don't know, except his girlfriend and a few friends who I would say are worried and scared stiff because they know that Billy is in trouble and in serious trouble I reckon". (Interviewee 8)

This participant used the term 'in serious trouble' to express his thoughts on *Billy* and his heroin use. This participant ignored the facts of the vignette and adopted his own interpretation of the situation instead. By doing this he alleged that *Billy* 'is in trouble' and needed help, which perhaps supports his existing beliefs of heroin use.

Participants felt challenged by *Billy's* heroin use and this was predominantly due to the alleged control *Billy* had over his heroin use. This challenged participants' existing knowledge of heroin use and it was noted that this was not the usual way that heroin was portrayed in the media. One of the main reasons that participants had concerns for *Billy* was their belief that heroin could not be used in this way:

> "I'm a bit surprised that he can turn it on and off when he likes, I thought with heroin that you would become addicted to it, that you would need it more, I thought you would need it every day, I never thought you could just use it at the weekends". (Interviewee 4)

The vignette challenged the participants' perceptions of heroin being addictive. Some participants were surprised that *Billy* had a regular job and a regular

girlfriend because that would suggest that *Billy* had some degree of stability in his life. Participants explained that this was not their usual perception of a person who used heroin.

> "Hmm, seven years! Yeah, I think he is a very lucky man, if he has been using heroin for seven years and doesn't have to use it only when he feels like it of a weekend, I don't think there would be many people like that". (Interviewee 3)

In order to reconcile the vignette of *Billy* with their existing understandings of heroin use participants chose to see *Billy* as an exception to the rule. Many participants believed that not many people could use heroin in this way, that is, for seven years, without becoming heavily addicted. As discussed previously, other participants felt that it was possible that there were some people using heroin in a recreational way, like *Billy*, but that they were not visible within society and perhaps couldn't discuss their actions with others. On the whole the majority of participants argued that the vignette went against all of their existing perceptions of heroin use:

> "I don't know what his dose is like or anything, it sounds very sensible but is there such a thing as sensible heroin use? I would have thought that heroin controls you, I wouldn't have thought that you could control it". (Interviewee 17)

5.7.3 Death

Other participants who felt uncomfortable with the vignette focused on the physical dangers that faced *Billy*:

> "It seems more tinged with danger and you know selling to people who are in desperate need and therefore they can sell them any old crap". (Interviewee 7)

In this extract the participant argued that *Billy* may not fit into the stereotypical image of a heroin user but he still faces the same health risks that they do. In other words, his heroin use still posed a threat due to the unpredictable quality of what he may buy. *Billy's* life was also seen to be at risk from the overdose potential of heroin:

> "I would be really concerned about where he is getting it cause he could get a bad batch some time and he could overdose and die, is he being safe with his needles, ... I just think that the problem with illegal drugs is you don't always know what you are getting, so it could put him in serious danger". (Interviewee 13)

Participants who could not understand why *Billy* did not appear addicted to heroin drew attention to the other apparent risks involved in heroin use, namely overdose and death. The mention of 'being safe with his needles' also alluded to the risks of blood borne virus such as HIV and hepatitis that are strongly associated with heroin use. Therefore, perhaps the participant was also expressing that they did not find heroin use acceptable even if there was no apparent addiction:

> "Yes, I do, because there is no positive outcome unless he resolves it, I cant see a heroin user being ok forever, I can only see it declining and getting worse and worse eventually, leading to even his death possibly so you know, why carry on using it, why not try to nip it in the bud now and get him off it". (Interviewee 18)

The majority of participants were uncomfortable with the vignette and they were clear in their discussion that they did not find *Billy's* heroin use acceptable. Participants constantly referred back to their existing knowledge of heroin and heroin use and recreated *Billy* within their existing framework of knowledge. Therefore, despite the information in the vignette, that suggested that *Billy* was using heroin in a casual and non-threatening way, participants still predicted that

this story would end with *Billy* being addicted or dead. As seen in the earlier stages of the interviews, participants associated addiction with a loss of control and therefore *Billy's* apparent sense of control in this vignette challenged their existing beliefs.

Many participants confessed that they did not have first hand knowledge of heroin and therefore they had no real way of knowing if the vignette was true or even possible. Participants had to rely on their existing knowledge and the media was one popular source of knowledge that was frequently cited:

> "He sounds like a fairly decent guy, holding down a flat and a job and a girlfriend, I think for me that this is the kind of stuff that surprises me cause you get these media impressions of all heroin users being junkies". (Interviewee 12)

5.7.4 Stigma

In this vignette *Billy* was using heroin in a way that suggested he was in control of his drug use. The participants struggled to find heroin use acceptable under these circumstances or any circumstances. This implies that it is not just the physical properties of heroin that participants found objectionable. Participants did not believe that a person could speak openly about casual heroin use to their friends:

> "No, I don't think so, they might talk about the minor drugs but not heroin, I don't think someone would talk about it at all". (Interviewee 8)

Participants acknowledged that *Billy* did not appear to be addicted to heroin or to be suffering any apparent detrimental effects of his heroin use. Objections to *Billy's* behaviours and drug of choice were heavily associated with social image:

> "Yeah, I guess it could be seen as difficult as coming out as being gay, you know, cause people in general often have negative images and stereotypes of the whole thing and people are worried about what other people's reactions would be". (Interviewee 5)

In this extract this participant drew an association between heroin use and being homosexual. Traditionally, 'coming out as being gay' has been perceived as stressful and full of anxieties. Part of the reason for this is that you are admitting you are different from the norm, which in most societies is perceived as being heterosexual. The comparison this interviewee made suggests that heroin use is not perceived as 'normal' behaviour within society and is also not acceptable behaviour.

Although there was strong evidence that participants had a fear towards heroin addiction, as they perceived it, and the associated loss of control, the stigma of heroin use also influenced their reactions to the vignette:

> "It's the stigma attached to it isn't it, it's the stigma attached, you don't want to openly admit it, you know, dare I say it, its almost like openly admitting you have HIV, you know, in some views, you know, it's the stigma, you don't want to be associated with that stigma". (Interviewee 20)

This participant was speaking about his own personal heroin use. He felt that he could not speak openly about this with the people in his life as there was a negative stigma associated with heroin use. In this extract heroin use is compared to being

HIV, which this participant believed also carried a social stigma of its own. Other participants made reference to AIDS and its associations with heroin use:

> "Do you know what, I'm actually thinking, besides it being scary, but also going back to my perception of heroin use as being a bit dirty and a bit scrawny and a bit ill, it also makes me think of AIDS, definitely makes me think of AIDS, and that makes me think, like, disease ridden and so, I would not want to touch a heroin user, I do feel terrible saying this". (Interviewee 6)

In this extract the participant clearly stated that she would not want to associate with a heroin user because she perceived them as 'disease ridden'. She completely distances herself from the heroin user and any other association with them. She also spoke about *Billy's* girlfriend:

> "No way, I couldn't be Billy's girlfriend, I couldn't be around the heroin, only if I was helping heroin users could I be around heroin, but that would be in a professional way, and I suppose I would be ok if they didn't have pussy blood running everywhere, but that is my perception really". (Interviewee 6)

There was a strong association in this extract between heroin and needles. This is what would lead to the 'pussy blood running everywhere'. The imagery was quite strong in this extract and the fear of the blood, as she explained later, was the fear of AIDS. Although other participants were not so graphic in their response they still spoke about *Billy* and heroin users and the act of keeping a distance from them:

> "I don't think I would turn my back on him, but I think I would be inclined to keep him a little bit at arms length, you know, and I would be keeping a wary eye on how he was behaving or if there was anything, you know, but I wouldn't like to think I would turn my back on him anyway". (Interviewee 3)

This participant was explaining that if *Billy* was his friend he hoped he would not 'turn my back on him'. There was a strong suggestion, however, that *Billy* would be perceived differently, due to his heroin use and as a result the participant would 'be keeping a wary eye'. In this extract *Billy* was perceived solely as a heroin user and someone who warranted monitoring of 'how he was behaving'. Throughout the interviews, participants sought ways to keep a discursive distance from *Billy* and his heroin use:

> "I just don't know about it because I just don't associate with these kind of people". (Interviewee 6)

This participant was clear that heroin users were not the 'kind of people' he would associate with. Many participants were very clear that people who use heroin in any way are not a part of their social circle. Despite the fact that *Billy* did not fit any of the stereotypes of heroin use, participants were clear they would not be comfortable to have him in their social circle. In this data it can be seen that there are stigmas associated with heroin use and it is these that cause the participants to express a desire to distance themselves from heroin users. One participant saw the stigma as a positive thing:

> "I think stigmatisation, demonisation is a form of socialisation and I think society would be a weaker place without that. Obviously it doesn't want to be meaningless, it doesn't want to be barbaric, but I think there does need to be an acknowledgement that some choices are negative". (Interviewee 15)

In this argument stigmatisation was seen as a form of social control, a reiteration that heroin was a negative choice. This was the general consensus in the data and many participants expressed that they were 'uncomfortable' with *Billy's* heroin use

and would prefer him to stop. All the participants stated that they would not like to see a more liberal use of heroin within today's society even if someone like *Billy* could remain in control of his heroin use. Participants believed that the stigma of heroin use contributed to the informal social control of its use. Participants argued that *Billy* was an exception to the rule and heroin use should never be seen as a good thing.

5.7.5 Perceptions

The case study gave no information about why *Billy* started using heroin but merely stated that he had used it for seven years, on weekends only. It was stated that '*Billy* enjoys using heroin. He likes the way it makes him feel'. Some participants accepted this as a reason why *Billy* might use heroin but others searched for their own reasons why someone would use heroin for seven years:

> "I would definitely want to know exactly what happened seven years ago, ehmm, is his girlfriend encouraging it, that's another thing, I'd want to know that". (Interviewee 16)

Many participants believed that something must have triggered his heroin because it was seen as a very extreme thing to do. Some participants suggested he had experimented with heroin and as a result had become addicted to it. Others suggested reasons such as child abuse or a broken relationship with his parents or his family. The common theme was that he had experienced some kind of psychological trauma and it was something he was trying to block out:

"I'd be interested to know what it gives him that he cant get elsewhere, is he trying to numb something so I'd be interested in Billy the person, I mean because, is he trying to block something out, is he trying to numb some feeling of pain or something or whatever that he has. I'd be interested to know what it is that only comes to him at the weekends, or does he do it just because it makes him feel euphoric?" (Interviewee 9)

In this extract the participant suggested that the motive for his heroin use might have been to 'block something out' or to 'numb some feeling of pain'. In the vignette there was no evidence that *Billy* is living in poverty. Therefore escape from poverty did not seem like a viable explanation in this case. This participant associated the need to escape with some kind of psychological reason instead. In this way poverty was replaced by psychological problems as a reason for using heroin and the participant was still able to explain heroin use through a need to escape.

"I mean anything that inhibits, it must stop something, if it damages the senses which is what it does, it envelops you in a cloak like a big warm blanket, its not facing reality, it's hiding". (Interviewee 19)

This was a popular opinion, that *Billy* had unresolved psychological problems and heroin was a way of dealing with them or in this case hiding from them. Many participants suggested that something had happened in *Billy's* life to make him want or need to do heroin and rejected the notion that he used it only because he enjoyed it: Participants found this explanation of mere enjoyment difficult to accept and therefore offered reasons of their own for why he would use heroin. For others though *Billy's* reasons for using heroin merely caused them great confusion:

> "I mean he is obviously managing but it is a bit sad, you know, if he feels he has to do heroin or maybe he is doing it for a laugh, you know, I don't really know what I think about this, I think it is very odd, this is just not something my perception of heroin would associate with". (Interviewee 6)

The notion that someone would use heroin freely and happily because of its enjoyment value was just too 'odd' for some participants who just found the whole vignette perplexing. It seemed alien to many participants that *Billy* would use heroin because he enjoyed it. It made more sense instead to argue that he had unresolved psychological issues and therefore the explanation of 'the need to escape' could be kept in tact.

5.8 Heroin and associations with other drugs

In the course of the interviews the participants discussed other illicit drugs and alcohol. Only one of the participants declared personal experience of heroin use and therefore other participants had to 'imagine' what heroin use was like. Moscovici (1984) posits that the objective of all representations is to make the unfamiliar, familiar and one way this is done is through anchoring. As discussed in chapter two, anchoring is a process by which unfamiliar objects are given meaning through classification and naming by comparing them with existing culturally accessible categories. Therefore participants compared what was unfamiliar with what was familiar to them and this enabled them to identify with heroin use through association. Participants therefore discussed heroin use through their understanding and personal experience of alcohol and some other recreational drugs, such as cocaine, ecstasy and cannabis.

> "Yeah, you know I think that's because I've always thought alcohol to be really safe, especially in my circle, when I grew up, like my family were, like, really into drinking (laughs) ... I always associate alcohol with fun and then you start to drink alcohol and it was hilarious, when you are, like, fourteen, it was just, like, really fun and also, like, really cheap". (Interviewee 14)

Many participants saw alcohol as a normal part of socialising and having fun. This participant explained that she was indoctrinated into a style of drinking that enabled her to enjoy it in a 'safe' way. Alcohol had positive connotations for this participant. Ninety per cent of interviewees reported drinking alcohol at some stage in their lives and the data showed that the majority of participants saw drinking alcohol as a natural part of the socialising process. The following participant was discussing his experiences of alcohol:

> "Well, no, I didn't think if it is good to drink alcohol, it just came, I was at University and everybody was drinking so it was just like, yeah!" (Interviewee 2)

On the whole alcohol was perceived as acceptable within society and it became apparent from the data that very little if any thought had been given to the use of alcohol in society in general. Alcohol use was identified in terms of a normal behaviour:

> "I think equally, you know, getting pissed and throwing up is still a much more socially acceptable thing than taking heroin, just because we have all done it". (Interviewee 1)

One of the most striking phrases of this quote was 'just because we have all done it'. This participant gave himself permission to see 'getting pissed and throwing up' as 'a more socially acceptable thing' because he believed that so many people

do this in the course of a night out. By suggesting that 'we have all done it' he stressed the normality of this kind of behaviour. Participants in general felt comfortable with their own alcohol use and perhaps this was due in part to their perception of the large cohort, imaginary or real, that partakes in these very activities all the time. In comparison to heroin, alcohol was seen in a much more positive light and it was not seen to be as addictive as heroin. It was associated with fun and was seen as a normal and acceptable behaviour. The opinions on cigarette smoking were less consensual:

> "I don't smoke but yes I have thought about smoking though maybe because I don't see it as harmful as taking heroin". (Interviewee 2)

Cigarettes were seen by some participants as less detrimental to the body than heroin. The following extract showed a different side to the argument that is one against cigarettes and alcohol also. The participant was discussing drugs education in school and whether or not cigarettes and alcohol should be classified as drugs:

> "Yeah, I think they should have talked about cigarettes and alcohol cause I think they are a drug and just because its legal doesn't mean it is good for you, I mean some people say it is harder to come off cigarettes then it is to come off cocaine or heroin". (Interviewee 18)

This participant clearly saw cigarettes as more addictive than heroin or cocaine. This was not a commonly held view although many participants believed that cigarettes and alcohol could be harmful if they were misused or used to excess. This interviewee also raised the issue of legality and believed that the legal status of a substance did not determine its harmful status. Participants also spoke openly about other drugs which unlike alcohol and cigarettes are illegal in today's society:

> "Whereas with other drugs you can just smoke them with very little preparation or you just pop a pill, you know, or you snort it, but you don't ... preparing an injection feels medicalised but also that in itself feels dangerous cause you get a air bubble in it, there's that risk in addition to the risk of the heroin you are taking".
> (Interviewee 9)

In this extract the interviewee discussed the dangers of injecting and also the risk of heroin itself. What was notable was the more casual approach to the topic of other illicit drugs. The participant pointed out the ease involved to 'pop a pill' or to 'snort it'. There was no focus here on risks or dangers and this created the sense that other illicit drugs are safer to use. Participants talked openly about other illegal drugs and the data showed that they considered heroin to be the most taboo.

> "Its not a fun drug, like everyone has a bit of a smile at like cannabis, even sort of more party drugs like E, but that seems to have no element of fun in it, it seems to be like a serious drug". (Interviewee 14)

Again, the use of other illicit drugs, cannabis and ecstasy, were described in a casual way that would suggest normality. In this extract they were strongly associated with parties and fun. People have 'a bit of a smile' at cannabis suggested that the participant considered it to be harmless and acceptable. Participants' associations with heroin were more 'serious' throughout the data and it was cannabis that evoked the most casual response from participants:

> "I suppose internally I would raise an eyebrow but it wouldn't be an issue, no, I suppose I would notice they were doing it and clock it, but no more, but I would rarely see it amongst my friends". (Interviewee 1)

The participant above was discussing how he would react to seeing his friends smoking a cannabis joint at a party. He didn't feel it would be 'an issue' and this

suggested that he believed that it is an acceptable behaviour to expect at a party and not one that would cause a strong reaction. The comment 'internally I would raise an eyebrow' suggested that although he would notice it was happening he would not feel the need to react outwardly to such behaviour. When asked if he would do the same if someone was using heroin he declared he would be shocked and outraged. Clearly the two drugs had very different levels of acceptability in his world. Other drugs were also associated with different settings:

> "I mean you think of people in PR or in the City at a nice elite party and you immediately imagine them with a nice glass table snorting a line of nice white coke or speed but you wouldn't expect to see someone, you know, injecting heroin in their arm". (Interviewee 6)

This extract created an association between cocaine and speed and their relationship to a sense of affluence. These drugs were described in a positive way here and were depicted as appealing. Participants associated cocaine mainly with night-clubs and people with money. The other interesting fact was that participants did not seem to focus on the illegality of cannabis or cocaine or speed but regularly mentioned that heroin users often broke the law because heroin was illegal. In this way heroin use was seen as unacceptable to the majority of interviewees whereas other illicit drugs were seen as acceptable:

> "I've used cocaine lots of times and I don't particularly like it, ehmm, I don't like that kind of stimulant, cocaine is in my social circle, this is the perfect fucking irony of it, its perfectly acceptable for my friends to sit around and lecture me about heroin!" (Interviewee 20)

In this extract the interviewee was explaining that his friends would prefer him to do cocaine with them rather than smoking heroin. He explained that in his social

circle cocaine was seen as 'perfectly acceptable' in a way that heroin was not. In his world it appeared that the emphasis therefore was placed on how tolerable a substance is rather than a person's preference. This participant explained that his friends were worried about the consequences of him getting caught doing heroin although they themselves did cocaine. This could suggest that the perceived consequences of getting caught doing cocaine were not seen as similar to getting caught doing heroin. There was a clear demarcation between the social acceptability of heroin and all other drugs:

> "Yes, I don't think all drugs are the same, I made the distinction that I wouldn't do heroin because I guess to me it had ... well it seemed really scary, it seemed to me like the kind of drug that if you do it once then you could get hooked on it but then, back in the day they used to say the same about speed and coke and yet I did that". (Interviewee 6)

In this extract one of the perceived differences between heroin and other illegal drugs was the effect it had on the user. This was similar to the previous theme of the loss of control. This participant had a fear that heroin is very addictive and therefore the user will lose control of their lives. Although she had heard something similar about speed and cocaine she still took those drugs anyway. She perceived heroin to be the scariest drug of them all. Therefore, heroin emerged from this data set as the benchmark of what was acceptable or not with regard to illicit drug use:

> "... like, someone is smoking some weed then they'll look at someone who is taking heroin as worse than them, so between drug users they are worse". (Interviewee 12)

In this extract the participant explained the perceptions that drug users have of each other. This interviewee explained that a cannabis user will consider someone who uses heroin as 'worse than them'. Regardless of legality heroin use was considered to be the worst drug and the drug that most participants would not consider trying. The data in this study also showed that non-drug users accepted illicit drug use as a normal part of society today. Those participants that used or had used illicit drugs themselves spoke about it in a very casual way, making no apologies for their drug use and paying little or no attention to the legal status of drugs such as cocaine, speed or cannabis.

5.9 Participants discussion of *Billy* and their own experience

In the course of the interviews the participants were presented with a vignette about *Billy* and as discussed earlier in this chapter, *Billy* did not have the 'usual' characteristics of a heroin user. In order to make sense of *Billy* and the world of heroin use that he presented, that the majority of participants had no experience of, participants compared what was unfamiliar with what was familiar to them and this enabled them to identify with heroin use through association. Participants therefore discussed *Billy* through their understanding and personal experience of alcohol and some other recreational drugs, such as cocaine, ecstasy and cannabis. In the following extract a comparison was drawn between *Billy's* heroin use and the use of cocaine or cannabis:

> "Alright, he seems alright, I mean he lives with his girlfriend, he works hard, on his weekends off he likes to, I mean, he enjoys some heroin, seven years, that's a lot of heroin, ehhmm, (....) he just seems like a guy, like any guy, taking any drugs with a normal job, he does his job, he earns his money and he likes to have fun with drugs,

like some people like to sniff some coke or smoke some weed, so yeah, he just seems like a normal guy just using some heroin". (Interviewee 11)

This participant compared *Billy's* heroin use to the use of cannabis or cocaine. In this extract the use of illicit drugs was associated with having fun in the sense that they are not seen as addictive. This was not the typical explanation of heroin use however and most participants found it difficult to believe that heroin could be used in this way:

"I don't think heroin is a drug you would use to just have a bit of a laugh, I think you would do that with a bit of weed (laughs) or snorting a bit of coke or whatever people do to have fun". (Interviewee 19)

Heroin was seen, throughout the data, to serve a very different purpose than other illicit drugs that are used in a recreational manner. Heroin was not associated here with 'having a laugh' whereas other drugs such as cocaine or cannabis were. Many participants spoke about drug taking during their years in university and considered this as a normal part of university life. Alcohol was seen as regular and acceptable feature of the socialising process also:

"I associate having a glass of nice wine when you are with your friends as socialising, whereas I associate taking heroin every weekend as dark and gloomy, I see a dark and gloomy image, so I can picture Billy sitting down and injecting and not looking physically good, but I don't associate that with having a glass of wine". (Interviewee 2)

Participants distinguished heroin as something 'dark and gloomy' and therefore it was not a drug that was associated with other 'more acceptable' forms of recreational drug. This distinction between heroin and other recreational drugs

meant that participants were unable to see anything positive in *Billy's* drug taking and continued to associate his heroin use with negative images. Meanwhile other recreational drugs were seen as part of a weekend scene:

"...but I've known people who've just taken ecstasy at weekends, when I was at university, that was the real thing, to take ecstasy at the weekends and during the week they would be fine, but with heroin that feels less likely, but maybe that is just me". (Interviewee 3)

Many participants spoke about the normality of weekend ecstasy use during their university years or during their twenties. Ecstasy did not have the same associations with addiction that heroin had and it seemed perfectly acceptable for someone to use ecstasy casually at the weekends. Because heroin has been traditionally depicted as a highly addictive drug, it was inconceivable to the majority of participants that it could be used at weekends only. Therefore participants rejected the notion that heroin did not have the addictive qualities they believed it to have. Throughout the data heroin use was strongly associated with the use of needles and this was also associated with risk:

"Well, what is he, yeah, he is injecting, well anytime you use needles that's got to be more dangerous than just drinking something". (Interviewee 11)

Heroin was seen, in general terms, as more dangerous than other recreational drugs and alcohol. However, it was the association with needles and the fact that heroin was injected that created the biggest distinction, between heroin and other recreational drugs, for most participants. This was also seen as something that lead to an overdose and therefore death. The act of injecting heroin created an association with something dangerous and most participants argued that this was

why they would never try heroin. Although alcohol was seen as part of the socialising process and was not considered as dangerous as using heroin, participants still drew a distinction between moderate alcohol use and heavy alcohol use:

> "Hmmm, probably not, I mean depending on how much alcohol you drink, you know, the doctors say a glass of red wine every now and then is actually quite good for your heart, but if you are going to be drinking heavily then no, its not better or no worse than drinking alcohol". (Interviewee 18)

This participant was debating whether or not alcohol was less harmful for a person's body than heroin. Her conclusion was that the abuse of a substance, whether legal or illegal, still carried problems for a person's physical health. In this sense the only distinction she drew between the two was that alcohol was legal and heroin was illegal:

> "Ehmmm, I don't think its more acceptable, I mean alcohol is still a drug, its just it's legal which I think pulls the wool over people's eyes a bit, they see it as legal so they think, yeah, so we can abuse it any which way we want, all drugs at the end of the day, its all the same thing". (Interviewee 12)

This was an interesting comment, that the legal status of alcohol 'pulls the wool over people's eyes a bit'. Many participants had in fact stated that they didn't think it was good to over indulge in alcohol regularly but had noted that they were not breaking any laws and it was an acceptable part of socialising. This extract put forward the opinion that although heroin was deemed to be the most dangerous and harmful drug, heavy alcohol use was seen as the next most harmful option. Cocaine, ecstasy and cannabis were seen, by most participants, as something that

people used, mainly on the weekends, and therefore were not deemed to be in the same league as heroin.

5.10 Summary

Twenty participants were asked to discuss their attitudes and opinions to drug users. They were then presented with a vignette and asked to discuss their thoughts and reactions to *Billy*. The data was analysed separately to ascertain if there were any distinguishable differences in themes. The initial interview discussions revealed four themes: death, control, stigma and the heroin arena. The analysis of the participants' reactions to the vignette revealed five themes: invisibility, control, death, stigma and perceptions. Therefore there were similarities in themes in the data produced by the interviews and that produced by the participants discussion of the vignette.

The majority of participants were unfamiliar with heroin, except one participant who claimed to occasionally smoked heroin. In order to discuss what was unfamiliar and to make sense of it participants used a process of anchoring. They discussed heroin through alcohol use, smoking and the use of other illicit drugs, such as cannabis, ecstasy and cocaine. In this way they were able to make heroin more familiar by comparison and association with what was socially and culturally familiar to themselves.

The addictive qualities of heroin and the perceived lack of control was of particular interest to the participants in this study. They valued being in control and this was

discussed as a reason not to use heroin or associate with heroin users. There were moral tones in the data in relation to heroin use and it was deemed to be stigmatised in a way that alcohol and other recreational drugs were not. On the whole, participants' attributions of heroin users were negative and these were influenced by the perceived addictive properties of heroin and the lack of control associated with heroin use.

Chapter Six: Social Representations of a heroin user

6.1 Introduction

In chapters three, four and five I presented the main themes that emerged from my three studies. The three studies produced a vast corpus of data and the aim of my research was to find the core representations of heroin and heroin users within this data set. For this purpose it was now necessary to find the main themes that emerged across all three studies in order to condense the data further. This enabled me to have manageable data in order to search for the social representations of heroin and heroin users. Table 6.1 shows a summary of the main themes from the three studies.

Study One	**Study Two**	**Semi-structured Interviews**	**Vignette**
	Police Review		
Impact	Crime	Death	Invisibility
	Demand Reduction		
Control	Legalisation Debate	Control	Control
	Heroin users environment		
Perceptions	**BMJ**	Stigma	Death
	Death		
	Perceptions	Heroin users environment	Stigma
	Impact		
	Newspapers		Perceptions
	Perceptions		
	Legalisation Debate		

Table 6.1. Summary of main themes from study one, two and three.

The main themes within the three studies were further analysed to find the main themes across the three studies. A content and thematic analysis enables the researcher to establish recurring patterns throughout the data. In this way these themes were subsumed into super themes which required a more systematic analysis of the data. In order to achieve this I spent a lot of time reading and re-reading my findings from my three studies and thinking about the themes that emerged (see table 6.1). I explored the distinctions and consistencies across these themes and in accordance with a content and thematic analysis I established recurring patterns across the data. I paid great attention to the themes that emerged from my existing themes and in this way I established super themes.

Within the corpus of data I found that heroin and heroin users were discussed from the following four perspectives: the impact of heroin, the nature of heroin users, the heroin arena and the legal status of heroin. These super theme categories were the tools I worked with until distinct social representations emerged. It enabled me to organise the data from the three studies. Before I discuss the social representations of heroin in section 6.7 I will discuss heroin and heroin users from the perspective of these four super themes. I will then discuss the two distinct social representations of heroin focusing on the core and peripheral aspects of the representations and explore the process of anchoring in greater detail.

6.2 The impact of heroin

Across the data the impact of heroin was an important theme which encompassed the impact of heroin on the individual heroin user and the impact of heroin on

others, namely the family and community at large. Therefore, this theme consisted of these two sub themes, impact on the individual and impact on others. (See Appendix Q for a table of the themes from each of the three studies which contributed to this super theme). The data showed that the impact heroin had on the individual had consequences for society also as it leads to crime, links with prostitution and a loss of control in the heroin users' day-to-day life. The data supported the claim that heroin influenced the heroin users life in two main ways; loss of control and risk of death.

Throughout the data heroin users were associated with crime, mainly street crimes, prostitution, and driving under the influence. They were also associated with lying which is, in certain circumstances, punishable by law but is also deemed a social crime and immoral by certain facets of society. What was interesting however was that addiction was deemed to be the main driving force behind these behaviours. A heroin user was described as 'a slave to heroin' and was believed to be 'sucked into a spiral of despair and destruction'. Therefore the impact that heroin had on their lives, that is, a total loss of control, was judged to influence the links with crime, prostitution and theft. The data supported the belief that heroin users would 'do anything' to obtain their heroin, and this strong desire usually resulted in criminal behaviours. This was particularly salient in the Police Review and some of the newspaper articles.

This theme was also salient in the interview data. Interviewees focused on the addictive qualities of heroin and the associated loss of control that accompanies the experience. Participants discussed this theme using terms such as 'zombie' and the

'slippery slope'. Many participants believed that 'once you are hooked you are hooked' and discussed heroin use in terms of a compulsion, something that 'takes you over'. At this point, it was argued, the heroin user will 'do anything' to 'feed their habit'. The loss of control was perceived by participants as scary and associated with social stigma and social exclusion

The other impact on the individual heroin user, that was salient across the data, was the risk of death. In all three studies heroin was associated with overdose risks and death. It was argued in Study one that a heroin user had a risk of 'dying younger'. The articles in the BMJ highlighted the strong associated between heroin and heroin related deaths, estimating that 2% of injecting heroin users die every year. The risk of death was again linked to the addictive qualities of heroin. Some newspaper articles argued that the 'addict is helpless'. Heroin addiction was deemed to be so powerful that not even the risk of death was a deterrent. The overall tone of the data suggested that for this reason heroin users should be treated as patients and not criminals. This argument was particularly salient in the Police Review articles.

Within the data also was a focus on the impact that heroin has on the community and society at large. This was not surprising because for every crime the heroin user commits there will be a victim of crime. The impact on others was a particularly strong theme in study one and was salient in the media analysis also. Crime and prostitution was deemed to have a strong impact on other members of the community. Crime is a threat to others and also leads to a loss of a sense of safety. There is also an economic cost to crime and it is the victims who most often incur this cost. When a heroin user drives under the influence of drugs or alcohol

to attain their heroin, the safety of other road users is in jeopardy. It was also argued that families of heroin users are affected, children are neglected and the impact heroin has on the family is seen to have far reaching consequences for society. Participants discussed the impact that heroin has on communities with arguments such as it 'tears communities apart' and the 'social field will be breaking down'. Heroin use was seen as having a detrimental affect on everybody in close proximity to its use.

One other perceived risk to others was the risk of AIDS. This was discussed mainly in the focus group data and the interviews. This theme was less salient in the media analysis. Needle use, particularly the sharing of needles, was strongly associated to HIV and AIDS. The data suggested that injecting heroin users posed a risk to others as they could potentially spread the HIV virus throughout the community. The impact of heroin was seen in a negative way and no positive aspects were highlighted in the data but rather it was seen as scary and threatening to others.

6.3 The nature of heroin users

The data across my three studies provided varied descriptions of heroin users. I called this theme the 'nature of heroin users' and within this theme I am discussing these descriptions of heroin users that were found across all the data. (See Appendix R for a table of the themes from each of the three studies which contributed to this super theme). The impact of heroin, discussed above, highlighted the addictive qualities of heroin and the associated criminal behaviours

associated with acquiring the drug. The image of the heroin user and the criminal were inextricably linked throughout the data. A heroin user is a criminal by the very deed of using an illegal substance. Heroin users are associated with street crimes and theft in order to 'feed their habits'. The heroin user as a criminal, however, was represented in two ways across the data. On the one hand, the heroin user was described as a reluctant criminal. They committed crimes because of their addiction but it was the addiction that was driving the crime and not the heroin addict themselves. This was a particularly salient argument in Police Review where it was argued "If they could just get free of heroin, they would not commit crime".

On the other hand heroin users were also associated with heinous crimes, mainly in the newspaper articles. Heroin users were associated with the death of a two-year old boy, 'culpable reckless conduct' which involved unsafe sex with knowledge of being HIV positive, and stabbing fruit in shops with dirty needles in order to clean the needles. Each of these crimes was presented as the behaviour of a heroin addict rather than the behaviour of a person who subsequently used heroin. In these articles there was no reference to the effect that heroin had on the individual. In this way, these articles drew attention to the nature of heroin user regardless of the impact heroin has on their behaviours. Therefore, the tone of the articles suggested that this was due to a lack of moral consideration for others. This highlighted the 'will do anything' aspect of heroin use that many participants found threatening and scary. The heroin user was not seen as a helpless victim in these articles but rather as someone who had lost all sense of consideration for others. Some of the BMJ articles described heroin users as 'difficult and disruptive' and argued that GPs did

not want to work with them as their cases were 'complex and time-consuming'. Heroin users were described as a burden on society, people who 'pester other people' to 'fund their lifestyle for free'.

Within other newspaper articles heroin users were described in a less threatening way. The terms 'naïve', 'easy prey' and 'slave' were used and this made reference to young people who were drawn into a life of heroin addiction. Within this depiction of a heroin user was the theme of addiction and also a suggestion that the 'naïve' young person in some way underestimated the effects of heroin. The theme of addiction was reinforced with the word 'slave'. Another term that was salient in the interview data was 'zombie'. Heroin users were associated with addiction that had 'taken them over' and they lost everything. The 'zombie' image of the heroin user was perceived as scary as they were described as 'ready to take or do anything, just to get their fix'. Heroin users were also associated with psychological problems and considered to be, in some ways, 'unstable'. This image was supported with the assertion that heroin users came from poor or 'troubled' backgrounds.

6.4 The heroin arena

Throughout the data heroin and the heroin user were described in terms of a 'specific problem' and linked to specific types of people or 'someone else'. For this reason I named this theme the heroin arena in order to describe the type of place and lifestyle associated with heroin and heroin users. It embodies the creation of a world associated with and inhabited by heroin users. This is an imagined

world as it was created by participants and media sources who, may or may not be mediated by first hand experience of heroin use or heroin users. (See appendix S for a table of the themes from each study which contributed to this super theme).

Heroin was associated with poverty across all the data. In Police Review the articles described 'deprived sprawling housing estates' and 'decaying inner cities and dump estates'. Similar themes were found in study three. Interviewees discussed how heroin users might 'feel trapped' and live in 'low income housing' and live 'shitty lives'. Those who started using heroin would end up in a squat if they didn't already live in poverty. This association between heroin use and poverty was reinforced with beliefs that heroin 'is not found in white affluent middle class areas', as suggested in Police Review, or 'not prevalent in posh parts of the city' as suggested by an interviewee in study three. Heroin was not associated with middle class society but was seen as something that existed in the more socially disadvantaged parts of the community. In some ways it was also suggested that this would provide some sort of understanding about why people use heroin, that is, as a means to escape their existence in poverty.

Within the heroin arena there was also an association with a particular style of living. Street crime and prostitution were rife but also gun crime too. Drug dealers were depicted as part of a heroin users world and they were associated with violent crimes, such as 'enforcement attacks', 'kidnappings' and 'beatings'. The Police Review drew a sharp distinction between the crimes of theft carried out by the heroin user and the more insidious crimes of the drug dealer. It was argued that most of the violence and gun crime was in fact 'fuelled by drugs'. The heroin arena

was also associated with 'the scum of the underworld' and this created an image of a scary, unappealing world.

The heroin arena was also associated with needles and injecting which many interviewees in study three found scary. There was an apparent stigma attached to injecting which was salient mainly in study three. The act of injecting heroin was also associated with overdose and risk of death as well as the risk of contracting the HIV virus. The heroin arena was therefore associated with sigma and emerged from the data as a very unappealing place to be. Within the heroin arena there were associations between the heroin user, addiction and loss of control. This was dominant across all the data and terms such as 'road to death' and 'slippery slope' were used. In this way the heroin arena appeared as a place of descent and decline. Participants in study three talked about being 'at a loss from yourself' and 'throwing everything away'.

In this way the heroin Arena gave the impression of a place where one gets lost and loses control of ones life. When the heroin user is in the heroin arena they are at 'rock bottom'. The ideas of descent and decline, which were reinforced by the use of the term 'slippery slope', created a sense that the heroin arena is a hard place to ascend from. Within this theme were the views that the heroin arena is the end of the road. Therefore, the heroin arena was an abstract place, within the data from my three studies. Participants distanced themselves from the heroin users world and their behaviours and implied that heroin use happens 'some place else' and heroin users 'do not inhabit our nice neighbourhoods'. The world of the heroin

user, therefore, is this abstract heroin arena that is inaccessible and distanced from people who don't use heroin.

6.5 The legal status of heroin

The legalisation debate was salient in all three sources of the media data and focused mainly on heroin and cannabis. (See Appendix T for a table of the themes from each of the three studies which contributed to this super theme). The focus of this debate was the addictive nature of heroin and the benefits that would be gained or the problems incurred by legalising the drug.

The main focus of the debate was cannabis and the question of whether it should be classified as illegal, in the same way that heroin is, if one is more harmful than the other. On the one hand, it was argued that most heroin users started using cannabis before they moved on to heroin and therefore cannabis was seen in terms of a gateway drug or a stepping stone drug. On the other hand, it was argued that most cannabis users never use other drugs and especially not heroin so therefore cannabis should not be constricted under the law in the same way as heroin. The data supported the need for a 'legal differentiation between highly addictive drugs and milder substances (i.e. cannabis).

Within this debate was the belief that hypocrisy exists within society today regarding drug use. In all three sources of media data it was argued that alcohol and tobacco cause more harm in society today than all the illicit drugs. In most of the articles it was implied that this included heroin. This debate on hypocrisy

centred on the addictive qualities of heroin and its negative social image. Alcohol and tobacco are not only legal but they don't have the same negative connotations and social image as heroin does. For this reason, it was argued that they were considered 'safer' substances. Across all the data it was argued that alcohol and tobacco cause more damage in society and have a greater economic cost than heroin.

6.6 Analysing and searching for social representations

Farr (1993) argued that "one cannot know, in advance, either the form or the content of the social representations that will emerge from one's investigation" (p. 20). In analysing the data, common categories and consistent themes emerged. It is important to distinguish between 'core' and 'peripheral' elements of a representation (Abric, 1993; Pereira de Sa, 1996). The core of the representation is therefore the 'heart', the fundamental essence of the representation and is "determined by historical, sociological and ideological conditions" (Abric, 1993, p.74). Therefore the core of the representation is more consistent and resistant to change. The core of the representation establishes the organisation of the representation. Yet Abric (1993) argued that social representations are both "consensual but marked by strong inter-individual differences" (p. 75). In this way then representations are both stable and dynamic, shared and personal.

This is due to the peripheral elements of the social representation and these are more responsive to challenge and revision. It is therefore the peripheral elements of the social representation that are dynamic and personal. The peripheral elements

are more sensitive to the immediate context and permits the integration of individual experiences and past histories. The distinction between core and peripheral representations is useful in that it allows us to conceptualise simultaneously the subjective and the social aspects of social representation.

Peripheral elements may be altered to fit one's own perspective, experience and identifications. However, the stability of even the core of a representation is relative. The significance of the core versus the periphery varies in different types of social representations. Hegemonic representations, those representations which make up the ideologies of cultures (Moscovici, 1988), are comparatively unchanging over time and so are almost completely dominated by the central nucleus of ideas. Other representations, particularly those that oppose the dominant order, are more contested and so more reactive to the peripheral elements of the representation. Jodelet's (1991) definition of what a social representation is was useful in the analysis:

> "As phenomena, social representations present themselves under various forms, more or less complex. Images that condense manifold meanings, systems of reference that allow people to interpret what is happening, and indeed give meaning to the unexpected; categories which serve to classify circumstances, phenomena and individuals with whom we deal; theories which permit us to establish facts about them. When we consider social representations embedded in the concrete reality of our social life, they are all the above together" (Jodelet, 1991, p. 64).

Within this study I sought to explore the social representations of heroin and heroin users within society today. I searched for the meaning my participants and my media sources gave to heroin and heroin users. Throughout my analysis I created

clusters of themes in an attempt to identify the common categories within the data that would "serve to classify circumstances, phenomena and individuals with whom we deal" (Jodelet, 1991, p. 64). Therefore the analysis of my data entailed my search for the social representations of heroin and heroin users.

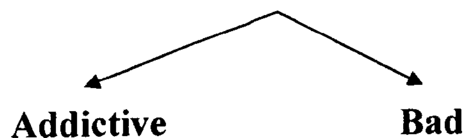
A content and thematic analysis enabled me to focus not only on the frequency of codes but also on their contextual meaning (Joffe & Yardley, 2004). This enabled me to systematically analyse the data for the most consistent themes and to identify the core elements of the social representation. Previous analysis had condensed a large corpus of data into themes (see table 6.1) and then super-themes (see section 6.2 – section 6.5). I spent a lot of time reading and re-reading these themes and paid great attention to the variability and consistencies across the themes.

In order to identify the core elements of the social representations of heroin and heroin users I needed to identify the main thread that linked all the themes together, paying particular attention to the 'historical, sociological and ideological conditions' (Abric, 1993, p. 74). However, as I discussed previously, social representations are both stable and dynamic at the same time with shared and personal elements. By noting the dynamic and individual elements of the representation I was able to identify the peripheral elements of the representation also. In the next section I shall introduce the social representations that emerged from my data and discuss the main peripheral elements.

6.7 Social representations of heroin and heroin users.

Two dominant social representations of heroin emerged from the data; heroin as addictive and heroin as bad. Within my study these representations attained their significance and their distinction in relation to each other. The social representation of heroin as addictive was inter-dependent on the social representation of heroin as bad. A representation can be manipulated in different ways to produce quite different versions of the same social object, namely heroin. Whilst heroin was represented as addictive throughout the data, how the heroin user was interpreted varied across the data. The same representation of heroin as addictive was used to perceive the heroin user in different ways.

Social Representations of Heroin



The representation, heroin is addictive, was more obvious as it was easily anchored in terms of 'zombies', 'slaves' and 'prey'. The representation, heroin is bad, was more subtle in some parts of the data, than others. In the newspaper data it was salient in some of the articles. In other parts of the corpus of data it was implied. Within this assertion, that heroin is bad, lies a moral judgement of heroin users. In the data the heroin user was depicted as both a deliberate criminal and an unwilling criminal who should be treated as a patient. This enabled participants and the media data to lessen the judgement from 'bad' to 'unwillingly bad'.

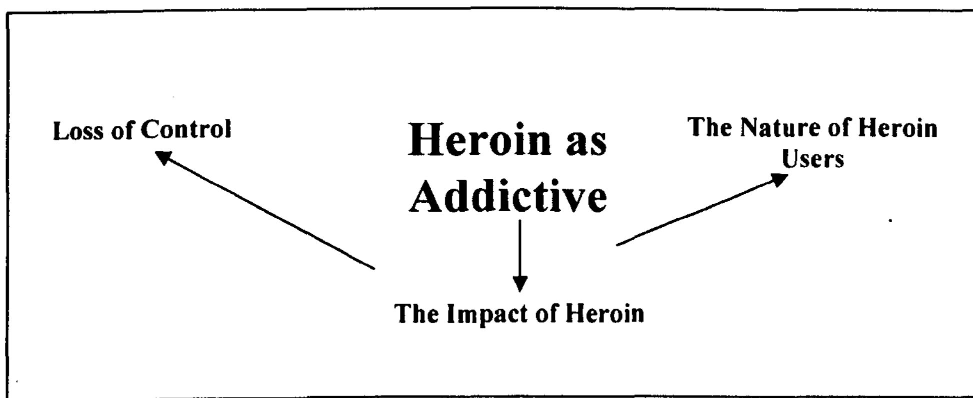
The representation of heroin as addictive was common in all the data in this study. It was a pervasive representation that included themes about loss of control, becoming a slave to heroin and the behaviours that are associated with addiction and loss of control. Heroin as bad included themes about threat, loss of morals and other behaviours that were considered socially undesirable but deemed to be driven by heroin addiction itself. Heroin as bad was more salient where it was intertwined with heroin is addictive. In this way both representations were constructed through and against each other.

6.8 Heroin as addictive

All descriptions of heroin across my data set emphasised that it is an addictive drug. As I discussed in section 6.6 the core of the representation is more consistent and resistant to change and is "determined by historical, sociological and ideological conditions" (Abric, 1993, p. 74). I will pay particular attention to these three aspects of the core of the representation in my discussion chapter. In this section I wish to focus on the three main peripheral elements. These were:

1. Loss of Control
2. The Nature of Heroin Users
3. The Impact of Heroin

The peripheral elements are not only consensual but are dynamic also, in that, they represent inter-individual differences. I will now discuss this in the following sections.



The core and peripheral elements of the social representation of Heroin as Addictive

6.8.1 Loss of control

The addictive nature of heroin was a theme that pervaded all the data. One of the consequences of heroin addiction, it was argued, was a total loss of control over the self and therefore the heroin users' behaviours. Crime that takes place to fund heroin use was associated predominantly with the addiction itself rather than a desire to commit crimes. Prostitution, which is also a crime in the UK, was also associated with the need to acquire money for heroin. It was argued that heroin causes the heroin user to loose control over their behaviours. Heroin drives the actions of the heroin user and therefore it can turn 'law-abiding citizens into thieves'.

Participants anchored a heroin user with a zombie and a slave and discussed how heroin 'takes you over' and once 'you are hooked, you are hooked'. Heroin in this way took on the image of the master and the heroin user as the slave. A small amount of data from study three made reference to the potential pleasurable qualities of heroin, 'it's a fantastic fucking thing' and 'from what I've heard it sounds lovely' were just some of the arguments put forward. But the potential

pleasurable qualities of heroin were also associated with a loss of control but this time the loss of control was attributed to how good heroin might be rather than the pharmaceutical qualities of heroin itself.

6.8.2 The nature of heroin users

The social representation of heroin as addictive supports *both* the claim that the heroin user is helpless *and* the claim that the heroin user is a threat. A representation can be manipulated in different ways to produce quite different versions of the same social object, in this case – the heroin user. The heroin user as helpless incorporates the process of loss of control. How loss of control is perceived impacts on how the heroin user is perceived. Some of the data supported the image of the helpless heroin user. This was supported by the image of the heroin user as a patient as opposed to a criminal. Other data suggested that heroin users were helpless in their need to commit crimes, they were driven but the crime itself was not intentional and without the need for heroin they would not do it.

Other data supported the image of the heroin user as a threat. This was also linked to the idea of loss of control but in this instance this signified a loss of morals. The idea that a heroin user 'would do anything' to feed their habit was scary to some participants and interpreted as threatening. Heroin users' behaviours were seen as threatening to others, the spread of AIDS, crime and also to social cohesion. It was argued that the very fabric of society would break down. Some of the data supported the social image of a heroin user with no morals who did not care about the consequences of their actions on others and therefore caused the death of a two-

year old child, had unsafe sex when they were knowingly HIV positives and used fruit in a public shop to clean their needles. This type of unchecked behaviour was deemed to be threatening to others. Therefore, the heroin user was seen as helpless and threatening at the same time.

Cognitive polyphasia explains how it is possible to support two versions of the same social representation at the same time. This was evident in my findings as it was possible to see the heroin user as helpless and threatening at the same time. This was demonstrated perfectly in the image of the zombie that participants anchored a heroin user to. A zombie is believed to be a person who died and was brought back to life by a spiritual person who has the power to do so. Zombies are strongly associated with voodoo and when they are brought back they are in the power of the person who resurrected them. In this way they have no speech or free will. A zombie is to be pitied and feared at the same time, pitied because they have no free will and they were brought back to life against their will, and feared because they have no free will and are therefore unpredictable and threatening. Participants anchored a heroin user with a zombie and this would suggest that a heroin user should also be pitied and feared at the same time. Therefore there is a plurality of fields within the social representations of heroin as addictive and the conflicting styles of thinking, demonstrated by the data, is best represented by the association with a zombie.

Cognitive polyphasia was introduced by Moscovici (1961/1976) in his seminal work and researchers in the field of social representations have explored and expanded this concept further in recent years (Jovchelovitch, 2002, 2007; Wagner,

Duveen, Themal & Verma, 1999; Wagner, Duveen, Verma & Themel, 2000; Jovchelovitch & Gervais, 1999). Within social representations there are a plurality of representational fields and this means that there can be differing and at times conflicting styles of thinking within any one representational field. Cognitive polyphasia explains the heterogeneity and diversity of social knowledge and the social fabric at the same time. Polyphasic representational fields allow individuals and communities to have an assortment of co-existing knowledge resources from which they can draw. It enables differing and conflicting systems of thought to co-exist at the same time. This concept expresses the dialogical nature of knowing and explains how this influences the knowledge systems which allow us to make sense of the world.

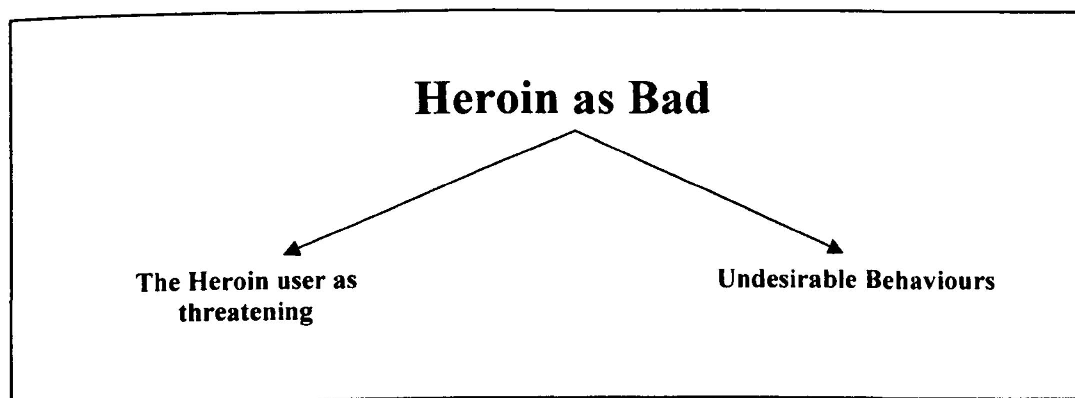
6.8.3 The impact of heroin

The impact of heroin is also the impact of addiction. Addiction was described in the data as a very destructive thing. This argument is supported when the impact on the heroin user and society is considered. The impact of heroin use on the individual is the risk of overdose and death. For others it is contracting the HIV virus through the use, particularly, sharing of needles. The impact on the community is also negative and destructive in my data. Children are neglected, family values are undermined and 'communities are torn apart'. The heroin user becomes a scourge and a burden on others. The impact of heroin is associated with the addictive nature of heroin and therefore it is addiction itself that has the impact rather than heroin itself. Heroin and addiction are almost inseparable and throughout the data heroin and addiction were perceived as the same thing.

6.9 Heroin as bad

Within the data heroin was described as bad and this was emphasised through comparisons with alcohol and other recreational drugs such as cannabis, cocaine and ecstasy. This was salient throughout all the data and therefore was identified as a core theme. The social representation of heroin as bad was constructed though and against the social representation of heroin as addictive. This will be discussed in more detail in section 6.10. There were two main peripheral elements. These were:

1. The Heroin user as threatening
2. Undesirable Behaviours



The core and peripheral elements of the social representation of heroin as bad

6.9.1 The heroin user as threatening

Across the data heroin users were associated with threatening people, namely drug dealers and 'the scum of the underworld'. Drug Dealers were depicted as dangerous and calculating. They appeared more dangerous as there was no apparent loss of control. There was an implied intent in their behaviours which

include gun crime and violence towards others. Heroin users, it was argued, kept company with 'the scum of the underworld' and this association supported a social image of a threatening heroin user.

Heroin users were also associated with crimes and behaviours of their own. Associations with crime, such as petty crimes and street crimes, for most members of the public, is threatening and unsettling. The data supported associations with prostitution, AIDS, needles and most importantly a loss of control due to the influence of heroin itself. Heroin users were also associated with a loss of morals and there were assertions that they 'would do anything' to continue using heroin. This loss of morals goes further than a mere loss of control. A loss of morals is threatening to others because it incorporates a loss of social awareness and social responsibility. The heroin user becomes symbolic of a breakdown in social norms and social rules. This representation of a heroin user was supported across all the data.

6.9.2 Undesirable behaviours

Heroin users were aligned with behaviours that caused the death of a two-year old child and were involved in unsafe sex that was described as 'culpable reckless conduct'. Other behaviours included stabbing fruit that was on sale to the public, with used syringes, with the intention of cleaning them in the citric acid of the fruit. The way these stories were reported was significant in how these behaviours should be interpreted. There was no reference to the addictive qualities of heroin in any of these stories and therefore the behaviours themselves were the main concern of the

story. Addiction to heroin was merely implied in these newspaper articles. Other data supported the theme that heroin users are hedonistic and indulge a 'free lifestyle' that is funded by others, i.e. members of the community. It was a perceived loss of morals that was driving this bad behaviour and an addiction to heroin was inter-linked with the loss of morals.

As discussed in section 6.8.2 the social representation of heroin as addictive supports *both* the claim that the heroin user is helpless *and* the claim that the heroin user is a threat. Similarly, the social representation of heroin as bad supports *both* the claim that the heroin user is bad and associated with bad behaviours but *also* that the heroin user is helpless. In this way the data supported two separate social representations. But the majority of the data supported a representation of heroin and heroin users that was an interaction or overlapping of the two.

6.10 The heroin user as a threat and helpless

As I discussed in section 6.7 the social representations of heroin as addictive and heroin as bad were inter-dependant and figure 6.1 below shows where the themes of the two representations overlapped. The two outer sections of the diagram show where the themes were mutually exclusive. Where the two circles intersect I have described the themes that formed the representations of both *addiction* and *badness*. It is here that both representations were constructed through and against each other. For example, loss of control was attributed to addiction but was perceived by many participants as a moral issue and was therefore associated with *badness* also.

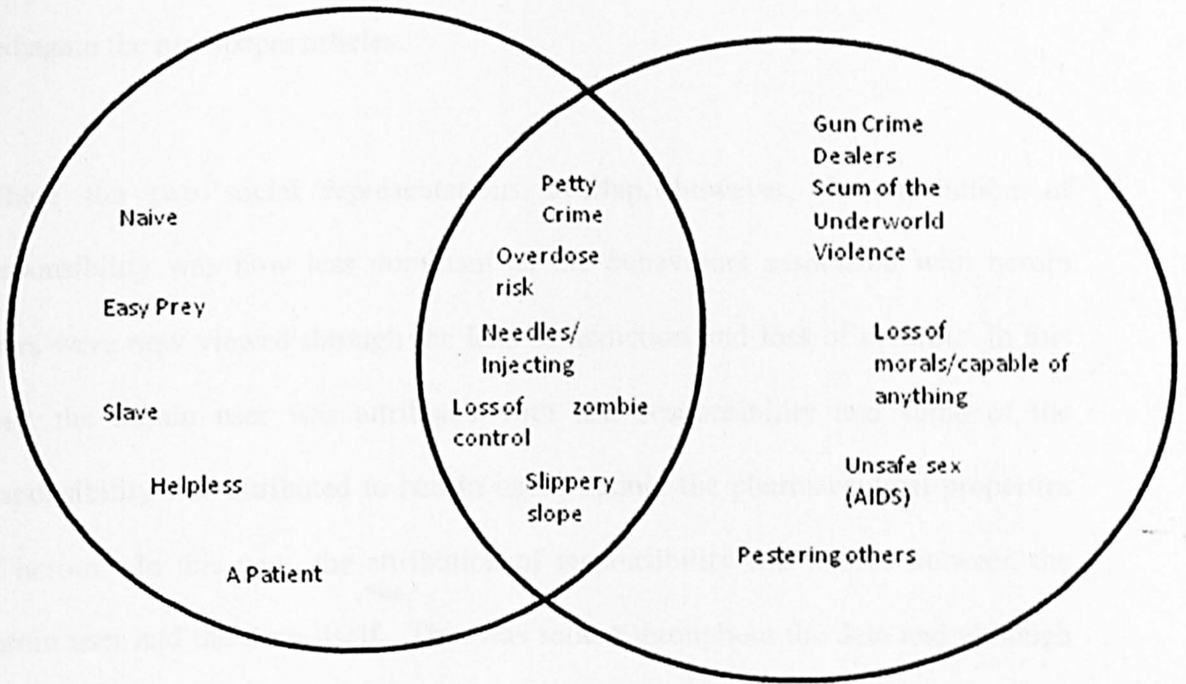


Fig. 6.1. The interaction between the social representations of heroin as addictive and bad.

Markova and Farr (1995) highlighted that the attribution of responsibility forms an important element within the social representation of illness. They argue that it is normally 'externals' who are blamed for diseases within any society but if this is not possible then an easily identifiable sub-group within the society, normally of low social standing (Sontag, 1979), will be attributed with responsibility. This is of great relevance to my study and sheds light on the significance of how the two social representations overlap. Within the social representation of heroin as bad the attribution of responsibility was an important element as the data supported the claim that heroin users were to blame for their behaviours. This was particularly supported by a selection of the newspaper articles. The behaviours described were associated with a lack of morals and hedonistic in nature. It was also pertinent in

the attributions made about heroin dealers and this was salient in the Police Review and again the newspaper articles.

Where the two social representations overlap, however, the attribution of responsibility was now less dominant as the behaviours associated with heroin users were now viewed through the lens of addiction and loss of control. In this way, the heroin user was attributed with less responsibility and some of the responsibility was attributed to heroin itself, mainly the pharmaceutical properties of heroin. In this way, the attribution of responsibility was shared between the heroin user and the drug itself. This was salient throughout the data and although the associated behaviours of the heroin user are still socially undesirable and a threat to others it was deemed that it was not their fault. This was supported by terms such as zombie and a strong association with loss of control.

Finally, the social representations of heroin as addictive focused on the impact loss of control has on the heroin user. Where the themes in the social representation of heroin as addictive were mutually exclusive the data was predominantly descriptive. The focus of these themes was on the nature of heroin users rather than associated behaviours. Therefore the heroin user was described as 'naïve', 'helpless', 'easy prey' and most importantly 'a patient'. It is here that responsibility was attributed to heroin itself and not the heroin user. In this way, the heroin user was blameless and was now perceived as a 'slave' to heroin. The heroin user was no longer deemed to have control of his/her behaviours and therefore was in some ways not culpable or responsible for his actions. The data

supported the argument there was a need for professional intervention in order to support or perhaps rescue the 'helpless' addict.

6.11 Anchoring and objectivity

Representations surround us, entice us and are all pervasive (Moscovici, 1988). In becoming aware of them, we incorporate them into our current ways of understanding, i.e. into the social representations which we have already developed. How does this actually happen? In modern cultures we tend to (a) anchor and (b) objectify representations. I introduced these processes in chapter two (see section 2.8) and I shall now discuss them in greater detail as they have particular relevance to the organisation of social representations and shed light on how participants become familiar with the unfamiliar, in this case heroin and heroin users.

Anchoring integrates new phenomena into existing world-views in order to lessen the shock of the new. Anchoring involves ascribing meaning to the object being represented. "By classifying what is unclassifiable, naming what is unnameable, we are able to imagine it, to represent it" (Moscovici, 1984, p. 30). In this way new images are then attached to a recognisable reference point, and generalised or particularised to the familiar categories of everyday cognition (Moscovici, 1981). In the course of anchoring the unfamiliar in the familiar, representations are modified (Moscovici, 1988; Bartlett, 1932). As the general public first became aware of the relatively recent disease, AIDS, for example, representations of AIDS were anchored in historic representations of the plague (Markova & Farr, 1995). In

this way representations of the plague were transformed by virtue of serving as anchors to the novel.

In this study, heroin was an unfamiliar phenomenon for the participants in both studies. There was no evidence in the media data that any of the authors were writing from the perspective of a heroin user with knowledge of heroin use. In study three only one participant disclosed personal experience of heroin use. Therefore, it was necessary to anchor the unfamiliar in the familiar and this was most evident in the data from study three. This was done by anchoring heroin with other recreational drugs such as cannabis, cocaine and ecstasy. Not all participants had experience of these drugs but the majority of participants had personal experience of alcohol and therefore anchored heroin with their existing knowledge of alcohol.

This is not, however, a neutral process (Jodelet, 1991). By classifying a person, a thing, an event, or a nation, we are at the same time assessing and evaluating it/them. It was evident that although the participants in study three were anchoring heroin with alcohol and other recreational drugs, they did so by drawing attention to the differences between the effects of heroin and their own drugs of choice. The most notable difference being the effects the different drugs had on the individual. Whilst heroin was believed to lead to a total loss of control within the heroin users life, the same was not to be said for alcohol or the other drugs mentioned. Participants stressed that the use of alcohol and other illicit drugs, such as cocaine, ecstasy, cannabis, were 'occasional' pursuits and did not lead to a loss of control and therefore addiction.

Within this study I also found that representations of heroin as addictive were anchored with 'a zombie'. This is resonant with how representations of AIDS were anchored in historic representations of the plague (Markova & Farr, 1995). A zombie is both to be pitied and feared at the same time as they are both lost and a threat simultaneously. I discussed this previously as an example of cognitive polyphasia (see section 6.8.2). By anchoring heroin users with zombies the participants reinforce the concept of otherness and it becomes apparent that their understanding of heroin is in relation to the self and their need for a categorical differentiation between heroin users and their own recreational behaviours (Markova & Farr, 1995).

The process of objectification can be more active than anchoring because it saturates the idea of unfamiliarity with reality, turning it into the very essence of reality. In other words, it produces the materialisation of an abstraction (Moscovici, 1981). Wagner's work on the social representations of reproduction, particularly our visual representation of the sperm, is a good illustration of this (Wagner , Elejabarrieta & Lahnsteiner, 1995). In this way images cease to be images or signs; they become a part of reality (Moscovici. 1984). Participants in study three spoke about heroin use as 'a slippery slope' and this was a good example of the process of objectification. Participants associated heroin addiction with the rapid and irreversible movement down a slippery slope and this was the materialisation of an abstraction.

Through objectification, Moscovici (1984) has explained that image take the form of reality and are no longer just elements of thought. In this study participants

discussed their *perceptions* of heroin use as they had no experience of the *reality* of heroin use. For them the process of descent and decline that is the result of being on a 'slippery slope' enabled them to materialise the abstract effects of heroin addiction brought about through loss of control. The experience of a 'slippery slope' was more familiar and enabled them to produce a domestication of the unfamiliar descent of the life of the heroin addict.

It can be argued that the two processes of anchoring and objectifying, though analytically distinguishable, are interdependent. If a representation is securely anchored, it must also be objectified, and *vice versa.* Lloyd and Duveen (1992) provide a clear example of this: "the descriptions of electrons circling an atom was *anchored* in an earlier physical model of planets rotating around a sun. Once *anchored* in this way the model is *objectified* so that the reality of the atom is construed in terms of orbiting electrons/planets" (p.21, italics authors own).

Representations about heroin users are statements about the self and statements about the heroin user at the same time. In re-presenting heroin users participants are attributing an identity to them and through an identity they attribute to themselves. We are either affiliated with or reject the identity that is attributed.
Social representations, as Moscovici (1990) has stated, are "not mental creations that have social consequences, they are *social creations,* constructed via mental processes, that acquire reality". Social representations support a particular version of reality and therefore protect particular interests over others.

This reality has to be confirmed by the reality of other community members. We make sense of things by assessing the reactions of others. The meaning of an act is found in the nature of the response it elicits from others, as Mead (1934) has told us. Thus, through the process of social re-presentation, we come to learn about the world and we learn the current ways of attaching meaning to social and physical objects around us. In sharing the representations around us, not only do we come to build a common understanding, we also come to embed ourselves in the communities significant to us.

6.12 Conclusions

Through a systematic analysis of the data I found that two main social representations of heroin and heroin users emerged from the data; heroin as addictive and heroin as bad. In this chapter I focused on the main core and peripheral elements that make up the social representations of heroin and heroin users. The representations of heroin and heroin users had mutually exclusive themes but also overlapped and in this way the two representations were constructed through and against each other. Participants anchored heroin users to the image of a zombie and this demonstrated how heroin users were to be pitied and feared at the same time. The role of control was an important dimension in both social representations and through the process of objectification it became manifest in the image of the slippery slope. In conclusion, I found that the social representations of heroin and heroin users had conflicting elements which enabled participants to support two versions of the same social representation simultaneously.

In my final chapter I shall explore the broader issues focusing on the sociological, historical and ideological conditions as recommended by Abric (1993). I shall discuss the salient attributions that emerged from the data and discuss these within a social representations context. I shall then explore the broader themes of health and 'the Other' and the themes of responsibility and control. I will explore how participants distanced themselves from heroin users through the creation of the heroin arena and how this reflected on their own drug-using behaviours. Finally I shall examine the implications of my findings for national treatment options and policies and briefly consider how the social representations of heroin and heroin users influence participants' attitudes and perceptions of recreational drug use.

Chapter Seven: "At least I don't use heroin"

7.1 Introduction

In my final chapter I intend to discuss my findings in more detail and pay attention to how attributions form part of the social representation process, paying particular attention to responsibility and control. However, the aim of my thesis was to explore the social representations of heroin and heroin users. I shall therefore examine how social and cultural norms of responsibility and control are part of the social representations process. I shall explore how heroin and heroin users are situated within a society that has a greater tolerance for recreational drug using and develop the concept of the heroin arena further. Finally I shall briefly examine the implications of my findings for future drug campaigns and heroin users themselves.

The aim of this thesis was to explore the social representations of heroin and heroin users. Two dominant social representations of heroin emerged from the data; heroin as addictive and heroin as bad. The social representation of heroin as addictive was anchored with images of 'zombies', 'slaves' and 'prey. The social representation of heroin as bad contained strong associations with heroin users as a threat and was strongly linked with a moral evaluation of the use of heroin. As outlined in chapter two, a social representations approach pays particular attention to the way members of society construct their social reality and in doing so make sense of the world (Hadley & Stockdale, 1996). For many lay people the heroin addict can seem like an abstract concept or image, particularly if they have not had personal contact themselves. Only one participant had first hand knowledge of

heroin and therefore participants anchored heroin with their own alcohol use and their varied experience with other illicit drugs such as cocaine, ecstasy and cannabis.

I found that the two social representations had overlapping themes that were strongly intertwined (see figure 6.1). Within the different social representations, heroin users were discussed as criminals or patients. Within the social representation of heroin as bad the heroin user was deemed extremely bad and was associated with crimes that lacked morals or any consideration for others. This association with *badness* was therefore perceived as hedonistic and considered to impact severely on others. Within the social representations of heroin as addictive the heroin user was described as a patient, desperately in need of professional help. The heroin user as a patient was totally helpless to the controlling power of heroin. Hammersley (2005) explains that "we remain beguiled by a fifty-year-old stereotype of drug 'addiction' as akin to tapping directly into the pleasure centres of the brain, leaving the 'addict' obsessively consuming in mental ecstasy but physical squalor" (p. 202). Where the themes of the two representations overlapped the heroin user was linked to crime but they were seen as 'reluctant criminals'. Their crime was attributed to their addiction to heroin and in this way they were seen as criminals and patients at the same time.

I found that the social representations of heroin encompassed strong dimensions of morality and blame. However, the level of blame attributed varied across the two social representations. I showed in figure 6.1 how some of the themes of the two social representations overlapped but they both also had themes which were

mutually exclusive. The mutually exclusive themes of the heroin user as bad highlighted the heroin user as a hedonistic criminal associated with despicable crimes. The tone of the data suggested that heroin users were totally to blame for their crimes which were a result of their indulgence heroin. Therefore, the attributions of responsibility and blame were part of the social representation of heroin as bad process.

Where the themes of the two social representations overlapped, the heroin user was seen as a criminal and a patient at the same time. As a result of this there was a reduction in the amount of blame that was attributed to their behaviours. The heroin user committed crimes but they were not totally responsible because they were driven by their addiction to heroin. Finally, the social representation of heroin as addictive also had themes that were mutually exclusive. The heroin user was described as naïve and helpless; a patient rather than a criminal. The tone of the data suggested that heroin users were not responsible for their plight and needed help rather than punishment.

7.2 Attributions as part of the social representations process

It was not my intention to do an attribution analysis of my data but it is relevant to pay attention to the salient attributions that were evident throughout my findings. As I discussed in chapter two attribution theories emphasise how people interpret their own and others' actions. "Attribution of responsibility for disease has always been part of the social representation of the illness process" (Markova, McKee, Power & Moodie, 1995, p. 113). This statement has particular relevance to my

study because although the focus of my study was to explore the social representations of heroin and heroin users certain attributions were made that were of great relevance within this process. I found in my data that the attribution of controllability and therefore responsibility was a part of the social representation of heroin process.

Firstly I shall look at the attribution of responsibility as part of the social representation of heroin process. As I mentioned above, Markova et al., (1995) identified the attribution of responsibility as part of the social representation of illness process and heroin addiction is frequently identified as a health issue. Others focused more on the legal aspects of heroin addiction and saw it as a criminal issue. The data supported both assertions and also supported the notion of heroin addiction as a social problem. Within the social representations of heroin as addictive and bad, the attribution of responsibility was an influential dimension. The claim that a heroin user uses heroin themselves is an irrefutable fact. However, if the perceiver makes an attribution along Heiders' (1958) person/environment dimensions then a judgement will be made on intentionality and therefore responsibility.

The data in my study supported a pharmaceutical explanation for the effects of heroin. This meant that the drug itself exerted its influence on the heroin user. As Jones and Davies (1965) argued, the perceiver has to make decisions on the knowledge and ability of the actor. By supporting the belief that heroin strips the heroin user of control over their own lives it also supports the claim that the actors ability to control their behaviours is reduced or lost. Therefore, diminished

intentionality absolved heroin users of responsibility for their actions to some extent. This varied across the data and there were notable differences in the extent to which responsibility was attributed to the heroin user or the heroin itself. In this way the data supported an internal and external attribution of responsibility that existed simultaneously. The heroin user was responsible to some degree for their behaviours but this varied according to how much responsibility was attributed to the drug itself.

As I discussed in chapter two, Weiner (1986, 1995) introduced three new dimensions to Heider's (1958) locus of causality: stability, controllability and globality. Although I did not analyse the data for attributions, I observed from careful reading of my data that the behaviours of heroin users were perceived as stable over time, the heroin user had little or no control over their behaviours and the behaviours were attributable to all heroin users. This was particularly salient in chapter three when participants were given a vignette of a heroin user named *Billy* and asked to comment. *Billy* had none of the characteristics of a stereotypical heroin user. The data showed, however, that participants spoke about *Billy* in terms of these three dimensions.

Billy challenged the belief that the behaviours of heroin users are stable over time and therefore participants predicted that it could only be a matter of time before *Billy* was using heroin every day and loosing control of his life. In this way participants were aligning *Billy* with their beliefs about all heroin users and in this way the dimension of globality remained stable. According to Weiner (1995) attributions made along these dimensions lead to future expectations and enable an

individual to predict future behaviour. It is possible then that participants were trying to predict the future behaviour of *Billy*, using these three dimensions and sought to fit them with their original and stable attributions of heroin users. Further research would be needed here to explore this further.

7.3 From attributions to social representations

The data showed that the attribution of responsibility and control were a part of the social representation of heroin process. However, in chapter two I highlighted the assertions of Moscovici and Hewstone (1983) that it is social representations that provide the fundamental base upon which attributions are built. Therefore we move from Heider's (1958) assertion that the individual is a *naïve scientist* who makes attributions in order to understand behaviours to Moscovici's (1981) claim that "any causal explanation must be viewed within the context of social representations and is determined thereby" (p. 207). Therefore, I shall now explore responsibility and control within a social representations context, focusing on social and cultural contexts.

The description of the heroin user as the 'unwilling criminal' driven primarily by the power of heroin and not their own desire to commit crimes is a derivative of the disease model of addiction. Responsibility and control are key dimensions within this social image of the heroin user. The 'disease model of addiction' is the lasting legacy of this otherwise largely ignored episode in medical science (See chapter one, p. 9). The disease model of addiction supports the view of the heroin user as naïve and helpless, which were prominent themes within my social representations.

Therefore, within this model heroin users do not carry out their actions with absolute intentionality because they are not in control of their behaviours. This leads to a reduction in responsibility for the actions and behaviours, particularly those of a criminal nature, associated with heroin use.

Throughout all the data the theme of control featured significantly. The relationship between heroin use and control was the focus of much the data and it was argued that heroin use led to a loss of control. Heroin use was anchored with 'a slave' and 'a zombie' and this re-enforced the belief that the heroin user was helpless, lost to heroin. The participants' anchoring, in a shared practical and cultural background, invest the representations with specific contents and shades of meaning which translate something of the cultural identity of the participants themselves. The work of Joffe (1999) was informative to my findings of heroin users and the perceived loss of control. She draws on the work of such cultural theorists as Said (1978) who identified specific patterns for a Western understanding of 'the Other'. "According to Said (1978), a distinctive aspect of being 'other' is that one is the object of someone else's fantasies, but not a subject with agency and voice" (cited in Joffe, 1999, p. 18).

Heroin users were anchored with zombies in my data and traditionally zombies do not have a voice, they cannot speak. They merely carry out the desires of the one who has brought them back from the dead, that is, their master. This symbolises an absolute loss of control from the perspective of the heroin user. In my findings, heroin users were the zombies and the master of the zombie was heroin itself. Therefore, it could be argued, that once the heroin user is addicted they no longer

have a voice. To anchor heroin users with zombies is in some ways to dehumanise them, and they become 'the Other'. Joffe (1999) explored this concept of dehumanisation in her exploration of the Nazi's propaganda against the Jews between 1933 and 1945 and with further exploration and research this could shed light on this process of dehumanising heroin users. Bailey (2005) believes that "addiction, is then, at its very essence, a moral concept; resting in a dualistic conception of the mind-body relationship, it is conceptualised as a failure of the self in its imperative to exercise control over bodily desires and functions" (p. 539). Therefore control was important to the cultural identity of the participants and loss of control was seen as a failure.

The enduring belief that opiate use is 'deviant' pleasure survives in today's official discourse, particularly terms like 'drug abusers' and 'drug misuse' which still have the hybrid qualities of clinical diagnosis and moral judgement. Markova and Wilkie (1987) argued that it is understandable that in an age of individualism it is accepted that a person somehow deserves punishment for behaviour if it is deemed to be improper by mainstream society. Social representations theory acknowledges the social and cultural influences on how we see and come to understand the world. It was evident in my findings that some of the data supported this enduring belief of opiate use as a 'deviant' pleasure. This approach would mean that heroin users were responsible and therefore to blame for their behaviours. However, as I argued above, it is possible to reduce the amount of blame attributed to their behaviours if there is an acknowledgement that the heroin user has lost control of their actions. The 'deviant' criminal is at the same time a patient, powerless under the influence of heroin, and therefore 'an unwilling criminal'.

7.4 Health and 'the Other' in western cultures

Crawford (1994) identified the relationship between health and identity and the many metaphors that have come to represent the healthy self. He argues that within Western cultures there is still the influence of a Protestant ethos of moderation and a Calvanist horror of disorder. From this perspective 'the Other' is the antithesis of the desired characteristics of self-control, self denial and self-discipline. Therefore, excess addiction, such as the drug user, the alcoholic, the smoker or the person with AIDS are all seen as a loss of cherished qualities. Joffe (1999) traces the ethos of moderation back to Aristotelian times through the work of Gottfried (1978). She explores the "ongoing debasement of 'Others' in Western societies" (p. 27) and argues that in times of crisis the process becomes magnified. She defends this argument through her research on AIDS and perceived risks. In Joffe's opinion representations that identify groups and practices which threaten the stability and order of the community are themselves a form of control. Joffe (1999) identified an identity-protective quality of 'otherness' and posited that "chaos is ordered" by "means of self-protective representations" (p. 33). This involves forming representations which protect the positive identity of the in-group.

Participants in my study asserted that heroin users are the very antithesis of the responsible social drinker or weekend drug user. But if you ignore the pharmacological properties of a drug and focus on the individual instead, then any drug, legal or illegal, or alcohol, could have the potential to be addictive. Participants in this study distanced themselves from that by asserting the addictive

qualities of heroin and stressed that when they drink or use other types of illicit drug they were always in control. Participants valued the importance of control which supports Joffe's (1999) assertion that "control, as opposed to indulgence, is a core norm in Western society" (p. 24). Participants projected their fear of losing control onto heroin and heroin users. It is possible that participants were adopting an identity-protective quality of 'otherness' as identified by Joffe (1999) and by stressing the differences between heroin use and the use of alcohol or other recreational drugs, such as cannabis, cocaine and ecstasy, they were protecting the positive identity of their own in-group.

Individualism is now a value that is enshrined within North American and Western European societies and in our views about health care (Marks, 1996). Participants would therefore be influenced by an approach to health that cherishes personal responsibility for their own health and wellbeing. In this way, individualism can be seen to influence the discussion about choice versus addiction and focus attention on the role of control. Sulkunen (2003) discusses the characteristics of individualism and posits that the concept of the responsible individual brings with it the requirement for self-control. It also suggests the idea of a 'normal identity' and implies that to be in control of ones behaviour is a normal state of mind (Wetherell & Potter, 1992). This highlights the complexity of heroin taking behaviours and goes some way to explaining why participants distanced themselves from the behaviours of heroin users. Heroin addiction was perceived in my study as a loss of control and was believed to rob the heroin user of the ability to be responsible for their health and well-being. But as I discussed earlier, in an age of individualism it is acceptable that a person deserves punishment for these kinds of irresponsible

behaviours (Markova & Wilkie, 1987). However, participants anchored heroin users with zombies and slaves and in this way introduced the social image of the helpless heroin user and reinforced the pharmaceutical properties of heroin.

Parker and Measham (1994) discuss the 'pick 'n mix' attitude towards recreational drugs in society today. The 1990s saw a notable shift in social conceptions towards drug use and this was mixed with a greater availability of recreational drugs (Parker el al., 1998). In chapter one I presented a table (1.1) with estimations of numbers of adults who have taken drugs in their lifetimes. It is worth noting if my participants' drug use was comparable to these findings.

In Table 1.1 (p.3) we saw that cocaine, ecstasy, amphetamines and amyl nitrate were the most popular drugs of choice with two to three million people claiming to have used them at least once in their lives. Nine million people surveyed admitted to using cannabis at least once in their lives. In comparison to this 203, 000 people surveyed admitted to using heroin. Heroin use was higher only than methadone and anabolic steroids. Among my participants in both study one and study three, cannabis was also the most popular drug of choice. In study one 58% of all participants reported having tried cannabis in their lives. This was in comparison to 17% for cocaine and 38% for ecstasy for all participants.

Similarly in study three 60% of all participants reported trying cannabis at least once in their lives. This was in comparison to 30% for cocaine and 25% for ecstasy. In study three one participant admitted to using heroin. It is notable that cannabis remains the most popular drug of choice and my participants illicit drug

use was comparable with the findings from table 1.1. Heroin is distinguishable from other drugs, in that, it is used by the smallest percentage of people within society. Parker et al. (1998) attempted to address this in their research.

Despite the normalisation theory and the comfortable co-existence of non-users and users, for many young people heroin is still seen as a 'hard drug' and not something they would wish to try. In their studies Parker et al. (1998) found that most young people see 'taking hard drugs and actually injecting as anathema: a Rubicon they will never cross' (p.132). Parker and colleagues (1998) posit that heroin uptake is usually associated with poverty, educational under-achievement and unemployment and surmise that "the least worst scenario is that heroin 'trying' does not become accommodated within the larger 'recreational' drugs scene but remains predominantly associated with 'degrees' of social exclusion. The whole issue needs careful monitoring and profiling" (p. 45-46).

Participants valued a cultural norm of being in control and taking responsibility for their behaviours. Heroin is perceived by many as a 'hard drug' and is believed to lead to addiction and therefore a complete loss of control. This challenges the notion of a 'normal identity' (Wetherell & Potter, 1992) and therefore is associated with the out-group or 'the Other'. In an age of individualism heroin use challenges the notion of the 'normal identity' and the normal state of mind more than any other recreational drugs discussed by the participants in this study and has "not become accommodated within the larger 'recreational' drugs scene" (Parker et al., 1998, p. 45-46). In the world of dugs heroin signifies 'the Other' and through association the heroin user also signifies 'the Other'.

7.5 Looking into the heroin arena

Participants in this study discussed how heroin appears to be rather than how heroin is, due to a lack of personal experience. The eighties brought about the existence of many stereotypical images of heroin users, mainly from the Governments' health campaigns and the media. For most of the participants in this study heroin users are therefore a conceptual group. Within my findings I described the world that the heroin user inhabits as 'the heroin arena'. The heroin arena therefore is a conceptual world where heroin users exist. All the data supported the belief that heroin is associated with poverty. The heroin arena is a place of descent and this was anchored in 'the slippery slope'. The conceptual world of the heroin arena supports the findings of Parker et al., (1998) that propose that heroin is distinct from all other recreational drugs. The association between the heroin arena and social exclusion supports the social image of the heroin user as 'the Other'.

What was the significance of the social representations of heroin for the participants in my study? Heroin was associated with discrete social groups and deprived neighbourhoods throughout the data. In my findings I described this as the heroin arena. I now propose that this serves two purposes for the participants; it reduces personal anxiety of any contamination by association and it also encourages beliefs that other illicit drugs and alcohol are more fun and more socially acceptable. Furthermore, questions of social acceptability and moral judgements were also relevant and important. Heroin users are linked to the out-group, or 'the Other' which means participants form a 'tentative' in-group primarily through social

distance and a different drug of choice. Their choice of drug, whether it be illicit drugs or alcohol have the characteristics of being more socially acceptable.

In fact many participants in this study admitted using other types of recreational drugs either in the past or currently and in this way they were acknowledging that they were recreational drug users also. Those who claimed to have never used recreational drugs themselves showed a degree of tolerance for some of the 'softer' drugs, such as cannabis and ecstasy. How then was a distinction drawn between their recreational drug use and that of heroin users? Participants employed the social representations of heroin as addictive and heroin as bad to establish and maintain their distance from heroin users. Heroin on its own is addictive and bad but when heroin is perceived in association with the heroin user or the heroin addict it is no longer just an illegal drug. Heroin in conjunction with the heroin addict takes on meanings for the participants who don't use heroin and creates perceptions of those who do.

As Barry, Osborne and Rose (1996) argued discourses themselves are not a form of social control but rather explicate how people are recruited into their own self-government. Participants can push the boundaries of acceptable self-control because there is someone else, 'the Other', to make them look better. They can digress from abstinence and self-control if they can avoid addiction, or if they can avoid the 'slippery slope' that is anchored with heroin use. Participants are recruited in their self-government to avoid heroin but to have the option to use alcohol or other recreational drugs. In this way participants may be recreational drug users but they are associated with a different lifestyle. Heroin and heroin

users are kept separate and exist in the heroin arena. In this way heroin remains distinct from other recreational drugs and heroin users are not part of the mainstream recreational drug scene.

Giddens (1991) explored the role of lifestyle in identity and discussed the concept of 'life politics'. Giddens argues that the lifestyle we choose has become intrinsic in how our identity is constructed. He argues that "the more post-traditional the settings in which an individual moves, the more lifestyle concerns the very core of self-identity, its making and remaking" (Giddens, 1991, p. 81). Participants live in an age when health is strongly associated with lifestyle and identity. They have to negotiate their worlds and negotiate their choices and actions to themselves and others. Heroin signifies death and addiction, a complete loss of control in all aspects of one's life. There are many illicit drugs available in society today. Heroin is a stigmatised drug and is considered by many to present the greatest risks. This directs participants to avoid heroin but to choose other less threatening drugs from what is available. Heroin in this way unintentionally directs people to the use of other drugs such as cannabis, ecstasy and cocaine. Alcohol use was also justified by participants in this study in comparison to heroin use. "At least I don't use heroin" became a defence for the use of other illicit drugs or the abuse of alcohol. In this way the use of heroin enables those who use other illicit drugs to take a moral high ground and justify why their choice is acceptable.

Jodelet (1991) defined social representations as "Images that condense manifold meanings, systems of reference that allow people to interpret what is happening, and indeed, give meaning to the unexpected; categories which serve to classify

circumstances, phenomena and individuals with whom we deal; theories which permits us to establish facts about them" (p. 64). Participants were able to discuss how heroin and heroin users appeared to be and in this way "classify ....individuals with whom we deal". But by describing how heroin users appeared to be they were also putting forward their own sense of self in relation to the lifestyle choices they made. Participants used the social representations of heroin as addictive and heroin as bad to defend their own lifestyle choices of alcohol use or the use of cannabis, ecstasy or cocaine. In a society where self-control and self-discipline is valued their own preferences for alcohol or other recreational drugs can be justified. The heroin user embodies the social image of a person lacking in self-control and self-discipline. By distancing oneself and one's behaviours from the heroin user and classifying them as 'the Other' it is possible to justify one's own behaviours in a more socially acceptable way.

Hall (1997) posited that social representations or "cultural meanings are not only 'in the head'" but they "organise and regulate social practices, influence our conduct and consequently have real, practical effects" (p.3). What I have found in this thesis is that the social representations of heroin had a real and practical effect on the participants in my studies. It is hoped that my research illustrated that the same representations of heroin are used to denigrate those who use heroin and at the same time provide validation for those who use alcohol or 'less threatening' illicit drugs.

7.6 Health, responsibility and control

In an age of individualism, a person's ability to take responsibility, not only for their health but for other aspects of their life, is valued. Heroin addiction makes it difficult to take responsibility for your life. If you have lost control over your life and lost a sense of who you are then you become a burden on other members of society. At this point you are no longer contributing to society but are now availing of its resources. Addiction was seen as 'the destructive thing' but this was in contrast to an alternative. If addiction is seen as a loss of control and therefore this is seen as destructive then it has to be assumed that being in control is constructive and creative in some way like Wetherell and Potter's (1992) 'normal identity'.

According to the data in this study, addiction destroys an individual's life and participants identified with the values of self-control by expressing how 'scary' it would be to be out of control. Control was therefore a quality that they valued and anything that would take that away was to be avoided. If participants were unable to feel comfortable with the idea of being out of control then they were unable to identify with heroin users. In this way heroin users became 'the Other'.

Crawford's (1994) theories on the self and the unhealthy other show how a post-modern society that is controlled by production and consumerism, differentiates between an ideal healthy way of living and the unhealthy other. According to Crawford the unhealthy other abandons Calvanistic and puritanical ideals and adopts hedonistic behaviour resonant of the swinging sixties. The image of the self-indulgent unproductive heroin addict has also become strongly associated with

AIDS. The mark of AIDS and other untold illnesses associated with this lifestyle is a total inscription of otherness, as defined in Crawford's terms. In terms of the heroin user, who may already be socially excluded for their drug of choice, there is further rejection due to the fear of AIDS associated with intravenous heroin use. "Indeed fear of AIDS has become as much a social reality as the illness itself" (Sontag 1978, p. 399)

Crawford (1994) posits further how an 'at risk' unhealthy individual can have implications for greater society who are striving to be healthy and therefore put off the idea of death as a probability in their lives. He argues that health is vital to survival as being unhealthy can make the possibility of death a bigger issue. It therefore makes sense that those who are healthy need to protect themselves from unhealthy others. Crawford believes that one way to do this is through identity. The more distance one keeps from those who are unhealthy the less chance one has of being touched by contagion. There seems to be even less sympathy for those who are unhealthy due to their own behaviours (Crawford 1994). Joffe (1996, 1999) found "In the early years of the AIDS epidemic social representations research discerned an identity protective process at work in lay explanations of AIDS. This was expressed in associating AIDS with 'the other', namely foreigners, out-groups and deviant practices".

Participants distanced themselves from heroin use, viewing the heroin user as the unhealthy other and also in order to protect their own identity as an illicit drug user or a user of alcohol. The fact that their practices were different was stressed. They also stressed that they did not lose control. In a society where there exists the

normalisation of drug use an use is more prevalent than ever before the heroin user serves as a useful image, a negative stereotype of the 'other', in the preservation of an acceptable image of the self. Crawford (1994) expounds how the identity process works in this way by "protecting or reformulating self boundaries, reinforcing images or re-imagening the other – is required of people as they respond to fears of contagion or stigma, as they adopt strategies to protect themselves from implication, that is, symbolic connection to 'infected' others and the negative characteristics ascribed to them". (p. 1348). In this way heroin use is not just a social crisis or a health crisis but a crisis of identity.

In my study heroin was a signifier of addiction and in the world of recreational drugs, a signifier of a negative stereotype of 'the Other'. Drugs exist in society and alcohol is freely available and therefore people have many choices. Within this world of recreational drugs heroin sets the benchmark, it signifies everything that is not acceptable and indirectly sets the parameters for what is acceptable. Therefore the identity of an 'un-acceptable recreational drug user' is sustained by the existence of 'the Other', namely the heroin user. Similarly, the use of needles amongst a large percentage of heroin users is for some a digression from the 'healthy self' and creates the demarcation between the recreational drug user and the 'other', namely the heroin addict. The association with AIDS, crime, prostitution, poverty and particularly, loss of control all distinguish the heroin user from other recreational drug users and the heroin addict becomes a signifier for what is *not* acceptable and therefore requires a greater social distance.

7.7 Implications for policies and treatment options

Throughout the UK the dominant principles for recovery from addiction are those of the twelve-step programme. These principles are the foundation for self-help groups such as alcoholics anonymous (AA) and narcotics anonymous (NA). NA is a self-help group for people who believe them-selves to be addicted to drugs such as heroin. One of the central tenets of this program is the belief that addiction is a disease and the addict is powerless over whatever it is they are addicted to (NA, 2008). In the UK, the National Treatment Agency (NTA) has been allocated 398 million pounds for the 2007/2008 financial year. This money will be distributed through the Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) as part of the Pooled Treatment Budget (PTB) (Home Office, 2008). The money will go to various rehabilitation programs across the UK but the dominant principles for recovery, in all of these programs, is based on the twelve-step program.

In my research I found that the social representation of heroin as addictive embodies the powerful pharmacological properties of heroin and its effects on the heroin user. This is a stereotype of heroin that has abounded for the last fifty years (Hammersley, 2005). What impact does this have on policy and treatment options for heroin users? Davies (1992) argues that the proliferation of popular conceptions of addiction and smoking may actually make it more difficult for smokers to stop. Could the same be said for heroin addiction? Davies (1997) posited that a dominant discourse of addiction can serve as a self-fulfilling prophecy whereby in order to have a place within society the protagonists are eventually forced to

assume addiction styles of conversation. In my study, the social representation of heroin as addictive and heroin as bad overlapped and were notably interlinked.

Not all the peripheral elements of the social representations overlapped however and where the social representation of heroin as addictive was anchored with 'slave' or 'prey' I found that these themes were mutually exclusive. This supports a dominant ideology of the concept of addiction as disease and a possible consequence of this is the medicalisation of heroin addiction. Also participants were influenced by individualism which Farr (1998) described as an example of a hegemonic representation. Moscovici (1988) illustrated hegemonic representations as coercive, uniform and unchallenged. We can see the unquestioned influence of individualism in such meritocratic institutions as schools and universities where it is accepted that successful achievement lies with the individual and not the institution. According to Davies (1997) addiction as a disease functions as an excuse for bad behaviour, a means of absolving blame, and as a legitimation for punishment and/or treatment. This is perhaps even more the case in an individualistic society where members are responsible for their own behaviours.

Therefore, the social representation of heroin as addictive and heroin as bad become the dominant framework for understanding heroin and the heroin user in society today. Participants described their own drug use and their use of alcohol as the antithesis of this drug and the social image of the heroin user. Participants were perhaps influenced by the hegemonic representations of individualism, and if so it is also on the basis of this representation that they attribute sympathy or blame to the heroin user. They also saw the heroin user as threatening and helpless at the

same time. This creates the 'should we treat or should we criminalise' dichotomy which is a both a product of a cultural value of abstinence and control and an ideology of individualism.

These social representations of heroin can also stigmatise heroin users, impacting on their self-awareness, perhaps challenging their self-esteem. When one sees oneself in the eye of the other, and feels the prejudices towards your chosen lifestyle, how does one respond? What are the consequences of stigmatising social representations? One response to threats to self-esteem is to accept and "play the role" of the stigmatised (Goffman, 1968). This means "accepting the behaviour prescriptions associated with the threatening position; living up to expectations" (Breakwell, 1993, p.121). This is one strategy that heroin users may use and all of this needs to be considered and further explored as I believe it could be of practical use for working with the rehabilitation of heroin users. Future research then would need to explore the experiences of heroin users themselves in order to understand their reality and their interpretation of the social representations of addictiveness and badness.

As research has shown heroin users at times adopt the image of the 'addict' as it serves a functional purpose (Davies, 1997) which is to avoid moral judgement and condemnation. However, for those individuals who are using heroin or trying to stop using heroin, their identification as the 'addict' or the 'patient' can become "further reinforced when interactions with nonusers are unsympathetic or critical" (Levy & Andersons, 2005, p. 251). Joffe (1995) argued that "the place in society occupied by the group whose representations are being studied is of great

relevance" (p.600). As I argued in this discussion, these social representations of heroin and heroin users were held by participants who had no experience of heroin. In this way heroin users are a conceptual group who live in a conceptual world, the heroin arena. More work needs to be done to understand the social representations heroin users have of themselves and if either of the social representations in this study are relevant to their lives.

7.8 Impact on drugs campaigns

In the eighties the UK Government put drug use on their political agenda and many Government health campaigns depicted the 'tragic face' of heroin and warned the public of the dangers of heroin (e.g. figure 1.1). Within these posters were symbolic images with a political message. However, it is important to remember that symbols carry different messages and in the wider context of society nobody can predict how they are interpreted. What might have been a well meaning warning about heroin led to the association between heroin use and scary imagery which contributed in some way to stigmatising heroin users. But it also perpetuated the idea that other drugs were less harmful. Therefore, as the association between heroin and threat grew stronger in the media and the minds of the public so too did the belief that other recreational drugs posed less of a threat or no threat at all.

Duveen and Lloyd (1986) argued that "membership in particular social categories provides individuals with both a social location and a value relative to other socially categorised individuals. These are among the basic prerequisites for participation in social life, and can be described as social identities" (p. 221). In my

study participants distanced themselves from heroin users through the social representations of heroin as addictive and heroin as bad. They situated heroin users as 'the Other' and therefore identified instead with groups who use alcohol, cocaine, ecstasy or cannabis. These were seen to be more socially acceptable and not stigmatised in the same way heroin was. Association with non heroin users provided them with a 'social location' that was removed from loss of control and a 'value' that was socially acceptable.

Throughout my research it was apparent that there was a greater tolerance for other illicit drugs, such as cannabis, ecstasy, speed and cocaine, both among participants and in the media data. Similarly, in study one, smoking was regarded as less harmful than heroin use and alcohol consumption, on the whole, was seen as a shared social experience. None of these substances were deemed to be as addictive as heroin and therefore heroin was seen to be distinguishable from alcohol and these other illicit drugs. If heroin addiction is the worst drug then all you have to do to maintain an acceptable social image is to avoid heroin. Other addictions have to be avoided also but apart from alcohol, cannabis, cocaine and ecstasy were not discussed in terms of addiction. Only heroin was seen to be associated with a social stigma.

Social representations demonstrate how expert knowledge becomes assimilated into everyday common sense knowledge. It was in the eighties that heroin use became salient in the media and was identified as an emerging social problem. The general population at this time would probably not have been familiar with heroin or heroin users. Therefore, perhaps their first encounters with heroin and heroin users would

have been through government health campaign posters and media headlines. In the eighties these would also have been associated with the AIDS epidemic.

Indeed, as my research shows, within the social representations of heroin as addictive and heroin as bad, the only way that *addictive* can be separated from *bad*ness is by admission of helplessness and loss of control. In other words to avoid the label of the criminal, or the amoral pleasure seeker, the heroin user has to adopt the label of the patient. There are health campaigns that warn the public about the consequences of alcohol abuse and other recreational drug use. It is noteworthy then that heroin was a symbol of addiction and a benchmark for many participants about what was unacceptable drug use. Participants used the social representations of heroin and heroin users to manipulate what is and what is not acceptable recreational drug use. They associated heroin use with a 'slippery slope' caused by loss of control and eventual social decline. In contrast to this, alcohol and other drugs were depicted as 'less scary' and 'just a bit of fun'. This could be of particular significance in drugs education work and further research is needed to understand how young people perceive recreational drugs, and the role they play in their lives today.

7.8 Conclusions

The aim of this research was to explore the social representations of heroin and heroin users and when I embarked on this journey I did not know what to expect. Since the eighties, when heroin became headline news and moved into the public's psyche, its social image has been predominantly negative. Heroin was associated

with AIDS and death and heroin users were linked with crime and a lack of morals. However, Parker and Measham (1994) have argued that society has seen a change in attitudes towards recreational drug using and therefore I wanted to explore the impact this may have had on the social image of heroin. What I found in my research was that heroin and heroin users don't sit comfortably alongside, other recreational drugs. In fact heroin and heroin users are separate and distinct from other recreational drug users and exist in a conceptual heroin arena The data supported the findings that at the core of the social representations of heroin was a social and cultural respect for control and a real fear of loss of control. In my data, participants associated heroin with a total loss of control and I found that this mediated how participants perceived and behaved towards alcohol and other recreational drugs. I found that the social representations of heroin can unexpectedly influence choices and attitudes to other drugs. "At least I don't use heroin" can be manipulated to justify the use of cocaine, ecstasy and cannabis.

I found that the social representations of heroin and heroin users was complex and the heroin user was perceived as an addict, a criminal and a patient at the same time. Moscovici's description of cognitive polyphasia offered some explanation for how participants held diverse views of the same object at the same time. However, this leads to the existence of conflicting views of a single phenomenon. This may be reflected in how society deals with the problem, offering punishment and treatment simultaneously. Further research is needed to explore the implications these conflicting views have for our policies and treatment approaches but also for heroin users themselves.

I used a social representations approach to the exploration of heroin and heroin users. My contribution therefore was to explore a phenomenon that has not previously been explored in the field of social representations. I believe that more work needs to be done to understand the complexities of drug use in society today which can often have devastating effects on people's lives.

References

Abric, J-C, (1993). Central system, peripheral system: their function and roles in the dynamic of social representations. *Papers in Social Representations*, 2 (2), 75-78.

Advisory Council on the Misuse of Drugs (1998). *Drugs Misuse and the Environment.* London: Stationary Office.

Alexander, B. (1994). Do heroin and cocaine cause addiction? In P. Brisson (Ed.), *L'usage des drogues et la toxicamanie,* Vol. II. Montreal: Gaetin Mouin.

Augoustinous, M. & Walker, I. (1995). *Social Cognition: An Integrated Introduction.* London: Sage Publications.

Azjen, I. (1985). From decisions to actions: a theory of planned behaviour. In J. Kuhl and J. Beckmann (Eds.), *Action-control: from cognition to behaviour.* New York: Springer, 11-39.

Ajzen, I. & Fishbein, M. (1980). *Understanding attitudes and predicting behaviour.* Englewood Cliffs, NJ: Prentice Hall.

Bailey, L. (2005). Control and desire: The issue of identity in popular discourses of addiction. *Addiction Research and Theory*, 13 (6), 535-543.

Barry, A., Osborne, T., & Rose, N. (Eds.) (1996). *Foucault and political reason: Liberalsim, neo-liberalism and rationalities of government.* London: UCL Press.

Bartlett, F. (1932). *Remembering: A Study in Experimental and Social Psychology.* Cambridge: Cambridge University Press.

Bauer, M., & Gaskell, G. (1999). Towards a paradigm for research on social representations. *Journal for the Theory of Social Behaviour*, 29 (2), 163-186.

Bauer, M. & Gaskell, G. (2002). *Qualitative Researching with Text, Image and Sound.* London: Sage Publications.

Baumann, Z. (2001). *The Individualised Society.* Cambridge: Polity Press.

Bean, P. (1974). *The Social Control of Drugs.* New York: John Wiley.

Berridge, V. (1984). Drugs and Social Policy: The establishment of Drug Control in Britain 1900-30, *Addiction*, 79 (1), 17-29.

Berridge, V. (1996). *AIDS in the UK: The Making of Policy, 1981-1984.* Oxford: Oxford University Press.

Berridge, V. (1999). *Opium and the people: Opium use and drug control policy in nineteenth and early twentieth century England.* New York: Free Association Books Ltd.

Blackwell, J. S. (1983). Drifting, controlling and overcoming: opiate users who avoid becoming chronically dependent. *Journal of Drug Issues*, 13 (2), 219-35.

Blaxter, M. (1997). Whose fault is it? People's own conceptions of the reasons for health inequalities. *Social Science and Medicine* 44 (6), 747-746.

Breakwell, G. M. (1993). Social Representations and Social Identity, *Papers on Social Representations* 2, 198-217.

Buchanan, J., & Young, L. (2000). The War on Drugs – a war on drug users? *Drugs: Eductation, Prevention and Policy*, 7 (4), 409-422.

Campbell, C. (1997). Migrancy, masculine identities and AIDS: The psycho-social context of HIV-transmission on the South African gold mines. *Social Science and Medicine*, 45, 273-281.

Conrad, P. & Schneider, J. W. (1992). *Deviance and Medicalisation: From Badness to Sickness*. Philadelphia: Temple University Press.

Courtwright, D., Joseph, H., & Des Jarlais, D. (1989). *Addicts Who Survived: An Oral History of Narcotic Use in America*, 1923-1965. Knoxville: University of Tennessee Press.

Crawford, R. (1994). The boundaries of the self and the unhealthy other: Reflections on health, culture and AIDS. *Social Science and Medicine*, 38 (10), 1347-1365.

Crossley, M. L. (2003). 'Would you consider yourself a healthy person?': Using focus groups to explore health as a moral phenomenon, *Journal of Health Psychology*, 8 (5), 501-514.

Da Gloria, J & Pages, R. (1974-75). Problemes et exigences d'une theorie de l'attribution. *Bulletin de Psychologie*, **28**, 229-235.

Davies, J. B. (1992). *The myth of addiction*. Chur, Switzerland:Harwood.

Davies, J. B. (1997). *Drugspeak: The analysis of drug discourse*. Amsterdam:Harwood.

Davies, S. (1991). *The Historical Origins of Health Fascism*. Forest (Freedom Organisation for the right to enjoy Smoking Tobacco) Publication.

Deschamps, J. C. (1973-74). L'attribuion, la categorisation et les representations intergroupes. *Bulletin de psychologie*, **27**, 710-721.

Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists*. London: Routledge.

Duveen, G. & Lloyd, B. (1986). The significance of social identities. *British Journal of Social Psychology*, 25, 219-230.

Eiser, J. R. (1986). *Social psychology: Attitudes, cognition and social behaviour.* Cambridge: Cambridge University Press.

Elwood, N. E. (1994). *Rhetoric in the War on Drugs.* Westport: Praeger.

Fahnestock, J. (1986). Accommodating science: the rhetorical life of scientific facts. *Written Communication*, 3 (3), 275-96.

Falco, M. (1994). The making of a drug-free America: Programs that work. In N. E. Elwood, *Rhetoric in the War on Drugs*, p.131, Westport: Praeger.

Farr, R. (1987). Social Representations: a French Tradition of Research. *Journal of the theory of Social Behaviour,* 17 (4), 343-69.

Farr, R. (1989). The social and collective nature of representations. In J. Forgas & J. M. Innes (Eds.), *Recent advances in social psychology: An international perspective*, p. 157-166. Amsterdam: North-Holland.

Farr, R. (1993). Theory and method in the study of social representations. In D. Canter & G. Breakwell (Eds.) *Empirical approaches to social representations*, p. 15-88. Oxford: Clarendon Press.

Farr, R. (1995). Representations of health, illness and handicap in the mass media of communication. In I. Markova & R. M. Farr (Eds.), *Representations of health, illness and handicap*, (p. 3 – 30), Langhorne, PA: Harwood.

Farr, R. (1998). From collective to social representations: Aller et retour. *Culture and Psychology,* 4, (3), 275-96.

Finch, J. (1987). The Vignette Technique in Survey Research. *Sociology,* 21, 105-14.

Fischhoff, B. (1976). Attribution theory and judgement under uncertainly. In J. H. Harvey et al. (eds.), *New directions in attribution research* (Vol. 1). Hillsdale, NJ: Erlbaum.

Flick, U. (1991). Alltagswissen Uber gesundheit und krankheit: Uberblick und einleitung. IN U. Flick (Ed.), Alltagswissen Uber Gesundheit und Krankheit. Subjektive Theorien und soziale Reprasentationen (p. 9-27). Heidelberg: Asanger.

Flick, U. (1998). *The Psychology of the Social.* Cambridge: Cambridge University Press.

Flick, U. (2000). Qualitative inquiries into social representations of health. *Journal of Health Psychology,* 5, 309-318.

Gaskell, G. (2000). Individual and Group Interviewing. In M.W. Bauer & G. Gaskell (Eds.), *Qualitative Researching with Text, Image and Sound.* London: Sage Publications, 38-56.

Gergen, K. J. (1973). Social psychology as history. *Journal of Personality and Social Psychology*, 2 (2), 309-320.

Gervais, M., & Jovchelovitch, S. (1998). *The health beliefs of the Chinese community in England: A qualitative research study.* London: Health Education Authority.

Giddens, A. (1991). *Modernity and self identity.* Cambridge: Polity Press.

Goffman, E. (1963). *Stigma: Notes on the Management of a Spoiled Identity.* Englewood Cliffs: Prentice-Hall.

Goldberg, T. (1999). *Demystifying Drugs.* London: MacMillan Press Ltd.

Gossop, M., Marsden, J., Stewart, D. & Treacy, S. (2002). Change and stability of change after treatment of drug misuse: Two year outcomes from the National Treatment Outcome Research Study. *Addictive Behaviours*, 27, 155-166.

Gottfried, R. S. (1978). *Epidemic disease in fifteenth century England: The medical response and the demographic consequences.* Leicester: Leicester University Press.

Habermas, J. (1989). *The Structural Transformation of the Public Sphere: An inquiry into a category of bourgeois society.* Cambridge: Polity Press.

Hadley, C. & Stockdale, J. E. (1996). Children's Representations of the World of Drugs. *Journal of Community & Applied Social Psychology*, 6, 233-248.

Hall, S. (1997). *Representation: Cultural Representations and Signifying Practices.* London: Sage Publications.

Hammersley, R. (2005). Editorial: theorising normal drug use, *Addiction Research and Theory*, Vol. 13, No. 3, 201-3.

Harris, B. & Harvey, J. H. (1981). Attribution theory: From phenomenal causality to the intuitive scientist and beyond. In C. Antaki (ed.) *The psychology of ordinary explanations of social behaviour.* London: Academic Press.

Haynes, P. & Ayliffe, G. (1991). 'Locus of control of behaviour: Is high externality associated with substance misuse'. *British Journal of Addiction*, 86 (9), 1111-17.

Heider, F. (1958). *The psychology of interpersonal relations.* New York: Wiley.

Herzlich, C. (1973). *Health and illness: A social psychological analysis.* London: Academic.

Hewstone, M. (Ed.) (1983). *Attribution theory: Social and functional extensions.* Oxford: Blackwell.

Hewstone, M., Stroebe, W., & Stephenson, G. M. (1989). *Introduction to Social Psychology.* Oxford: Blackwell Publishers.

Hobsbawm, E. (1994). *The Age of Extremes: The Short Twentieth Century, 1914 - 1991*. London: Michael Joseph.

Holsti, O. R. (1969). *Content Analysis for the Social Sciences and Humanaties.* Reading, MA: Addison-Wesley.

Home Office (2008) www.homeoffice.gov.uk

Hutton, W. (1995). *The State We're in: Why Britain is in Crisis and how to overcome it.* London: Jonathan Cape.

Iccheiser, G. (1949). Misunderstandings in human relations: a study in false social perception. *American Journal of Sociology,* 55 (supplement), 1-72.

Ivie, R. L. (1974). Presidential motives for war. *Quarterly Journal of Speech* 60, 337-345.

Jay, M. (2000). *Emperors of Dreams: Drugs in the Nineteenth Century.* Cambs.: Dedalus.

Jellinek, E. M. (1960). *The Disease Concept of Alcoholism.* New Haven: Hillhouse.

Jodelet, D. (1984). The representation of the body and its transformations. In R. Farr & S. Moscovici (Eds.), *Social representations*, p. 211 - 38. Cambridge: Cambridge University Press.

Jodelet, D. (1991). *Madness and social representations.* Trans. T. Pownall. Hemel Hempsted: Harvester Wheatsheaf.

Joffe, H. (1995). 'Socail representations of AIDS: Towards encompassing issues of power'. *Papers on Social Representations, 4 (1), 29-40.*

Joffe, H. (1996). AIDS research and prevention: A social representational approach. *British Journal of Medical Psychology,* 69, 169-190.

Joffe, H. (1999). *Risk and 'the Other'.* Cambridge: Cambridge University Press.

Joffe, H. (2003). Risk, From perception to social representation. *British Journal of Social Psychology,* 42 (1), 55-73.

Joffe, H., & Bettega, N. (2003). Social Representation of AIDS among Zambian Adolescents. *Journal of Health Psychology,* vol. 8 (5), 616-31.

Joffe, H. & Yardley, L. (2004). Content and Thematic Analysis. In D. F. Marks & L. Yardley (Eds.), *Research Methods for Clinical and Health Psychology.* London: Sage Publications, 56-68.

Jones, E. E. & Davis, K. E. (1965). From acts to dispositions: The attribution process in person perception. In L. Berkowitz (Ed.), *Advances in experimental social psychology*, vol. 2, p. 219 - 66. New York: Academic Press.

Jones, E. E. & Harris, V. A. (1967). The attribution of attitudes. *Journal of Experimental Social Psychology*, 3, 1-24.

Jovchelovitch, S. (1995). Social Representations in and of the Public Sphere: Towards a theoretical Articulation. *Journal for the Theory of Social Behaviour*, 25 (1), 81-102.

Jovchelovitch, S. (2000). Social Representations, Public Life and Social Construction. In K. Deaux & G. Philogene (Eds.), *Social Representations: Introductions and Explorations*. Oxford: Blackwell Publishers.

Jovchelovitch, S. (2002). Re-thinking the diversity of knowledge: Cognitive polyphasia, belief and representation. *Psychologie & Societe*, 5, 121-138.

Jovchelovitch, S. (2007). *Knowledge in Context*. Cambridge, UK: Cambridge University Press.

Jovchelovitch, S. & Gervais, M. C. (1999). Social representations of health and illness: The case of the Chinese community in England. *Journal of Community and Applied Social Psychology*, 9, 247-260.

Kelley, H. H. (1967) Attribution theory in social psychology. In D. Levine (Ed.) *Nebraska Symposium on Motivation*, vol. 15, p. 192 - 238. Lincoln, NE: University of Nebraska Press.

Kelley, H. H. (1972) Causal schemata and the attribution process. In E. E. Jones, D. E. Kanouse, H. H. Kelley, R. E. Nisbett, S. Valins and B. Weiner (Eds.), *Attribution: Perceiving the causes of behaviour*, p. 151 - 74. Morristown, NJ: General Learning Press.

Kulik, J. A. (1983). Confirmatory attribution and the perpetuation of social beliefs. *Journal of Personality and Social Psychology*, 44, 1171-81.

Lalljee, M. (1981). Attribution theory and the analysis of explanations. In C. Antaki (Ed.), *The Psychology of Ordinary Explanations of Social Behaviour*. London: Academic Press, 119-38.

Langer, E. J. (1978). Rethinking the role of thought in social interaction. In J. H. Harvey et al. (eds), *New directions in attribution research* (vol. 2) Hillsdale, NJ: Erlbaum.

Laszelo, J. (1997). Narrative organisations of social representations. *Papers on Social Representations* 6, 155-172.

Levinson, M. H. (2002). *The Drug Problem*. London: Praeyer.

Levy, J. A. & Anderson, T. (2005). The drug career of the older injector. *Addiction Research and Theory*, 13 (3), 245-258.

Lloyd, B. & Duveen, G. (1992). *Gender Identities and Education: The Impact of Starting School.* Hemel Hempstead: Harvester Wheatsheaf.

MacDonald, R., & Marsh, J (2002). Crossing the Rubicon: youth transitions, poverty, drugs and social exclusion. *International Journal of Drug Policy* , 13 (1), 27-38.

Markova, I. (1982). *Paradigms, Thought and Language*. Chichester: Wiley.

Markova, I. & Farr, R. (1995). Professional and Lay Representations of Health, Illness and Handicap: A theoretical Overview. In I. Markova & R. Farr. (eds.) *Representations of Health, Illness and Handicap.* (p.93 – 110. Langhorne, PA: Harwood.

Markova, I, McKee, K. J., Power, K. G., & Moodie, E. (1995). The Self and the Other: Perception of the Risk of HIV/AIDS in Scottish Prisons. In I. Markova & R. Farr. (eds.) *Representations of Health, Illness and Handicap.* (p.111 – 129). Langhorne, PA: Harwood.

Markova, I. & Wilkie, P. (1987). Representations, concepts and social change: The phenomenon of AIDS. *Journal for the Theory of Social Behaviour*, 17, 389-407.

Marks, D. F. (1996). Health psychology in context. *Journal of Health Psychology*, 1, 7-21.

Marks, D. F., Murray, M., Evans, B., & Willig, C. (2000). *Health psychology: Theory, research and practice*. London: Sage Publications.

McArthur, L. Z. (1972). The how and what of why: Some determinants and consequences of causal attribution. *Journal of Personality and Social Psychology,* **22**, 171-193.

McDermott, P. (1992). Representations of drugs users: facts, myths and their role in harm reduction strategy, In P. O' Hare, R. Newcombe, A. Matthews, E. C. Buning & E. Drucker (eds.), *The Reduction of Drug-related Harm*. London: Routledge.

McSweeney, T. & Turnbull, P. J. (2007). *Exploring user perceptions of occasional and controlled heroin use, a follow up study.* York: Joseph Rowntree Foundation.

Mead, G. H. (1934). *Mind, self and Society.* Chicago: The University of Chicago Press.

Messick, D. M., & McClelland, C. L. (1983). Social traps and temporal traps. *Personality and Social Psychology Bulletin,* 9, 105-110.

Meyers, R. J. & Miller, W. R. (Eds.) (2001). *A community reinforcement approach to addiction treatment.* Cambridge: Cambridge University Press.

Michotte, A. E. (1946). *La perception de la causalite.* Paris: J. Vrin; translated as *The perception of causality.* New York: Basic Books (1963).

Miller, J. G. (1984). Culture and the development of everyday social explanation. *Journal of Personality and Social Psychology*, 46, 961-78.

Miller, D. T. & Ross, M. (1975). Self-serving biases in the attribution of causality: fact or fiction? *Psychological Bulletin*, 82, 213-25.

Moscovici, S. (1961). *La psychanalyse, son image et son public.* Paris:Press Universitaires de France.

Moscovici, S. (1973). *La psychanalyse, son image et son public.* Paris:Press Universitaires de France.

Moscovici, S. (1981). On social representations. In J. Forgas (Ed.) *Social Cognition*, p. 181-209. London: Academic Press.

Moscovici, S. (1984). The phenomenon of social representations. In R. Farr & S. Moscovici (Eds.), *Social Representations*, p.3-69. Cambridge: Cambridge University Press.

Moscovici, S. (1987). The conspiracy mentality. In C. F. Graumann & S. Moscovici (Eds.), *Changing conceptions of conspiracy.* New York: Springer, 151-169.

Moscovici, S., (1988). Notes towards a description of social representations. *European Journal of Social Psychology*, 18, 211-50.

Moscovici, S. (1990). The generalised self and mass society. In H. Himmelweit & G. Gaskell (eds.) *Societal Psychology.* London: Sage Publications.

Moscovici, S. & Hewstone, M. (1983). Social representations and social explanation: from the 'naïve' to the 'amateur' scientist. In M. Hewstone (Ed.), *Attribution theory: Social and functional extensions*, p. 98-125. Oxford: Blackwell.
Murray, M., Pullman, D., & Rodgers, T. H. (2003). Social Representations of Health and Illness among 'Baby-boomers' in Eastern Canada. *Journal of Health Psychology*, vol. 8 (5), 485-99.

Narcotics Anonymous (2008). www.ukna.org.

National Treatment Agency (2006a). Care Planning Practice Guide. London: NTA.

National Treatment Agency (2006b). Models of Care for Treatment of Adult Drug Misusers. London: NTA.

National Treatment Agency (2008). Available online at: http://www.nta.nhs.uk/about/background.aspx.

Nisbett, R. E. & Ross, L. (1980). *Human Inference: strategies and shortcomings of social judgement.* Englewood-Cliffs, NJ: Prentice-Hall.

O' Toole, F. (1999). Drug War Invented by Nixon to extend his power. *The Irish Times*, 13th August.

Parker, H., Aldridge, J., & Measham, F. (1998). *Illegal Leisure. The normalisation of adolescent recreational drug use.* London and New York: Routledge.

Parker, H. & Measham, F. (1994). Pick 'n' mix: changing patterns of illicit drug use amongst 1990s adolescents, *Drugs: Education, Prevention and Policy* 1, 5-13.

Parrott, A., Morinana, A., Moss, M., & Scholey, A. (2004). *Understanding Drugs and Behaviour.* Chichester: John Wiley & Sons Ltd.

Pearson, G. (1987). Social Deprivation, Unemployment and Patterns of Heroin Use. In N. Dorn & N. South (Eds.), *A Land Fit for Heroin? Drugs policies, prevention and practice.* Basingstoke: Macmillan.

Peele, S. (1990). A Values Approach to Addiction: Drug Policy that is moral rather than Moralistic. *The Journal of Drug Issues*, 20 (4), 639-646.

Peterson, C. (1980). Memory and the 'dispositional' shift. *Social Psychology Quarterly*, 43, 372-80.

Pereira de Sa, C. (1996). Determining the central nucleus of social representations. *Papers in Social Research Methods, Qualitative Series* (2).

Piaget, J. (1930). *The child's conception of physical causality.* London: Routledge.

Purkhardt, S. C. (1993). *Transforming Social Representations: A Social Psychology of Common Sense and Science.* London; New York: Routledge.

Rholes, W. S. & Pryor, J. B. (1982). Cognitive accessibility and causal attributions. *Personality and Social Psychology Bulletin*, 8, 719-27.

Robertson, R. (1987). *Heroin, AIDS and Society.* London: Hodder & Stoughton.

Robins, L. N., Helzer, J. E., Heselbrock, M., & Wish, E (1980). Vietnam veterans three years after Vietnam: How our study changed our view of heroin. In L. Brill & C. Winick (Eds.), *The yearbook of substance use and abuse*, p. 213-230. New York: Human Sciences Press.

Robins, L., Compton, W., & Horton, J. (2000). Is Heroin the Worst Drug: Implications for Drug Policy. *Addiction Research*, 8 (6), 527-547.

Room, R. (2007). Addiction concepts and international control in Global Drug Policy: Building a new framework. In RSA, *Drugs – Facing Facts.* London: Royal Society for the encouragement of Arts, Manufactures & Commerce.

Ross, L. (1977). The intuitive psychologist and his shortcomings: Distortions in the attribution process. In L. Berkowitz (Ed.), *Advances in experimental social psychology*, vol. 10. New York: Academic Press, 173-220.

RSA (2007). *Drugs – Facing Facts.* London: Royal Society for the encouragement of Arts, Manufactures & Commerce.
Said, E. W. ((1978). *Orientalism: Western conceptions of the Orient.* London: Routledge.

Schank, R. C. & Abelson, R. P. (1977). *Scripts, plans, goals and understanding: An inquiry into human knowledge structures.* Hillsdate, NJ: Erlbaum.

Scott, J. (1969). *A history of Opium.* London: Cox & Wyman Ltd.

Seddon, T. (2006). Drugs, crime, and social exclusion: social context and social theory in British drugs – crime research, *British Journal of Criminology*, Vol. 46, No. 4, 680-703.

Semin, G (1980). A gloss on attribution theory. *British Journal of Social and Clinical Psychology,* **19**, 291-300.

Semin, G. R. & Fiedler, K. (1991). The Linguistic Category Model, its bases, applications and range. In W. Stroebe and M. Hewstone (Eds.), *European Journal of Social Psychology* (vol. 2), p. 1-30. Chichester: Wiley.

Shewan, D. & Dalgarno, P. (2005). Evidence for controlled heroin use? Low levels of negative health and social outcomes among non-treatment heroin users in Glasgow (Scotland). *British Journal of Health Psychology,* 10, 33-48.

Silverman, D. (1993). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction.* London: Sage.

Sontag, S. (1978). *Illness as metaphor.* New York: Farrar, Straus & Giroux.

Stimson, G. V. (1973). *Heroin and Behaviour.* Shannon: Irish University Press.

Stockdale, J. E. (1995). The self and media messages: Match or mismatch? In I. Markova & R. M. Farr (Eds.) *Representations of health, illness and handicap*, p. 3-30. Amsterdam: Harwood Academic Publishers.

Stryker, S. & Gottleib, A. (1981). Attribution theory and symbolic interactionism: A comparison. In J. H. Harvey, W. J. Ickes & R. F Kidd (eds.), *New Directions in Attribution Research,* vol. 3. Hillsdale NJ: Erlbaum.

Sulkunen, P. (2003). *The European New Middle Class, individualism and tribalism in mass society.* Brookfield: Ashgate Publishing Company.

Surber, C. F. (1981). Necessary versus sufficient causal schemata: Attributions for achievement in difficult and easy tasks. *Journal of Experimental Social Psychology,* **17**, 569-586.

Tackling Drugs, Changing Lives (2008). *Drugs: protecting families and communities. The 2008 drug strategy.* London: The Stationary Office.

Tackling Obesity in England (2001). Report by the controller and Auditor General HC 220 Session 2000-2001. London: The Stationary Office.
Taylor, C. (1989). *Sources of the Self: The Making of Modern Identity.* Cambridge: Harvard University Press.

Taylor, D. M. (1981). Stereotypes and inter-group relations. In R. C. Gardner & R. Kalin (Eds.), *A Canadian Social Psychology of Ethnic Relations*, p. 151-71. Toronto: Methuen.

Tesch, R. (1990). *Qualitative Research Analysis Types and Software Tools.* New York: Falmer Press.

Thorngate, W. (1976). Must we always think before we act? *Personality and Social Psychology Bulletin,* **2**, 31-35.

Thorngate, W. (1979). Memory, cognition and social performance. In L.H. Strickland (ed.), *Soviet and Western perspectives in social psychology.* Oxford: Pergamon Press.

Wagner, W., Elejabarrieta, F. & Lahnsteiner, I. (1995). How the sperm dominates the ovum – Objectification by metaphor in the social representation of conception. *European Journal of Social Psychology*, 25, 671-688.

Wagner, W., Duveen, G., Farr, R., Jovchelovitch, S., Lorenzi-Coldi, F., Markova, I., & Rose, D. (1999). Theory and Method of social representations. *Asian Journal of Social Psychology*, 2, 95-125.

Wagner, W., Duveen, G., Themel, M., & Verma, J. (1999). The Modernisation of Tradition: Thinking about Madness in Patna, India. *Culture & Psychology,* 5 (4), 413-45.
Wagner, W., Duveen, G., Verma, J., & Themel, M. (2000). 'I have some faith and at the same time I don't believe': Cognitive polyphasia and cultural change in India. *Journl of Community and Applied Psychology,* 10, 301-14.

Weiner, B. (1985). At attributional theory of achievement motivation and emotion. *Psychological Bulletin,* 92, 548-573.

Weiner, B. (1986). *An attributional theory of motivation and emotion.* New York: Springer-Verlag.

Weiner, B. (1995). *Judgements of responsibility: A foundation for a theory of social conduct.* New York: Guildford.

Wells, A. (1987). Social representations and the world of science. *Journal for the Theory of Social Behaviour*, 17, 433-45.

Westphal, K. R. (1989). *Hegel's Epistemological Realism: A study of the Aim and Method of Hegel's 'Phenomenology of Spirit',* Dordrecht: Kluwer.

Wetherell, M. & Potter, J. (1992). *Mapping the Language of Racism: Discourse and the Legitimation of Exploitation.* Hemel Hempstead: Harvester-Wheatsheaf.

Willig, C. (2001). *Introducing Qualitative Research in Psychology.* Buckingham: Open University Press.

Young, J. (1999). *The Exclusive Society: Social Exclusion, Crime and Difference in Late Modernity.* London: Sage.

Zinberg, N. (1984). *Drug, set and setting: the basis for controlled intoxicant use.* New Haven:Yale University Press.

Zito, G. V. & Jacobs, J. (1979). Attribution and Symbolic Interaction: An Impasse at the Generalised Other. *Human Relations*, 32, 571-78.

Zuckerman, M. (1979). Attribution of success and failure revisited. *Journal of Personality*, 47, 245-87.

Appendix A. Standardised instructions for focus groups in study one.

Each picture on the board is representative of a different target group within society. Please examine the four different bundles of money on the desk and decide, as a group, which amount should be allocated to each group for their health care.

You need to reach a decision as a group. The task is not complete without group consensus. I would invite you as a group to discuss the task and make a decision where the money should be allocated.

The task will be recorded and there is no time limit.

Thank you

Appendix B. Questionnaire for the participants in study one.

Information Sheet

The information you give on this sheet will be treated with the strictest of confidence. You will not be identified in any way from the information that you give. Thank you for your help.

Age:____

Male or Female:____

Do you smoke?____

Do you drink alcohol?_____________________________________

Have you ever tried other illegal drugs?___________________________

If yes, which ones?_______________________________________

Have you ever tried heroin?__________________________________

Do you know anyone who has used heroin?_______________________

Do you know anyone who was addicted to heroin?___________________

Thank you for your participation in this study.

Appendix C. Consent form for participants in study one

CITY UNIVERSITY: PSYCHOLOGY DEPARTMENT 2002

Group Decisions in a Health Setting

Informed Consent Form

I understand that I will be participating in a group task which will require co-operation with other group members. The group discussion will be recorded using a mini disk machine and a microphone in order to assist the researcher with the data collection. My participation in this research is VOLUNTARY and I understand that I have the right to withdraw at any time. I understand that anonymity is guaranteed and that no identifying details are required for this focus group. Any information I give to the researcher will be treated in the STRICTEST CONFIDENCE. My name will not be recorded on any of the research records.

I UNDERSTAND THE NATURE OF MY PARTICIPATION IN THIS RESEARCH AND I AM WILLING TO PARTICIPATE.

Name .... Signature ....

Date

....

Appendix D. The pilot study from study one.

The Pilot Study

The pilot study was initially conducted to highlight any problems with my research design. Five participants took part (3 female and 2 male). Three of the participants were white British, one was Black British and one was Asian British. In the pilot study eight pictures were presented to the group using two boards and the group were presented with eight bundles of money. As the well as the four pictures presented previously in study one, chapter three (fig. 3.1 to fig. 3.4 respectively) participants were also presented with a picture of small children (fig. 3.5), a pregnant lady (fig. 3.6), a lady in a wheelchair (fig. 3.7) and an elderly man smiling (fig. 3.8). The participants were given the same standardised instructions (see Appendix A).

Figure 3.5. A picture of small children from the pilot study.

The group were also presented with eight bundles of money, representing one million, two million, four million, eight million, twelve million, sixteen million, twenty million and twenty five million pounds respectively. The participants were asked to allocate the money to the health categories that were represented in the pictures as opposed to the actual person or persons in the pictures. The focus group

had a discussion in order to complete the task and this discussion generated the data for the pilot study. The focus group was video-recorded and were given no time restrictions for the task.

Figure 3.6. A picture of a pregnant lady from the pilot study

The findings from the pilot study were interesting and proved invaluable for reviewing and finalising the design for this study. I found that the participants predominantly focused on the pictures of the children (fig. 3.5), the pregnant lady (fig. 3.6), the lady in the wheelchair (fig. 3.7) and the old man smiling (fig. 3.8). Very little discussion focused on the picture that represented heroin users (fig. 3.2). Some attention was paid to the smoker (fig. 3.1), the obese man (fig. 3.3) and the old man sitting on the bench (fig. 3.4). In light of this I realised that I was in danger of not generating enough discussion about heroin or heroin users for this study.

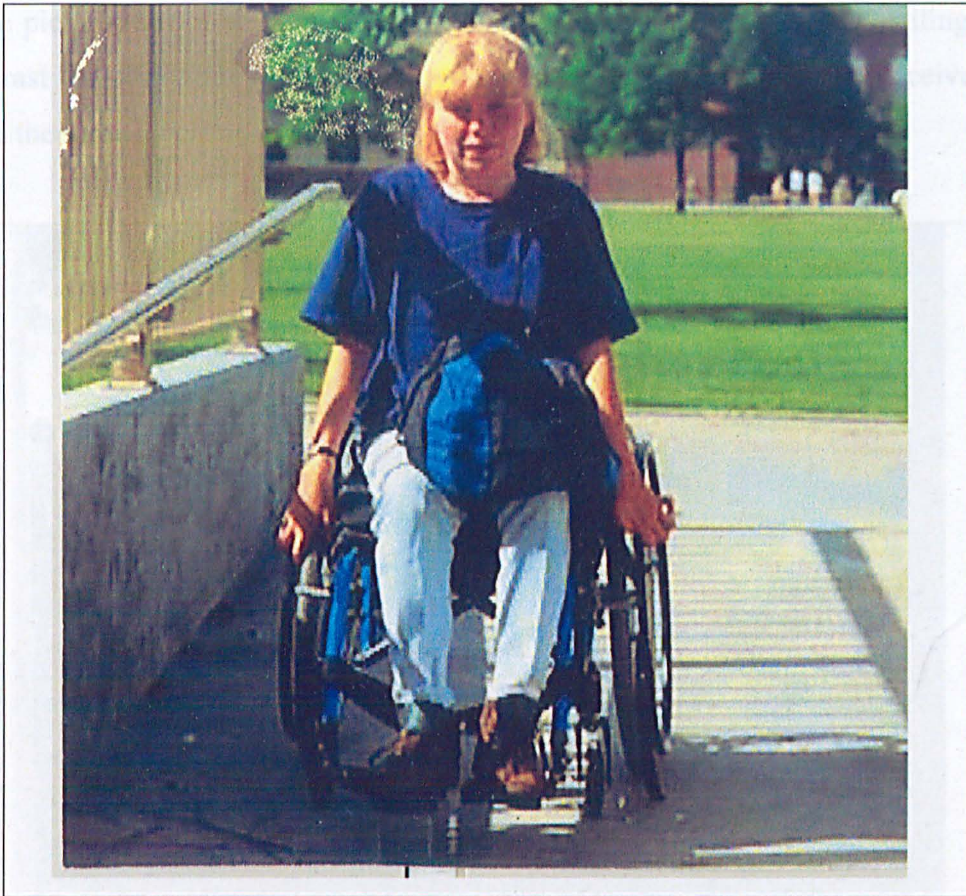


Figure 3.7. A picture of a lady in a wheelchair from the pilot study.

I watched the focus group video several times and notes were taken in order to get a flavour of the main themes. This was not an in-depth analysis but rather an ititial review of the main themes. It was noted from this initial examination of the data that participants regarded the categories represented by fig. 3.5 – fig. 3.8 as more vulnerable than the other four categories and were vulnerable through no fault of their own. They did not engage in any behaviours that were detrimental to their health.

The results for the money allocation task further supported this observation. The largest amount of money was allocated to fig. 3.6 which represented pregnancy. The second highest sum of money was allocated to fig. 3.5, which represented children. There was much debate and disagreement about the allocation of money to fig. 3.7 and fig. 3.8 and in the end fig. 3.7 (the lady in the wheelchair) was awarded the third largest sum of money and the fourth largest amount went to fig. 3.8 (the smiling old man). Therefore, participants showed a notably greater interest and preference for the four pictures (fig. 3.5 – fig. 3.8). It is noteworthy that two of

these pictures are of women, one is of children and one of a old man smiling. In contrast the other four pictures featured men who may not have been perceived to have the same levels of vulnerability.

Figure 3.8. A picture of an elderly man smiling from the pilot study.

Following the pilot study, the design of the study was reviewed and some alterations were made. I realised I had too many photos and therefore risked having no meaningful discussion in relation to any of them. I decided, therefore, that four pictures would be sufficient to facilitate a discussion that had enough depth and relevance to my research interests. I chose the pictures of the smoker (fig. 3.1), the man injecting his arm (fig. 3.2), the obese man sleeping in the chair (fig. 3.3) and the old man sitting on the bench with empty wine bottles at his feet (fig. 3.4). I chose each of pictures for the following reasons; pictures of men only removed any gender conflicts or bias, it is reported that there are a greater number of male heroin users than female heroin users, and finally, each of the behaviours represented in these pictures had something in common. None of these behaviours were a necessary for day to day living. Therefore, each of these behaviours could be perceived as a choice.

Finally, it was noted that two of the participants in the pilot study were so overwhelmed by the presence of the video recorder that they contributed very little to the discussion surrounding the task. Therefore, it was decided that there was nothing to be gained by video-recording the focus group and in actual fact it may inhibit some participants. For the remainder of the focus groups audio recording equipment was used to record the group discussion. This was less intrusive than the video recorder.

I ran the first focus group using the amended format and I was confident I had chosen the correct pictures and correct sums of money. I observed a steady flow of conversation and debate amongst the first focus group. The reduction in the number of pictures, from eight to four, allowed the participants to make comparisons and comments but still focus equally on all four. The picture representing the heroin user (fig. 3.2) featured more prominently in the discussion and I felt confident the focus group would yield worthwhile and useful data for analysis. Therefore, no more changes or amendments were made to the design of the study.

Appendix E. The coding frame for study one. (Abridged version)

Code name: Impact

Code Name	Description	Examples
Impact – on heroin user	More immediate risk of death	"I think I would give the more money to 2, 3, and 4 because I think they have much more of a chance of dying younger through what they are doing, whereas smoking in most people is gradual killing" (Focus Group 6)
Impact – on others	Spread of AIDS	"But then you have the problem of people giving AIDS whereas with alcoholism you can't pass it on, do you know what I mean" (Focus Group 2)
Impact – on families	Effect of heroin use on families and society at large	"It has social implications, it affects their families, their relationships" (Focus Group 2)
Impact – wider community	Risk of associated crime in community	"And there is also the links with crime. Robberies isnt it?" (Focus Group 2)
Impact – wider community	Risk of a breakdown in society	"...but where as 2 and 4 yeah, like the social field will be breaking down if they restart..." (Focus Group 4)

Code Name: Control (Abridged version)

Code Name	Description	Examples
Control – powerful pull of heroin	Heroin addiction will draw the heroin user back even when they stop	"I would give it (the largest sum of money) to the heroin people. I just worry about putting all that money in and then they just go back to their life again and then they start again" (Focus Group 4)
Control – role of choice	There is an element of choice in heroin addiction	"I would give the two less amounts to these two people (smokers and heroin users) because it is their choice". (Focus Group 3)
Control – degrees of addiction	Addiction occurs along a continuum	"Well I think the most should go to number two (heroin addicts) cause this is the hardest one to give up". (Focus Group 7)
Control – career of addiction	Once you are addicted to heroin, you are always addicted to heroin	"I think people who like to smoke heroin think it is like so addictive that they have to do it for the rest of their lives and there is like no way to stop and there are not enough programs out there to help people". (Focus Group 5)

Code Name: Perceptions (Abridged version)

Code Name	Description	Examples
Perceptions	Heroin is socially unacceptable	"…..like heroin is less acceptable than cigarettes. …….Everyone knows like when you are doing heroin you have a problem…." (Focus Group 5)
Perceptions	Heroin is associated with the lower end of the economic scale	"…cause you know alcoholics covers a whole spectrum of people whereas heroin addicts I tend to associate with people that are living in poverty, you know, have a lot less". (Focus Group 4)
Perceptions	Heroin use is confined by age.	"This (heroin use) is like a particular age group and can like to try and confine it and try to deal with it in your own way whereas this (obesity) is like an epidemic among more people and age groups as well" (Focus Group 2)
Perceptions	Heroin use is a 'specific' problem	"These are like….that's like a specific problem (heroin use) whereas this is like normal everyday (obesity)…." (Focus Group 2)
Perceptions	Heroin use has negative associations.	"….I would look at the drug addict and might think oh this person is like a thief or whatever, you are thinking many negative things associated whereas for the fat person they are just fat and that is their sin but you don't think they are into bad things…" (Focus Group 6)

Appendix F. A list of the sample of forty articles from Police Review for study two.

Call to link drug tests to treatment. *Police Review.* April 4, 2003, p.10

Customs deny telling officers to ignore Jamaican drug 'mules'. *Police Review.* February 1, 2002, p. 10.

Driving out drugs. *Police Review.* December 21, 2001, p. 22-23.

Chief constable urges rethink on 'disastrous' drugs policy. *Police Review.* December 21, 2001, p. 9.

Drug treatment wait is 'insane'. *Police Review.* September 12, 2003, p. 9.

Serious drugs fear over cannabis pilot scheme. *Police Review.* January 25, 2002, p. 14.

Force dogs sniff out child drug users. *Police Review.* June 28, 2002, p. 7.

Concern over cannabis law. *Police Review.* July 19, 2002, p. 7.

Counter Intelligence. *Police Review.* February 22, 2002, p. 22-23.

Rough Idea. *Police Review.* December 20, 2002, p. 22-23.

Should cannabis be reclassified? *Police Review.* November 9, 2001, p. 26-27.

Smoke alarm. *Police Review.* November 2, 2001, p. 18-19.

Drugs campaign targets nightclubs. *Police Review.* October 12, 2001, p. 9.

Needle scheme approved for use. *Police Review.* November 2001, p. 2.

Capital concern over drug-related gun crime. *Police Review.* November 15, 2002, p. 15.

How to end the drugs war. *Police Review.* September 6, 2002, p. 16-17.

Increase in drug deaths in Scotland. *Police Review.* August 23, 2002, p. 6.

Rural crack down. *Police Review.* July 5, 2002, p. 18-19.

Lambeth Lessons. *Police Review.* May 10, 2002, p. 32-33.

Minority stops on the rise in Met area. *Police Review.* April 12, 2002, p. 6.

Cannabis 'reclassification' urged by reports. *Police Review.* March 22, 2002, p. 13.

Lessons from America. *Police Review.* March 1, 2002, p. 6.

Raving rights. *Police Review.* January 18 2002, p. 23.

Breaking the vicious circle. *Police Review.* January 4, 2002, p. 18-19.

Street Life. *Police Review.* October 25, 2002, p. 18-19.

Dealing with the dealers. *Police Review.* October 18, 2002, p. 26-27.

Operation Ensconce. *Police Review.* September 20, 2002, p. 22-23.

When your son is an addict. *Police Review.* August 30, 2002, p. 16-17.

Intimate Details. *Police Review.* August 9, 2002, p. 20-21.

Pot Shot. *Police Review.* July 19, 2002, p. 22-23.

Committee report outlines UK drugs policy. *Police Review.* May 31, 2002, p. 10.

Tough on Drugs. *Police Review.* May 31, 2002, p. 22-23.

Disruptive influence? *Police Review.* May 24, 2002, p. 22-23.

Patients not addicts. *Police Review.* February 1, 2002, p. 20-21.

Early warnings. *Police Review.* June 13, 2003, p. 20-21.

Project uses treatment to break link between drugs and crime. *Police Review.* July 18, 2003, p. 8.

Kicking the habit. *Police Review.* July 11, 2003, p. 20-21.

Cannabis users might not face arrest under chiefs' guidelines. *Police Review.* September 11, 2003, p. 6.

Drug war cry. *Police Review.* October 24, 2003, p. 18.

The dangers of liberalising drugs. *Police Review.* June 28, 2002, p. 15.

Appendix G A list of the sample of forty articles from BMJ for study two.

10 year follow up study of mortality among users of hostels for homeless people in Copenhagen. *BMJ* 327:81. July 12, 2003

Supervised drug injecting room trial considered a success. *BMJ* 327:122. July 19, 2003.

Medical prescription of heroin to treatment resistant heroin addicts: two randomised controlled trials. *BMJ* 327: 310. August 9, 2003.

Science forced to retract article on 'ecstasy'. *BMJ* 327:579. September 13, 2003.

Comparing cannabis with tobacco – again. *BMJ* 327: 635-636. September 20, 2003.

Reviews show that cannabis use is a risk factor for schizophrenia. *BMJ* 327: 1070. November 8, 2003.

Cannabis and mental health. *BMJ* 325: 1183-1184. November 23, 2002.

UK government approves heroin use on prescription. *BMJ* 325: 1321. December 7, 2002.

Review of deaths related to taking ecstasy, England and Wales, 1997 – 2000. *BMJ* 326: 80-81. January 11, 2003.

Social costs of smoking are triple those of illicit drugs. *BMJ* 326: 242 February 1 2003.

Risk of prevalent HIV infection associated with incarceration among drug users in Bangkok, Thailand: case –control study. *BMJ* 326: 308. February 8, 2003.

New Courts offer treatment for drug offenders. *BMJ* 322: 70. January 13, 2001.

Our favourite drug. *BMJ* 324: 1410. June 15, 2002.

Home testing kit allows parents to detect their children's drug misuse. *BMJ* 325: 182. July 27, 2002.

Cardiovascular complications of recreational drugs. *BMJ* 323: 464-466. September 1, 2001.

Takeaway shop converts to drug centre. *BMJ* 323: 532. September 8, 2001.

Doctors should do more for drug addicts, committee says. *BMJ* 324: 1295. June 1, 2002.

A new method to monitor drugs at dance venues. *BMJ* 323: 603. September 15, 2001.

Drug users receive worse care in prison than in the community. *BMJ* 323: 654. September 22, 2001.

Number of deaths from volatile substance misuse is falling. *BMJ* 323: 252. August 4, 2001.

Glossy magazine launched for women drug users. *BMJ* 323: 184. July 28, 2001.

Canada legalises the medical use of cannabis. *BMJ* 323: 68. July 14, 2001.

BMA calls for action on 'drug driving'. *BMJ* 323: 70. July 14, 2001.

Germany sets up register to promote safer use of methadone. *BMJ* 322: 1510. June 23, 2001.

Reducing deaths among drug misusers. *BMJ* 322: 749 – 750. March 31, 2001.

Pregnant women cannot be tested for drugs without consent. *BMJ* 322: 753. March 31, 2001.

Cannabis trial launched in patients with MS. *BMJ* 322: 192. January 27, 2001.

Doctor struck off after patient dies from detoxification treatment. *BMJ* 323: 955. October 27, 2001.

Strategies for preventing heroin overdose. *BMJ* 326: 442-444. February 22, 2003.

Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. *BMJ* 326: 959-960. May 3 2003.

Comparing cannabis with tobacco. *BMJ* 326: 942-943. May 3, 2003.

Ecstasy produces Parkinsonian effects in monkeys. *BMJ* 325: 736. October 5, 2002.

Cocaine use rises markedly among 16 – 29 year olds. *BMJ* 325: 794. October 12, 2002.

Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study. *BMJ* 325: 1212-1213. November 23, 2002.

Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study. *BMJ* 325: 1199. November 23, 2002.

Cannabis use and mental health in young people: cohort study. *BMJ* 325: 1195-1198. November 23, 2002.

Netherlands considers prescribing heroin to addicts. *BMJ* 324: 385. February 16, 2002.

GPs asked to do more for drug misusers. *BMJ* 324: 501. March 2, 2002.

BMA calls for government action on drugs and driving. *BMJ* 324: 632. March 16, 2002.

Drug misuse causes major problems for women in India. *BMJ* 324: 1118. May 11, 2002.

Appendix H. A list of the sample of forty newspaper articles for study two.

Tories stand by drug policy. *The Times*. January 14, 2003, p. 10.

Pensioner's killer gets life term. *The Times*. January 25, 2003, p. 15.

Heroin prescription ban 'was a disaster'. *The Times*. September 12, 2002.

Man killed puppy with a bread knife. *The Times*. December 28, 2001, p. 6.

22 criminal drug addicts cost a city £1m each. *The Times*. October 23, 2003, p. 10.

Boredom drove Rebecca to drugs, says brother. *The Times*. March 18, 2002, p. 11.

Life for addict who beat and starved boy to death. *The Times*. April 5, 2002, p. 8.

Blair backs police on heroin treatment. *The Times*. May 9, 2002, p. 4.

Home Office is cool on drug report. *The Times*. May 3, 2002, p. 10.

Death of heroin; Sunday press briefing. *The Times*. March 4, 2002, p. 14.

Letter: Victim of prejudice. *The Independent*. March 20, 2002, p. 2.

Lie around all day pumping my veins with drugs? I should be so lucky. *The Independent Sunday*. August 24, 2003, p. 24.

Letter: Legalise cannabis. *The Independent*. May 2, 2003, p. 21.

We should aim to reduce the damage from drugs; not punish the users. *The Independent*. November 22, 2001, p. 3.

The harm heroin causes. *The Independent*. November 18, 2001, p. 31.

Shock tactics wont stop the drug deaths; Only recognition of the scale of the problem and speedy, accessible treatment will prevent recurring tragedies, says Victor Adebowale. *The Independent Sunday*. March 3, 2002, p. 25.

Letter: Our irrational and harmful drug laws. *The Independent*. May 22, 2002, p. 17.

Reader's letter: Clampdown doomed. *The Independent Sunday*. May 26, 2002, p. 27.

Letter: Heroin supply. *The Independent*. December 7, 2002, p. 19.

Letter: Controlling drugs. *The Independent*. November 9, 2002, p. 21.

End the madness of methadone. *The Daily Mail*. September 15, 2003, p. 10.

A last chance for junkie shamed by mother's TV plea; Pregnant addict from family tainted by drugs is spared jail. *The Daily Mail*. September 30, 2003, p. 23.

Scandal of cocaine use at Holyrood; Parliament shamed as special Daily Mail investigation reveals shocking extent of drug abuse across Scotland. *The Daily Mail*. October 16, 2003, p. 1.

Man who sentenced his lovers to death; Asylum seeker guilty of deliberately infecting women with HIV. *The Daily Mail.* October 15, 2003, p. 1.

Brothers who built heroin empire jailed. *The Daily Mail.* October 15, 2003, p. 29.

Deaths soar among drugs weekenders; More than 1, 500 killed by cocaine, speed and Ecstasy. *The Daily Mail.* October 24, 2003. P. 15.

Warning over crack cocaine. *The Daily Mail.* October 23, 2003, p. 11.

A plague on the pursuit of slenderness; As the Atkins diet gains three million devotees, a devastating critique of our obsession with slimming. *The Daily Mail.* September 3, 2003, p. 12.

Carjack thug said he would shoot me. *The Daily Mail.* October 30, 2003, p. 35.

Voice of the Daily Mirror: Say no to ads. *The Mirror.* May 24, 2003, p. 6.

Crime Shock Issue. *The Mirror.* July 12, 2002, p. 4.

Real Lives: My baby was born a junkie; Michelle Ritchie first tried heroin in the summer of 1999 – and was hooked immediately. A few months later, she discovered she was pregnant – but she couldn't kick the habit. Her daughter was born critically ill and addicted to the drug. Here she tells their story...*The Mirror.* September 17, 2002, p. 23.

Daily Mirror 100 years: Britain Talking: The times I wished my junkie sons were dead .. I even planned to do it; In this fascinating series to mark the Daily Mirror's centenary we reveal the heart of our nation through your lives. *The Mirror.* October 27, 2003, p. 26.

Killer jailed for punching girl, 2; Rage after mum didn't make tea. *The Mirror.* October 17, 2003, p. 17.

Boys, 15 killed by a junkie. *The Mirror.* October 4, 2003, p. 19.

Needle Horror; Drug users 'cleaning' syringes in shop fruit. *The Mirror.* September 29, 2003, p. 19.

Juliet Wilson Column: Lock up druggies to kick the habit. *The Mirror.* September 4, 2003, p. 23.

Shame of our Boozers: Alcohol causes more damage to our society than heroin and all other drugs put together. *The Mirror.* September 5, 2003, p. 6.

Voice of the Mirror: Act now to save victims like Rachel. *The Mirror.* March 1, 2002, p. 6.

Charlene, go back home. *The Mirror.* February 18, 2002, p.6.

Appendix I. The coding frame for the forty Police Review articles in study two. (Abridged version)

Police Review

Code Name	Description	Examples
Crime	Crime is fuelled by heroin addiction	"Heroin does not make you commit crime; it gets you addicted. If you could get free of heroin you wouldn't commit crime". (1 Feb. 2002)
Crime	Heroin dealers are associated with violent crimes	"PC Maloney has noted the rise in kidnappings and serious assaults on the county's local 'players', which, he is convinced, are a hallmark of the Yardie gangs' attempt to gain control of the local market". (5 July 2002)
Crime	Less obvious crimes fuelled by heroin addiction	"...it is right to remind ourselves it is not only the use of these drugs that is of concern but also drug abusers who will often have to drive to find their 'hit' ". (21 Dec. 2001)
Reduce Demand	The war on drugs could be approached by removing the need for heroin	"Critics of the Governments 'get tough' approach on dealers say a better way of dealing in the drugs trade is to tackle demand so dealers have no market to sell". (11 July 2003)
Reduce Demand	Education is an effective way to reduce demand	"It is only through a combination of thorough education at all levels of society, including parents and professionals, appropriate enforcement and adequate and sustained treatment that we can hope to achieve a reduction in the demand for drugs" (2 Nov. 2002)

The legalisation debate	No illicit drugs should be legalised	"Nor should it be a question of 'look at all of us who smoked cannabis, we're not heroin addicts'. Just show me the heroin addict who did not start with cannabis". (9 Nov. 2001).
The legalisation debate	Cannabis should not be treated the same as heroin	"While most heroin users have used cannabis, the reverse is certainly not true. (9 Nov. 2001)
The legalisation debate	Hypocrisy of legal drugs	"Let us make something very clear, all drugs are dangerous and that includes alcohol and tobacco". (19 July 2002)
Heroin users' environment	Deprivation and poverty	"Much of Middlesborough is taken up by deprived, sprawling housing estates on which drug dealing, particularly in heroin, is rife". (4 Jan. 2002)
Heroin users' environment	Prostitution and drugs	"Another major problem, according to the force is the strong link between the town's prostitutes and dugs". (4 Jan. 2002)

Appendix J. The coding frame for the forty articles from the British Medical Journal in study two. (Abridged version)

British Medical Journal

Code Name	Description	Examples
Death	Heroin causes a risk of overdose	"The recent 'heroin epidemic' has led to a dramatic increase in the incidence of fatal and non-fatal heroin over-dose in many countries". (22 Feb. 2003)
Death	Heroin causes a risk of death	"Heroin related deaths occur at a steady rate and are not caused by sudden changes in the purity of heroin". (22 Feb 2003)
Perceptions	Heroin users still have basic constitutional rights	"The Supreme Court ruled that the facts of the women's pregnancy and of possible danger to their foetuses through use of illegal drugs did not change their basic constitutional rights". (31 March 2001)
Perceptions	Female heroin users have a right to information and advice on health issues ('Mainline Lady')	"Modelled on other women's fashion publications, it hopes to challenge the 'junkie' image, arguing that many of its readers will be middle aged, married mothers, wives and girlfriends". (28 July 2001)
Impact	Effects on families and communities	"The misery caused by the use of drugs and hard drugs that kill cannot be underestimated. It damages the health and life chances of individuals; it undermines family life, tears apart communities and turns law abiding citizens into thieves". (7 Dec. 2002)
Impact	Effects on other road users	"The BMA has called on the UK government to develop a campaign to highlight that taking drugs – whether prescribed, over the counter, or illegal – can impair driving capacity in a similar way to alcohol". (16 March 2002

Appendix K. The coding frame for the forty articles from the newspaper data in study two. (Abridged version)

The Newspaper data

Code Name	Description	Examples
Perceptions	The naïve heroin user	"It was the worst decision of her life. She was too naïve to realise the nightclub was a well known haven for drug dealers". (17 Sept. 2002)
Perceptions	The 'clever dealers	"The dealers are very clever, she says. They sell a quarter of a gram to you for practically nothing, then raise the price as soon as you become dependent". (17 Sept. 2002).
Perceptions	The heroin user as prey	"Mine got into drugs with their pals. It was that time in the eighties when the kids here were easy prey for dealers". (27 Oct. 2003)
The legalisation debate	hypocrisy	"It has become obvious that our drug laws are not working. .... There was always something odd abut cannabis being treated in the same way as opiates". (22 Nov. 2001)
The legalisation debate	Hypocrisy in drug laws	"Parents often feel alcohol is the least of their worries but the fact is that it causes much more damage to society than heroin and all other illegal drugs put together". (5 Sept. 2003)

Appendix L. Semi-structured interview schedule for study three

Interview Schedule

Part One:

1. Please tell me what thoughts or images come into your mind when I ask you to talk about heroin users.

2. Please tell me what thoughts or images come into your mind when I ask you to talk about heroin.

3. Please tell me a little bit about your own experience with alcohol.

4. Please tell me a little bit about your own experience with recreational drugs (e.g. cannabis, cocaine, ecstasy, etc)

5. Please tell me a little bit about the drugs education you received in school.

Part Two:

Case Study - Billy

6. Please read the following case study and when you have finished please tell me what you think about 'Billy'.

Appendix M. Questionnaire for the interviewees in study three.

Information Sheet

The information you give on this sheet will be treated with the strictest of confidence. You will not be identified in any way from the information that you give. Thank you for your help.

Age:____

Male or Female:______________________________________

Do you smoke?____

Do you drink alcohol?___________________________________

Have you ever tried other illegal drugs?__________________________

If yes, which ones?_____________________________________

Have you ever tried heroin?________________________________

Do you know anyone who has used heroin?_______________________

Do you know anyone who was addicted to heroin?____________________

Thank you for your participation in this study.

Appendix N. Consent form for interviewees in study three.

CITY UNIVERSITY: PSYCHOLOGY DEPARTMENT 2004
Views and Opinions on heroin and heroin users

Informed Consent Form

I understand that I will be participating in an interview where I will be asked to discuss my thoughts and opinions on heroin and heroin users. The interview will be recorded using a mini disk machine and a microphone in order to assist the researcher with the data collection. My participation in this research is VOLUNTARY and I understand that I have the right to withdraw at any time. I understand that anonymity is guaranteed and that no identifying details are required for this focus group. Any information I give to the researcher will be treated in the STRICTEST CONFIDENCE. My name will not be recorded on any of the research records.

I UNDERSTAND THE NATURE OF MY PARTICIPATION IN THIS RESEARCH AND I AM WILLING TO PARTICIPATE.

Name Signature

....

Date

....

Appendix O. Coding frame for the interview data in study three. (Abridged version)

Interview data

Code Name	Description	Examples
Death	Addiction/needles/risk/weight loss	"…..you know (laughs) wasting away, ehhh, living in a squat, ehhh, ….. withdrawing and not eating and becoming sick, sharing needles and that sort of malarkey and stuff". (Intv. 5)
Death	Scary/injections	"I don't know much about heroin but from the little I do know then I think it is definitely one of the scarier drugs, you know, just the way it is prepared and injected, you know, oh, it's horrible". (Intv. 18)
Death	Overdose and risk of death	"I guess I would imagine that they are people who were sort of at a high risk of death, …….. I've got a feeling that there is quite a high risk of overdose and death". (Intv. 14)
Control	Addiction/loss of control	"You might find a couple of youngsters who are hooked on heroin and they can't do nothing about it because once they are hooked, they are hooked and that is it". (Intv. 8)
Control	Addiction/loss of control	"No drug addict has control, I think once they are on it, it is compulsive after that, and unfortunately it is on the increase and not on the decrease, so now". (Intv. 8)
Control	Addiction/loss of control (possibly loss of morals)	"I think about junkies and stuff like that and

	Anchored to Zombie	it's about the junkie, they are just like this zombie walking around and he is ready to take or do anything just to feed the habit". (Intv. 19)
Control	Addiction/loss of control/ total loss/scary	"I completely don't understand the dependence to the point where you throw everything in our life away, that's the part that is really scary". (Intv. 16)
Stigma	Stigma/clandestine/secretive	"Oh my social life, I think its difficult, I think what you have to understand is heroin use for me is very, what is the word I should use? I have a very clandestine heroin habit". (Intv. 20)
Stigma	Stigma/slippery slope Anchored to a slippery slope	"I think they'd be very concerned, cause there's the stigma attached, you know, it's a slippery slope, the first step on the slippery slope". (Intv. 20)
Heroin users' environment	Heroin is not found among the middle class community/the Other	"...that's cause I've had a nice middle class upbringing and I wouldn't know where to buy heroin". (Intv. 7)
Heroin users' environment	Edinburgh was poor and depressed so there was lots of heroin	"I know that during the eighties Edinburgh was like the heroin capital of Europe and Edinburgh itself was quite depressed and had a huge population that was poor.....". (Intv. 5)
Heroin users' environment	Heroin helps people in poverty to cope	"We've got a society that is very unequal and it is very easy to fall out at the bottom, yeah, and to need something to cope". (Intv. 7).

Appendix P. Coding frame for the interview discussion of the vignette – *Billy* – in study three. (Abridged version)

Billy* and impressions of *Billy

Code Name	Description	Examples
Invisibility	Middle class, working, not addicted	"I could imagine that there are a lot of Billy's and we wouldn't know about them because it is not a very dramatic story I guess it doesn't hit the papers, I wouldn't know, I'd just say I wouldn't know". (Intv. 14)
Invisibility	Middle class, working, not addicted	"Hmmmm, I would say that there are probably lots of Billy's that we don't know about, that's probably what I've learnt as I've become a little bit older and a little bit less naïve". (Intv. 12)
Invisibility	Type of person who uses heroin/ poverty/lower socio economic classes	"I'm part of the urban myth as well, I know there are more people like me as well, I cant be certain but the very fact that the person I have asked to score for me has never been surprised, you know, and presumably he makes a lot of money off people just like me who are doing exactly the same thing" (Intv. 20)
Control	Addicted/Control	"Well, what is different about Billy is that, if such a man exists, like he just hasn't been ..... he's not addicted to it, he enjoys using it and to me that sounds like someone who decides sure I'll go out and have a drink and he's not addicted but he's using it". (Intv. 3)
Control	Addicted/Control	"But I think Billy is fairly addicted in that he is coming close to it, he is at a dangerous point although he is probably not addicted, no, but then I wouldn't be sure, but I would say he cant go a weekend without it so he is somewhere close to being addicted, so I would say to him to get away from it, give it up, you are going nowhere with this thing and

		you are definitely heading for addiction". (Intv. 4)
Control	Control	"Hmmm, seven years! Yeah, I think he is a very lucky man if he has been using heroin for seven years and doesn't have to use it only when he feels like it of a weekend, I don't think there would be many people like that". (Intv. 3)
Death	Health risks	"It seems more tinged with danger and you know selling to people who are in desperate need and therefore they can sell them any old crap". (Intv. 7)
Death	Hasn't lost everything	"He sounds like a fairly decent guy holding down a flat and a job and a girlfriend. I think for me that this is the kind of stuff that surprises me cause you get these media impressions of all heroin users being junkies" (Intv. 12)
Stigma	Stigma/negative/hidden Anchored with homosexuality	"Yeah, I guess it could be seen as difficult as coming out as being gay, you know, cause people in general often have negative images and stereotypes of the whole thing and people are worried about what other people's reactions would be". (Intv. 5)
Stigma	Distance/dirty/blood/danger/threat.	"No way, I couldn't be Billy's girlfriend, I couldn't be around the heroin, only if I was helping heroin users could I be around heroin, but that would be in a professional way and I suppose I would be ok, if they didn't have pussy blood running everywhere, but that is my perception really". (Intv. 6)
Stigma	Distance/the Other	"I just don't know about it because I just don't associate with these kind of people". (Intv. 6)
Perceptions	Psychological problems/influence of girlfriend	"I would definitely want to know exactly what happened seven years ago, ehmmm, is his girlfriend encouraging it, that's another thing I'd want to know that "(Intv. 16)

Appendix Q. A table of codes for the super theme, the impact of heroin.

The following table is a summary of the themes that made up the super theme, the impact of heroin, which was discussed in section 6.2. This super theme is made up of themes, mainly from study one and study two. This super theme was sub-divided into the impact that heroin has on the individual heroin user (column 1) and the impact that heroin users have on others (column 2).

Impact on the individual heroin user	Impact on others
More chance of dying younger (study 1) Links with crime (study 1) Choice and addiction (study 1) It's a very addictive drug (study 1) Commit crimes to feed habit (PR) Drive 'under the influence' (PR) Prostitution (PR) Heroin users should be treated as patients, not criminals (PR) 2% of heroin users who inject – die (BMJ) Steady rate of heroin related deaths (BMJ) Damages the health & life chances of individual (BMJ) Turns law-abiding citizens into thieves (BMJ) Become a slave to heroin (NPs) Robs life of all meaning (NPs) Sucked into a spiral of despair and addiction (NPs) Addict is helpless (NPs) Addicts loose self-respect and become disinhibited in their behaviours (NPs) Associated with prostitution, lying, theft, and manipulation (NPs)	Giving people AIDS (study 1) Affects family relationships (study 1) Links with crime (study 1) Social field breaks down (study 1) Very disruptive locally – causes a lot of havoc (stealing, being disruptive) (study 1) Crime/prostitution (PR) Drive 'under the influence' (PR) Undermines family, tears communities apart (BMJ) Turns law abiding citizens into thieves (BMJ) Children suffer emotional and physical neglect (NPs) Communities suffer (NPs) Huge volumes of crime (NPs) Costs of crime and economic costs to society (NPs)

PR = Police Review; BMJ = British Medical Journal; NPs = Newspaper articles.

Appendix R. A table of themes for the super theme, the nature of heroin users.

The following table is a summary of the themes that made up the super theme, the nature of heroin users, which was discussed in section 6.3. This super theme is made up of themes from study one, study two and study three.

The nature of heroin users	
Zombie (study 3)	Murdered a 2-year-old (NPs)
Unstable person (study 3)	Indulged in heroin (NPs)
'Taken over' (study 3)	'Culpable reckless conduct' (NPs)
Poor background (troubled or abused) (study 1 and study 3)	Unsafe sex (HIV) (NPs)
A burden on others (NPs and study 3)	Inserting dirty needles into fruit (NPs)
Psychological problems (study 1 and study 3)	'luxury to pump veins all day for free (NPs)
Naïve (NPs)	Pester others (study 1, NPs)
Easy Prey (NPs)	Fund their lifestyles for free (NPs)
Slave (NPs and study 3)	Drive 'under the influence' (PR)
They have human rights like everyone (BMJ)	Difficult and disruptive (Study 1, BMJ) Threatening (BMJ)
Crime (study 1, study 2 and study 3)	Their care is 'complex and time-consuming' (BMJ
Street crime and prostitution (PR, NPs)	

PR = Police Review; BMJ = British Medical Journal; NPs = Newspaper articles.

Appendix S. A table of themes for the super theme, the heroin arena.

The following table is a summary of the themes that made up the super theme, the heroin arena, which was discussed in section 6.4. This super theme is made up of themes from study one, study two and study three.

The Heroin Arena	
People in poverty and deprivation (study 1)	Needles/injecting (study 3)
Deprived sprawling housing estates (PR)	Overdose risk/risk of death (BMJ, study 3)
Decaying inner city & dump estates (PR)	AIDS/stigma/social pariah (study 1, NPs, study 3)
Poor and deprived ethnic minorities (PR)	Addiction/loss of control (study 3)
Edinburgh in 80s was depressed (poor population) (study 3)	Slippery slope (study 3)
Low income/shitty lives/people feeling trapped (study 3)	Road to Death (study 3)
'Fallen out of the social net' (study 3)	Throwing everything away (study 3)
Wanting to escape (study 1, study 3)	Rock bottom (study 3)
Street crime/prostitution (PR)	Withdrawing/becoming sick (study 3)
Gun crime – fuelled by drugs (PR)	NOT found in white, affluent, middle-class areas (PR)
Drug dealers/enforcement attacks/axes/machetes (PR)	Parents in affluent suburbs need NOT worry (PR)
Kidnappings and beatings (PR)	NOT prevalent in posh parts of the city (study 3)
Unemployment (PR, NPs)	
Scum of the underworld (NPs)	
On the margins of society (NPs)	

PR = Police Review; BMJ = British Medical Journal; NPs = Newspaper articles.

Appendix T. A table of themes for the super theme, the legal status of heroin.

The following table is a summary of the themes that made up the super theme, the legal status of heroin, which was discussed in section 6.5. This super theme is made up of themes mainly from study two.

The legal status of heroin
Gateway drugs: Cannabis leads to heroin (NPs)
Cannabis is not as addictive as heroin and should be treated differently (PR, BMJ, NPs and study 3)
Hypocrisy: All drugs are dangerous. (PR, BMJ, NPs)
Hypocrisy: Alcohol and tobacco cause more damage than heroin or other illicit drugs but yet they are legal. (PR, BMJ, NPs)
There needs to be a legal differentiation between addictive drugs and milder substances (e.g. cannabis) (PR, BMJ, NPs)
Young people have a desire to use illicit drugs (NPs)
Illicit drugs are a reality in young people's lives and this needs to be acknowledged. (NPs)

PR = Police Review; BMJ = British Medical Journal; NPs = Newspaper articles.