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ORIGINAL PAPER

The Psychotropic Self/Imaginary: Subjectivity and Psychopharmaceutical Use Among Heroin Users with Co-Occurring Mental Illness

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Abstract Many people diagnosed with mental illnesses struggle with illicit drug addiction. These individuals are often treated with psychiatric medications, yet little is known about how they experience this treatment. Research on the subjective experience of psychiatric medication use highlights the complex, contradictory, and ambiguous feelings often associated with this treatment. However, for those with mental illness and addiction, this experience is complicated by the need to manage both psychiatric medication and illicit drug use. Using ethnographic data from a study of heroin use in Northeast Ohio, we explore this experience by expanding the pharmaceutical self/imaginary (Jenkins, Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology, School for Advanced Research Press, Santa Fe, NM, 2010b) to include psychopharmaceuticals and illicit drugs, what we call the *psychotropic* self/imaginary. Through this lens we explore the ways participants interpret and manage their psychotropic drug use in relation to sociocultural, institutional, and political–economic contexts. This analysis reveals how participants seek desired effects of legally prescribed and illicit drugs to treat mental illness, manage heroin addiction, and maintain a perceived "normal" self. Participants manage their drug use using active strategies, such as selective use of psychiatric medications, in the context of structural constraints, such as restricted access to mental health care, and cultural contexts that blur distinctions between "good" medicines and "bad" drugs.

Keywords Addiction · Mental illness · Illegal drugs · Subjectivity · Psychiatric medication

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Introduction

On a bright October afternoon, Susan,[1] a participant in a study of heroin use, sits with me in a small basement research office for our fourth interview. She has been taking multiple psychiatric medications since being diagnosed with Bipolar Disorder (BPD) and Post-Traumatic Stress Disorder (PTSD) 6 years ago. In the month leading up to this interview Susan has been in drug detoxification ("detox") treatment twice and inpatient psychiatric treatment once, resulting in multiple, drastic psychiatric medication changes to which she struggled to adjust. During our interview Susan reported experiencing several side effects of her current mix of psychiatric medications, including blurred vision, dry mouth, and motor agitation, in addition to nascent symptoms of heroin withdrawal, such as muscle aches, anxiety, and nausea. That afternoon our discussion began with Susan describing her first heroin "high" after her recent release from detox:

Susan: It's like you feel so good and you just, your whole body is just warm, and you just feel – oh, god, it feels so good. Any pain or – and I'm talking about emotionally, too – any pain or sorrow you have or a headache – god, if you have a headache or something, it's gone. So it just soothes everything over. It just makes everything better. And that's why I do it, I think, 'cause this Susan [*pointing to self*] can't stand to be walking around. I like the high Susan better – everybody does

Allison: Could you tell me more about what this Susan is like?

Susan: This, the sober Susan? Oh, Lord. I'm a bitch and I'm cranky all the time, I'm irritated real easy. I can't see real good, 'cause I'm used to the dope [heroin], so I can't see. And my ears pop. That always happens when I'm sick [from heroin withdrawal]

Allison: And then you use dope and what's that Susan like?

Susan: I'm all happy and nothing can touch me, nobody could get to me. You know, like super-woman. That's how I feel

Allison: What part of being high is different when you're taking your psych meds?

Susan: I just get high and then I lay down and go to sleep. That's what I do. [*Becoming frustrated*] It's stupid, because then I miss out on the high. It doesn't make any sense … It's the meds. They [psychiatrists] tell you not to take drugs if you're on the medication. They tell you don't take street drugs. [*Sarcastic tone*] "Okay, I won't. Don't worry."

This exchange highlights questions central to the experience of simultaneous psychiatric medication and illegal drug use: How are illegal drugs used as medicines to address physical and emotional pain, and how does this influence psychiatric medication treatment? How do heroin withdrawal symptoms and psychiatric medication effects interact to impact one's sense of self? What is the relationship between a heroin "high" and psychiatric medication use? How do exposures to addiction and mental health treatment affect the use of both psychiatric medications and illicit drugs?

[1] All names used are pseudonyms.

The need to understand how people like Susan experience simultaneous psychiatric medication and illicit drug use in relation to biological, sociocultural, institutional, and political–economic factors is at the core of these questions. In this article we explore how subjectivity is shaped by these complex dynamics drawing on the dual lens of the pharmaceutical self/imaginary (Jenkins 2010b). We expand this framework to include psychopharmaceutical medications and illegal drugs, constructing a more inclusive *psychotropic* self/imaginary. Susan's narrative provides a window into this largely unexplored, yet increasingly common, experience.

Medication "Compliance" and Co-Occurring Disorders

Susan's co-occurring mental illnesses and substance use disorder (Co-Occurring Disorders, or CODs) is not uncommon. In 2002, approximately 4 million people diagnosed with a severe mental illness were also dependent on or abused alcohol or illicit drugs (NSDUH 2004). Furthermore, research from community samples (Grant et al. 2004; Regier et al. 1990) and addiction and mental health treatment (Havassy et al. 2004; McGovern et al. 2006; Watkins et al. 2004) consistently indicates that over half of people with a substance use disorder also have at least one diagnosed mental illness. People with CODs often receive psychiatric medication treatment, and compliance[2] to these medication regimens is a significant concern among clinicians and researchers (Hunt et al. 2002; Osher and Drake 1996; Owen et al. 1996; Pristache and Smith 1990; RachBeisel et al. 1999). However, research on medication compliance among people with CODs typically emphasizes biologic and pharmacologic factors at the expense of psychosocial and structural dynamics (Drake et al. 2002). This focus is consistent with the broader body of research on compliance that has been sharply criticized as de-contextualized and framed from a biomedical perspective alienated from patient experience (Conrad 1985; Hunt et al. 1989; Kleinman 1980; Trostle et al. 1983; Trostle 1988; Whyte et al. 2002). When social issues related to psychiatric medication use among people with CODs do gain attention, the emphasis is often on violence associated with non-compliance (RachBeisel et al. 1999; Swartz et al. 1998a, b).

Critiques of biomedico-centric interpretations of compliance have stressed the need to understand patient agency in medication management, stressing that, "what appears to be non-compliance from a medical perspective may actually be a form of asserting control over one's disorder" (Conrad 1985, p. 29). Conrad (1985) argues that while physicians focus on compliance according to their prescribed medication regimens, from a patient perspective managing medications often involves careful self-regulation; for example, altering medications by reducing or terminating use in response to side effects that make everyday social interactions difficult. These active medication management strategies are deeply connected to the cultural contexts of medication use. Etkin (1988, 1992) stresses the need to understand medication

[2] "Compliance" has more recently been referred to as "adherence" or "concordance" in an effort to respect patient perspectives and autonomy (Applbaum and Oldani 2010). However, following Applbaum and Oldani (2010), we continue to use the term "compliance" in this manuscript to reflect the large body of research that indicates that "the patient remains vulnerable and subject to powerful individual and institutional forces outside of their control" (120).

management in relation to cultural constructions of medication efficacy, stressing that efficacy must be understood in relation to larger healing processes, interpretations of symptom causation and severity, and expected outcomes. Like Conrad (1985), Etkin (1992) emphasizes the importance of "side" effects, stressing the symbolic values with which these effects are often imbued (e.g., as evidence of disease egress) and describing the phenomenon of a "side" effect shifting to an intended, sought-after effect. Etkin's work reveals that, "what is a primary and what is a secondary or side effect is not given, but is open to cultural interpretation" (Whyte et al. 2002, p. 32). These dynamics underscore the importance of social and cultural contexts and subjective interpretation in shaping medication practices. People actively make decisions about their medication use and are far from passive recipients of the medical prescriptions of doctors, despite the tendency to regard them as such by biomedico-centric treatment systems.

The common biomedico-centric treatment of CODs in isolation from these critical psychosocial and cultural contexts in which addiction and mental illness exists belies the extensively documented links between illegal drug use, mental distress, and psychosocial dynamics, economic marginalization, and violence and victimization (Alverson et al. 2000; Alexander 1996; Bourgois 2010; Bourgois and Schonberg 2009a; Drake et al. 2002; Singer 2007, 2008). Additionally, people with CODs manage specific challenges distinct from those associated with addiction or mental illness alone, including difficulties navigating bureaucracies necessary to access entitlement programs, participating in treatment programs, maintaining stable housing, and avoiding victimization (Drake et al. 2002). Yet these factors are often neglected in considering medication treatment among these individuals.

Psychotropic Drugs and Subjectivity: The Reciprocal Self/Imaginary

Social scientists have increasingly explored the subjective experience of psychiatric medication treatment alongside the steady increase in the use of pharmacological agents to treat mental distress (Jenkins 2010a; Petryna and Kleinman 2006). The pharmaceutical self is a concept critical to analyses of the subjective experience of psychiatric medication use. Drawing on the self as the culmination of processes whereby the subject is oriented toward the world and others (Hallowell 1955), Jenkins (2010b) describes the pharmaceutical self as the aspect of self that is oriented by and toward pharmaceutical drugs (23). Yet, as Jenkins (2010b) emphasizes, the pharmaceutical self occurs in reciprocal relationship to the pharmaceutical imaginary, the aspect of culture oriented toward possibilities for human life increasingly connected to those possibilities shaped by pharmaceuticals. Attending to the link between the pharmaceutical self and pharmaceutical imaginary is crucial, as "the terminological pair, self/imaginary, points to the mutual grounding of the subjectivity of social actors in sensory experience and in a cultural context. Individual subjects are selves not of their own accord but by virtue of immersion in an intersubjective and institutional milieu" (Jenkins 2010b, p. 23).

Research focused on the pharmaceutical self/imaginary underscores the paradoxical, contradictory, and ambiguous feelings often associated with psychiatric medication treatment and the intersubjective dynamics shaping this experience

(Anderson-Fye 2009; Floersch 2004; Floersch et al. 2009; Jenkins 1994, 2010b; Jenkins and Carpenter-Song 2005, 2008; Karp 1996, 2006; Kleinman 1988; McKinney and Greenfield 2010). For example, Jenkins and Carpenter-Song (2005, 2008) describe paradoxes in the experience of second-generation ("atypical") antipsychotic medication treatment such as the perceived choice to be "crazy" or fat, sexless, and genderless given the side effects of weight gain and blunted sexual desire often accompanying the use of these medications. These authors also describe the keen awareness of social stigma among people with schizophrenia-related diagnoses, emphasizing the importance of intersubjective relations in their everyday lives and the variety of strategies used to deflect and resist stigma such as concealing medications from others (Jenkins and Carpenter-Song 2008). Longhofer et al. (2003) highlight the importance of social relationships in medication use by describing how formal (e.g., case managers, psychiatrists) and informal (e.g., friends, family) social networks comprise a "social grid" that co-produces the medication experience.

This emerging body of research suggests dynamics essential to understanding concurrent psychiatric medication and illicit drug use among people with CODs. For example, for people with CODs the stigma associated with mental illness combines with stigma of illegal drug use, increasing the importance of understanding the role of intersubjective relations in their lives. Further, illegal drug use is a social activity heavily reliant on relationships between participants in illegal drug markets (Hoffer 2006; Hoffer et al., 2009), and people with CODs, like others who use illegal drugs, participate in these social relationships. Alverson et al. (2000) have explored social relationships among people with CODs revealing their often significant involvement in drug-using social networks. The authors highlight the important social functions of substance use in the lives of these individuals that cannot be discounted or ignored when attempting to change substance use and treat mental illness. People with CODs are often embedded in a complex set of overlapping social relationships in both the social grid of medication management and the illegal drug market.

The dual lens of the pharmaceutical self/imaginary is essential to explorations of the experience of psychopharmaceutical use among individuals with CODs given the overarching sociocultural and political contexts that blur boundaries between medications and illicit drugs (Bourgois 2000; Lovell 2006; Montagne 1996; Singer 2008). Montagne (1996) stresses that culture shapes what constitutes drugs and drug use, arguing that there is a continuum of substances, and their distinction as "drugs" or "medicines" is mediated by social knowledge based on "accumulations of information and past experiences that exist uniquely in individuals and collectively in societies" (12). Socially mediated drug/medicine distinctions are perhaps most clearly exemplified by opiate replacement therapies (ORTs) such as methadone and buprenorphine (Agar 1977; Agar and Reisinger 2002; Agar and Stephens 1975; Bourgois 2000; Bourgois and Schonberg 2009b; Koester et al. 1999; Lovell 2006). These opiates are deemed "medicines," biomedically sanctioned pharmaceutical treatments that replace other opiates labeled "drugs," namely heroin. Bourgois (2000) emphasizes that distinctions between heroin and methadone are used by state and medical authorities to discipline heroin addicts by creating divisions that center on "moral categories concerned with controlling pleasure and productivity: legal versus illegal; medicine versus drug" (167). Yet the biomedical categorization of methadone

as "medicine" and heroin as "drug" contrasts sharply with the experience of addicts prescribed methadone, who often experience harsher withdrawal symptoms, stigma, and disruption of daily life on methadone compared to heroin. By contrasting biomedical discourses and patient experience, Bourgois shows how the distinction between methadone as "medicine" and heroin as "drug" is used in the cloak of science to inculcate moral discipline on economically unproductive bodies.

Ambiguity in distinguishing socially vilified "drugs" and socially sanctioned "medicines" occurs in an era of pharmaceuticalization in which pharmaceuticals have come to play a prominent role in everyday life (Abraham 2010; Biehl 2007). Thus, "good" and "bad" drugs commonly co-exist in the same social milieu (Montagne 1996; Saris 2010). It is in this context that people with CODs strive to manage their mental health and illegal drug addiction. However, analyses of psychopharmacology and addiction tend to ignore or elude this reality (Saris 2010). This gap is likely due, in part, to difficulty accessing people who simultaneously use psychiatric medications and illegal drugs, the social stigma associated with illegal drug use, and the alienation of these individuals from health care providers. As a result, little is known about how individuals with CODs experience their use of both "good" and "bad" drugs, and how these experiences relate to the conventional categories in which these drugs are placed.

A number of critical questions warrant attention in light of this gap. How is the experience of psychiatric medication treatment and illegal drug use constituted in relation to the increasingly active pharmaceutical imaginary in which, as Biehl (2010) observes, "human relationships to pharmaceuticals are increasingly constituted outside of the clinical encounter" (68), and, as Jenkins (2010b) stresses, consumers actively participate in the creation and circulation of significations that comprise the pharmaceutical imaginary through avenues such as peer exchange networks and "black market" economies? How is simultaneous psychopharmaceutical and illegal drug use experienced alongside what Saris (2010) describes as increasing consumer "pharmacological confidence" that "potentially allows the pharmacological subject to slip the surly bonds of medical expertise into 'cosmetic pharmacology,' choosing one's own regime of chemical manipulation, if not strictly by oneself, then outside of the institutional channels of legally and socially constituted expertise" (220)?

This article aims to address these questions by using the lens of the psychotropic self/imaginary to understand how people with co-occurring mental illness and heroin addiction manage their drug use. By using this framework, we build on previous research that tends to consider psychiatric medication and illegal drug use in isolation. We bring meaning to the medication "compliance" literature by humanizing psychotropic drug use among people with CODs. Finally, we bring to the fore the reality of the lives of people with CODs by exploring their experiences in the context of the drugs in their midst and the powerful sociocultural and political–economic dynamics that shape their drug use.

Heroin Addiction

This article focuses specifically on concurrent psychopharmaceutical use and heroin addiction. Participants in this study overwhelmingly described themselves as

"addicted" to heroin, and the biological and psychological dynamics of addiction must be understood to grasp their experience. Susan and other participants in this study consider themselves addicted to heroin because they have a physical and psychological "need" for heroin to avoid becoming ill. In other words, they have become dependent on the drug; their bodies and minds have adapted to the presence of heroin. Substance dependence is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV (APA 2000) by seven criteria; however, tolerance and withdrawal are central to both DSM and participant definitions of addiction.

Heroin tolerance is the marked decrease in the drug's effect despite increase in the amount or potency of drug used. When someone who is dependent reduces or stops heroin use they begin to experience withdrawal symptoms, sometimes only a few hours after their last heroin use. Withdrawal includes physical and psychological symptoms such as stomach cramps and vomiting, joint and muscle pain, cold flashes, kicking movements, insomnia, anxiety, and restlessness (Hanson et al. 2006b; NIDA 2010). Heroin addicts often refer to withdrawal symptoms as "dope sickness." Heroin withdrawal is often incapacitating, yet these symptoms can be alleviated quickly by heroin use. Therefore, users commonly refer to injecting heroin as "getting well" or "get right," alluding to the ability of heroin to return them to a state of physical and psychological wellbeing. It is important to stress that when someone is addicted, his or her experience of heroin use is often limited to staving off "dope sickness," not experiencing the euphoric "high" commonly associated with use. This absence of a "high" is the result of tolerance to the drug's effects. It is important to note that obtaining the amount of heroin necessary to achieve a "high" is unaffordable or otherwise impossible for many users, and therefore users often strive to maintain their addiction and avoid withdrawal, or simply "stay well," rather than experience a "high" (Hoffer 2006; Hoffer et al. 2012).

These complex biological and psychological factors interact with social and environmental contexts to shape an addict's lifestyle and impact how they experience a perceived "normal" self; therefore, the subjective experience of concurrent psychopharmaceutical treatment and heroin addiction must be understood in the context of these realities.

Methods

This article draws on data from *Merging Agent-Based Modeling Techniques and Ethnography: A New Analytic Tool for Studying Illicit Drug Use Behaviors, Markets, and Economies*, an ongoing study combining ethnographic research techniques with social simulation modeling to better understand heroin use behaviors and market dynamics in a major metropolitan area in the northeastern Ohio.[3] As part of this study, one to six ethnographic interviews were conducted with adult (18 years of age or older) active heroin users who were recruited through

[3] This research was conducted with the approval of the Case Western Reserve University Institutional Review Board.

collaboration with a local needle exchange program. Nearly all participants described heroin as their primary "addiction"; however, many also used other illegal drugs, most commonly crack cocaine. Despite polydrug use, heroin use dominated their narratives.[4] In addition to in-depth interviews, project ethnographers accompanied participants on field observations in the communities where they live or frequent in the course of their daily activities (e.g., to participate in drug exchanges or prostitution).

At this writing, 34 individuals have participated in repeated interviews and field observations. Just under half of participants, 15 (44% of participants; 9 women/6 men), self-reported diagnosed mental illness and have received psychiatric medication treatment from a health care provider. The narrative of one of these participants—Susan—highlights the variety of ways that these participants experience, interpret, and manage simultaneous psychiatric medication and illicit drug use. However, Susan's experiences and the narratives of participants who self-report CODs are supplemented by the experiences of all 34 participants, which provide context and depth since many participants who did not report diagnosed mental illness provided important information on the role of psychopharmaceuticals in the illegal drug economy and the use of psychopharmaceuticals to self-medicate undiagnosed mental illness, economic hardship, and other life troubles.[5]

Susan's narrative underscores the complexity of the experience of managing psychiatric medication and heroin use at once. Her experience, while unique in some ways, reflects common themes among participants in this study by highlighting the significance of the desire to maintain a "normal" self, the blurry boundary between "good" medicines and "bad" drugs, paradoxes around "side" versus intended drug effects, and the influence of exposures to mental health and addiction treatment on patterns of psychopharmaceutical use and heroin addiction.

The Psychotropic Self

Susan is a Euro-American woman in her forties who has been using heroin for the past 20 years. The deeply interconnected nature of her illegal drug and psychiatric medication use became clear over the course of six in-depth interviews and two field interactions over 12 months. Susan's partner, Nicole, is also a participant in this study and provides context, depth, and validity to Susan's self-reports.

[4] Participants clearly identified heroin as their primary addiction and rarely described their crack cocaine use in depth. Crack use was typically reported to occur sporadically and infrequently (e.g., approximately once a month). As a result, there is little information on how participant's crack use interacts with their mental health in contrast to the detailed narratives on how heroin use interacts with mental health.

[5] Interview transcripts and field notes from all 34 participants were indexed for psychopharmaceutical use to identify narratives on how participants view psychopharmaceutical use in relation to illicit drug use and the role of psychopharmaceuticals in the illegal drug market. Interview transcripts and field notes from the 15 participants who self-reported diagnosed mental illness were coded for themes related to how these individuals view and manage their psychopharmaceutical and illicit drug use in relation to self-perceptions and contextual factors.

Managing the Self Through Drug Use

Susan's life is strongly shaped by a lengthy history of sexual abuse as an adolescent and adult. Susan began using heroin at 20 years old when her boyfriend injected her with the drug for the first time and initiated her into street prostitution. After this first use, this boyfriend would "just keep me junked out, you know. Keep me sick and I'd get real sick and then he'd go ahead and give me some dope and I mean he purposely started me on it." By the time the relationship ended, Susan had developed a large heroin habit that she became dependent on prostitution to maintain. Susan considers herself a heroin "addict." Although she occasionally smokes crack cocaine, this is only when extra money is available after securing enough heroin to "get right," a rare occurrence. Because of her heavy daily heroin use and inconsistent income from prostitution, Susan's everyday life is chaotic and focused on obtaining enough heroin to support her large habit. Additionally, she has intermittently taken multiple psychiatric medications for the past 6 years prescribed by numerous psychiatrists to treat BPD and PTSD.

Susan's experience with these medications alongside heroin use is marked by frequent shifts in use shaped by her own self-regulation as well as shifting contextual factors highlighted through her complex narrative. This narrative begins with a 3-year period of infrequent illegal drug use. At this time, soon after her initial BPD and PTSD diagnoses, Susan received psychiatric treatment through Supplemental Security Income (SSI) benefits. She was prescribed seven psychiatric medications (a mix of antipsychotics, antidepressants, and benzodiazepines), in addition to methadone, by her psychiatrist.[6] Susan described her use of psychiatric treatment during this period in one of her first interviews.

Allison: Have you been able to be on the meds consistently?

Susan: Well, I was when I was sober – not sober, not sober – when I was living with my ex-fiancé, when I had everything I always wanted, you know, all the money and everything, I was on all the meds. But I was on like seven different medications. They really medicated me out. That's when I gained a hundred and twenty pounds. I've just lost a hundred and twenty pounds

Allison: Wow

Susan: Yeah. I gained it. The bipolar meds is what made me gain the weight. I was on so many different meds. I mean they [psychiatrists] wouldn't even talk to me, they'd just put me on a new med – take me off this one, put me on that one, take me off this one, put me on that one. And it was ridiculous. You know, I had a lot of symptoms and a lot of problems because of all the meds

[6] Susan stressed that at this time she was "sober" since she significantly reduced her use of heroin or other illegal drugs. She categorizes methadone as a "medicine" instead of a "drug" in contrast to the views of many users in this and other studies. Other participants in this study consider ORTs (specifically, methadone and Suboxone) "just another addiction." Such views and experiences of ORTs are consistent with those of heroin addicts taking prescribed ORTs described by other authors (Agar 1977; Agar and Stephens 1975; Bourgois 2000; Bourgois and Schonberg 2009b; Koester et al. 1999; Saris 2008; Schwartz et al. 2008).

Most troubling to Susan at this time was her dramatic weight gain and prevailing sense of "boredom" due to her departure from the heroin scene and the "exciting" lifestyle that she had become accustomed to as part of this life (e.g., daily efforts to "hustle" enough money to buy heroin). She considered herself a "housewife," and the tedium of this lifestyle, in addition to medication side effects, made her feel alienated from what she considered her "true," "normal" self. Susan eventually began using heroin again, and after relapse she quickly lost the weight gained and returned to the "exciting" life she preferred.

Many other participants in this study echoed the lure of excitement associated with the heroin scene and the influence this lifestyle has on one's perceived sense of "normal" self. Kathy, a Euro-American woman in her twenties diagnosed with depression, anxiety, and BPD, was prescribed an anti-depressant and sedative. While taking these medications, she felt "glazed" and unable to feel her desired range of emotions. She "didn't like the medium, everything medium." Kathy described a period while sober and taking psychiatric medications when she was able to care for herself by showering and keeping her home clean, but did this with an overall sense of dullness and "loss of self" due to the loss of her creative abilities, social relationships, and lifestyle connected with the heroin scene. During an interview after entering addiction and mental health treatment she explains her sense of loss after leaving the heroin scene:

> I feel like that huge piece is ripped away from me, and I loved it, I've never felt that happy and normal on a daily basis, even if it was a struggle, you know. But [*sigh*] I hope these antidepressants will fill at least that void, and I'll be able to do what I call my studies, and find myself again, but, uh… For now, it's like lost and empty, or just, uh, basically, uh… bored, lost, and empty.

After this point, Kathy intermittently discontinued psychiatric medication treatment and relapsed to heroin use only to return to medication treatment with renewed hope that different medications would not induce the familiar sense of dullness and loss of self.

"Good" Medicines and "Bad" Drugs

Susan's return to heroin use introduced the need to manage both her mental illnesses and heroin withdrawal symptoms—"dope sickness"—an ever-present threat given her inconsistent access to the drug. At the time of this relapse, Susan was prescribed an atypical anti-psychotic, anti-depressant, and benzodiazepine (Valium). She consistently took the anti-psychotic and anti-depressant as prescribed, but generally sold the Valium on the street for $1.50 per pill. When she did take the Valium it was in large amounts to get "high" or amplify her heroin "high" by simultaneous taking both.

At this point, Susan consumed a mix of drugs. The conventional ideology is that drugs obtained by legal prescription are legitimate, "good" medicines, and heroin is a "bad" street drug. However, Susan's use and experience challenges this dichotomy. Susan categorized some of her psychiatric medications as necessary

to treat her mental illness, and others as "drugs" able to induce a "high."[7] Specifically, she viewed her prescribed anti-psychotic and anti-depressant drugs as medications necessary to manage her BPD and PTSD, particularly to treat auditory hallucinations, insomnia, and other symptoms of mania, and generally took these medications as prescribed.[8] Susan accepted her diagnoses, particularly her BPD diagnosis, often stressing, "I'm *extremely* Bipolar." This acceptance of her BPD illness identity and consistent use of psychiatric medications that she links to BPD symptoms is consistent with Karp's (1996) claim that acceptance of a specific mental illness (e.g., Depression) as a disease ("I am depressed") is a predictor of medication adherence (see also Floersch 2004).

In contrast to Susan's view of her anti-psychotic and anti-depressant drugs as medications, she views her prescribed Valium as an illicit drug is the same category as heroin. When asked if she was currently using any drugs in addition to heroin during her first interview, Susan responded with, "just Valium, when I get 'em," adding, "when I get the prescription I usually take a couple for myself because I love the high; a Valium high is a good high." Over the course of our meetings Susan continually acknowledged that she sold or "abused" Valium despite feeling that if she took it as prescribed, it would help her manage her anxiety. However, the opportunity to make money by selling Valium on the street provided a means to subsidize her heroin use, and this outweighed her desire for the Valium "high" and her use of it to manage anxiety. She viewed heroin use as an alternative means to self-treat her anxiety, dispelling her need for Valium as an anxiolytic. Heroin, in effect, met multiple needs simultaneously; it quelled her "dope sickness" and treated anxiety and other symptoms attributed to BPD and PTSD (e.g., insomnia).

Selling psychiatric medications is not uncommon, and study participants consistently describe the glut of benzodiazepines (e.g., Valium, Xanax, Klonopin) in the local underground economy. Such an active underground market for psychiatric medications is consistent with reports of other street drug scenes (Bourgois and Schonberg 2009b; Estroff 1981; Luhrmann 2010; Saris 2010; Singer 2008). While illegal drug users and dealers may sell psychiatric medications in addition to other drugs, suggesting a significant overlap between the illegal drug economy and the black market for pharmaceuticals, these sales are not limited to illegal drug dealers and users. Participants in this study frequently reported acquiring psychiatric medications from "everyday people," meaning people who do not use or sell illegal drugs such as heroin. This generalized availability is an indicator of the ubiquity of psychopharmaceuticals, whether prescribed as treatment or not, and the active social lives (Whyte et al. 2002) of these medications outside of the confines of institutional encounters.

[7] Susan's categorization of some of her psychiatric medications as "drugs" in contrast to their conventional categorization as "medicines" parallels the previously noted findings of many other scholars regarding addicts' experiences of methadone as a "drug" despite it being regarded as a "medicine" by state and medical authorities (Agar 1977; Agar and Reisinger 2002; Agar and Stephens 1975; Bourgois 2000; Bourgois and Schonberg 2009b; Koester et al. 1999; Saris 2008; Schwartz et al. 2008).

[8] Susan also reported taking methadone as prescribed until she returned to heroin use and was withdrawn from the methadone program.

The concept of "bad" drugs and "good" medicines is further complicated by how the substances are used, such as Susan's use of Valium in combination with heroin to intensify her "high." This is a common practice reported by other participants in this and other studies; particularly the combination of two central nervous system (CNS) depressants to achieve increased sedative effects and unique "high" (Hanson et al. 2006a; Singer 2008). This synergistic effect was particularly desired when participants in this study used heroin only to "stay well" since the combination of highly available benzodiazepines and heroin provided the rare opportunity to experience euphoria.

Valium was also sought in the underground economy to treat provider- or self-diagnosed mental illness. Mary, an African American woman in her forties, bought Valium on the street to self-treat her depression, originally diagnosed when she was incarcerated. Mary was treated with an anti-depressant in prison, but lost access to this medication upon release and this abrupt termination resulted in her experiencing medication withdrawal, which she referred to as "detoxing." During this time, Mary had insomnia for 4 days and her depression worsened. To remedy this interrupted access, she self-medicated with Valium bought on the street, which was used primarily to help her sleep during her most intense periods of depression. Mary began the lengthy process of applying for SSI to cover mental health treatment at the start of the study and over a year later she was in the process of re-applying after initial rejection for failure to prove that she was "sick enough."

Benzodiazepines and other psychiatric medications (e.g., anti-depressants and anti-psychotics) are commonly used as self-prescribed "medicines" to cope with sleep disruptions associated with mental distress and symptoms of heroin withdrawal.[9] Diverted psychotropic drug consumption has been linked to deteriorating economic conditions and shifts in the availability and quality of illegal drugs (Epele 2010). That Valium and other benzodiazepines are used to both self-medicate emotional distress and as drugs to achieve a "high" when heroin is not available is not surprising given the history of debate around its categorization as a medication versus illegal drug and these medications' established addictive potential (Herzberg 2009). It is, however, surprising that participants report the use of anti-psychotics to self-medicate, and this is closely linked to their co-occurring heroin addiction. This connection blurs distinction between "side" and intended drug effects.

Medication Effects: "Side" or Intended?

Despite taking anti-psychotic and anti-depressant medications consistently as prescribed, Susan expressed conflicting feelings about their effects. Susan was particularly ambivalent about the anti-psychotic medications' sleep inducing effect, experiencing it as double-edged, as reflected in the opening exchange of this article. Drugs that are known to induce sleep are valuable commodities in the context of heroin addiction because they can be used to manage heroin withdrawal symptoms

[9] Like these psychopharmaceuticals, ORTs are bought in the black market to self-medicate heroin withdrawal, to attempt to control one's heroin habit, and to self-detox when access to formal detox is restricted or when one prefers to avoid formal treatment. These dynamics have also been documented elsewhere (e.g., Saris 2008).

(i.e., insomnia; enabling one to sleep through other painful physical and psychological withdrawal symptoms). At times Susan interpreted prolonged sleep as a respite from an emotionally painful life and an antidote to insomnia induced by heroin withdrawal, yet sleep was also seen as an unwanted nuisance and impediment to enjoying the heroin high.

Martin (2010) stresses the paradox of sleep as a desired state that remains increasingly elusive the more it is sought. For heroin addicts, this paradox is further complicated by heroin withdrawal-induced insomnia and the plethora of illegal and legal drugs available to address it. Like Susan, most participants in this study found insomnia associated with heroin withdrawal both distressing and disruptive to daily life. Some participants, such as Ray, a Latino man in his twenties diagnosed with depression, attempted to self-detox from heroin use only to relapse after several days of withdrawal-induced insomnia. He attempted to manage this withdrawal with Valium purchased on the street, but eventually returned to heroin use, quickly addressing his insomnia.[10]

The relationships between sleep, medications, and heroin addiction provide particularly powerful examples of the ambiguity of medication "side" effects. "Side" effects such as prolonged sleep were interpreted in relation to their effects on the ability to achieve a "high" and, failing that, a sense of "normal" self by using enough heroin to numb physical and emotional pain while avoiding heroin withdrawal symptoms.

The Psychotropic Self in the Institutional Circuit

Despite Susan's ambivalence about medication effects, she reported consistently taking prescribed anti-psychotic and anti-depressant medication, and selling her Valium, for extended periods of time. This pattern shifted drastically when she voluntarily entered drug detox treatment several times in the span of three months. During stays in detox, which lasted from 2 to 5 days each, Susan was taken off all psychiatric medications and placed on an altered mix of medications upon discharge. After her last detox episode, she was placed on the same three medications she had been previously prescribed, with the addition of one new anti-depressant, one new anti-psychotic, and an anti-cholinergic used to treat motor agitation, a psychiatric medication effect. Adjusting to this new cocktail of medications, Susan described herself as feeling "drunk" and began experiencing increasingly impairing medication effects such as dry mouth, psychomotor agitation, and prolonged sleep with vivid, frightening dreams.

Despite Susan's significant concerns about her state on this new mix of medications, she was unable to see her prescribing psychiatrist due to a combination of the bureaucratic process involved in accessing treatment (e.g., several weeks wait to get an appointment) and her chaotic life marked by housing and economic instability, lack of transportation, and the daily need to obtain enough heroin to

[10] The use of heroin to treat insomnia is reminiscent of the use of heroin and other narcotics as a sleep aids in the nineteenth century (Martin 2010), further highlighting the socially mediated, historically contingent nature of drug/medicine distinctions.

avoid withdrawal. Although Susan worked with a case manager at this time, she was not permitted to receive psychotherapy alongside medication treatment until she displayed discipline in making scheduled appointments and submitted documentation of health status. Susan explains:

Susan: I have to wait three months to see a counselor. But I have a doctor, a psychiatrist, and the case manager. And the case manager's supposed to help me with all my medical stuff, and like finding a place to live… she's supposed to help get my life together. You know, keep appointments and stuff like that

Allison: So, in about three months, you should be able to see a counselor?

Susan: Yeah, I'm supposed to be able… They have to make sure that I'm gonna keep my appointments and everything, so… But I just took the paper in 'cause I haven't been in there in like over a month, so I just took the paper in today to show her [case manager] that I was at the TB clinic and everything, so she's supposed to call me and let me, give me another appointment to go back and see her, and then to see the doctor

Other participants in this study experienced similar difficulties accessing publically funded mental health care with approximately half of participants with CODs describing wait lists over 3 months to access treatment, and discouragingly longer waits if psychotherapy is desired in addition to, or in lieu of, medications. Ray, whose experience of insomnia was recounted above, described the long process of arranging an initial appointment to address his depression that had gone untreated since the initial diagnosis at 13 years of age. He made an appointment for a preliminary in-person assessment, after which he was told to call back for a phone appointment during which an additional assessment was to be conducted. During this second assessment, Ray was offered the options of pursuing psychiatric medication treatment or counseling, but was warned that counseling would require a longer wait. His response was, "I wanna do some pills." Three months after he began this process, Ray had yet to get a follow-up appointment and was not receiving any formal treatment. He did, however, use benzodiazepines bought on the street to self-treat anxiety and depression.

Exposures to institutional settings such as residential addiction and mental health treatment and incarceration are problematic. Common exposure to these institutions combines with housing instability to place participants in an "institutional circuit" characterized by constant migration between these settings (Hopper et al. 1997; Luhrmann 2010). The institutional circuit has become increasingly influential in the lives of people reliant on publically funded health and social services due to the retraction of publically supported health and social services resulting in limited access to and shortened lengths of treatment. For participants in this study, movement through the revolving door of the institutional circuit resulted in dramatic and unsettling shifts in psychopharmaceutical and illegal drug use. Shifts in prescribed psychiatric medication treatment, often abrupt and unexpected, were largely beyond the control of participants; however, they actively re-claimed control by seeking the drugs available to them to modulate the self. They self-treated their addiction and mental health issues by purchasing black market ORTs (used to

eliminate or reduce heroin use outside of formal treatment) and psychiatric medications (used to self-treat mental distress). These pragmatic uses in response to structural barriers to formal treatment further blur the drug/medicine distinction.

Who Is "Sober Susan"?

In her severely impaired state from the new cocktail of prescribed medications, Susan was most disturbed by not feeling like her true "self"; she began our first interview after starting this new medication regimen by stressing, "you notice I'm not my punky self, and it's the *pills*… and I don't want to be like this." Susan resumed heroin use soon after leaving detox, and described the feeling of "normal" that this return to use provided. She explains: "it's *abnormal* for me to be sober, normal for me to be high."

Not only did heroin return Susan to her perceived "normal" state, but it once again offered a means to ease physical and emotional pain and return to her preferred "exciting" lifestyle as part of the heroin scene. As Susan explained in the opening exchange, without heroin she "can't stand to be walking around"; she likes "the high Susan better – everybody does." Here Susan refers to herself in the third person. Across interviews and observations, it is not uncommon for her to refer to herself using phrases such as "this Susan" and contrasting "good Susan" with "bad Susan," "sober Susan" with "normal Susan." This manner of self-referencing further suggests Susan's alienation from her perceived "true" self while abstaining from heroin and on psychiatric medications, indicating a sense of alterity to herself in this state and identification with her "normal" self when "high" on heroin. However, this mode of self-referencing was not common among other participants.

After returning to heroin use and experiencing increasingly distressing medication side effects, Susan eventually decided to more actively self-manage her medication use. She describes her medication self-management 1 month after her release from detox and return to heroin use:

Allison: Could you tell me about the appointment [at the mental health clinic] that you had after our last interview? You weren't feeling good on the meds, so I think you said you were going to work with them on your meds

Susan: Yeah. They… I went there and, um, they only prescribe Trazodone, Geodon, and Valiums. That's it, those three, and I sell the Valiums. I don't take 'em every day. Then, the other medicines are from the psych hospital. Nicole told me to not switch, to not use both medications from two different doctors. I'm doing medicine. But it's making me feel better, so…

Allison: Do the two different doctors know that you're seeing both?

Susan: No. So I'm playing the system, you know

Allison: But you're taking them and you said it makes you feel better?

Susan: Yep. Taking all the medicines together makes me feel much better. Like now I'm calm… I mean, I'm shaking my knee under the table; I always do that. But I'm calm and I'm… *lucid* – that's a good word [*laughs*]

Allison: How did you figure out that taking the meds together makes you feel better?

Susan: I just started taking 'em all, and I figured, well, if I get real bad side effects, then I'll stop taking whatever is new that I'm taking, 'cause I haven't taken the Trazodone and the Seroquel – on Seroquel I gain weight. As a matter of fact, I've gained about twenty pounds. Since we first started talking, I gained twenty pounds. I'm pissed off

When Susan resorted to active medication management independent of contact with psychiatrists, she described herself as "lucid," and she did indeed appear more coherent during this interview compared to others when she was adjusting to new medications and hardly able to walk on her own or sustain comprehensible conversation. Yet not long after this interview, she decided to take a full psychiatric medication "break," stopping all psychiatric medication use while continuing heroin use, in response to her recurrent and personally troubling weight gain. At this point she also began selling her multiple anti-psychotic medications to another heroin user who took them to sleep in response to heroin withdrawal-induced insomnia.

She described this medication break the following month as we sat in a fast food restaurant in her neighborhood. She had used heroin immediately prior to this meeting, but only enough to hold off withdrawal symptoms; she did not experience a "high." Despite the lack of "high" she was happy with her ability to get enough heroin to avoid the looming withdrawal symptoms that she pleadingly described as we arranged the interview earlier that morning. As she devoured her burger I asked her to describe how she was feeling. She pointed to herself, emphatically stating, "*this* is sober Susan," explaining that this is when she feels "normal," not when she is on her medications. She added, "I just took my medicine."

Discussion

The experiences described here highlight the complex and fluid nature of simultaneous psychiatric medication and heroin addiction as it is experienced in relation to biological, sociocultural, institutional, and political–economic factors. Susan, like other participants in this study, managed her mental illnesses and heroin addiction through actively seeking out the desired effects of the drugs available to her, both legal and illicit, to treat mental illness, manage heroin addiction, and achieve a perceived "normal" self. Physical considerations, such as the desire to avoid heroin withdrawal symptoms and unwanted effects such as weight gain, combined with social considerations, such as the desire to avoid blunted emotions and maintain an "exciting," "creative" life. These factors interacted with broader sociocultural, institutional, and political–economic contexts including the economic value of medications in the black market, exposure and access to addiction and mental health treatment, and the overarching cultural emphasis on psychopharmaceuticals to treat mental distress, to significantly alter both medication and heroin use patterns. These dynamics underscore the need to attend to the reciprocal

relationship between the psychotropic self/imaginary to fully understand the experiences of people with CODs.

In some ways the experiences of psychiatric medication use among participants in this study are similar to the experiences of people who are not addicted to heroin (e.g., discontinuing medication use based on personally troubling side effects (e.g., Sajatovic et al. 2011), self-medicating social suffering with psychopharmaceuticals purchased in the black market (e.g., Epele 2010), striving to achieve a "normal" self through medication self-management (e.g., Anderson-Fye 2009)). However, the experience is shaped in important ways by heroin addiction. Karp (1996) stresses that the experience of psychiatric medications "involves a complex and emotionally charged interpretive process in which nothing less than one's view of self is at stake" (102). For people managing psychiatric medications alongside heroin addiction, this fundamental interpretative process is further complicated. Susan's and other participant's experiences illuminate how heroin addiction significantly impacts interpretations of the "normal" self. After years of heavy heroin use, Susan's "normal" has become closely connected to a state where heroin withdrawal symptoms are prevented, and she manages her drug use in the context of this specific definition of "normal" driven by the physical and psychological dynamics of heroin addiction.

These physical and psychological dynamics shaping the "normal" self are, however, inseparable from the sociocultural dynamics of addiction. A long history of ethnographic studies of illegal drug use has emphasized addiction as a distinct, viable, and purposeful lifestyle providing one with a meaningful self-identity, often referred to as "the Life" (Agar 1973; Adler 1993; Bourgois 2003; Carlson et al. 2009; Hoffer 2006; Koester et al. 1999; Preble and Casey 1969). Susan and other participants in this study desired to maintain the "exciting" life associated with heroin use, and changes in heroin use (i.e., relapse) and psychiatric medication use (i.e., discontinuation) were often associated with efforts to maintain or reclaim this lifestyle. As Alverson et al. (2000) observe, "mental health clients, like others, consider substance use or abstinence in terms of a comparison level of alternative lifestyles" (567). Managing symptoms of mental illness is important to Susan, yet maintaining her perceived "normal" self inextricably connected with the physical, psychological, social, and cultural dynamics of heroin addiction, is primary.

Susan's narrative illustrates that people with CODs are not merely passive recipients of psychiatric medication treatment. Susan's drug self-management provides her the opportunity to assert some level of control in the context of an otherwise chaotic, unpredictable everyday life shaped by economic marginalization, social stigma, and trauma. This control, however, occurs in the context of broader structural and cultural dynamics that facilitate, and even encourage, the use of both psychopharmaceuticals and illicit drugs to modulate the self. In the current era of pharmaceuticalization, addiction and mental health treatment increasingly emphasizes pharmaceutical interventions despite the variety of contextual dynamics that shape the lives of people with CODs and the potentially useful alternative interventions available (Jenkins 2010a, b; Good 2008). In addition to pharmaceuticalization, neoliberal values have shaped the structure and delivery of health and social services. Bourgois (2010) writes that the marginalization of homeless heroin users in San Francisco has been exacerbated by retraction of the welfare state and

entrenchment of punitive neoliberal values of self-control. These highly vulnerable individuals are "deeply enmeshed in a mutually adversarial cycle of hostile interactions with medical institutions" (Bourgois 2010, p. 247). These dynamics are also reflected in the experiences of participants in this study who almost exclusively rely on publically funded addiction and mental health treatment and income-assistance programs to sustain themselves. For example, participants struggle to access SSI and psychotherapy by proving that they are "sick enough" and "responsible enough."

In this context, powerful psychopharmaceuticals are prescribed to these participants with limited meaningful, consistent contact with psychiatrists. When contact does occur, it is often contentious, as reflected in Susan's frustration with frequent medication changes without her consultation. A similar antagonism is evident in Mary, Ray, and other participant's interactions with drug detox, psychiatric, criminal justice, and social welfare institutions. However, akin to the treatment of illicit drug-using patients in other contexts, there is likely to be physician mistrust and uncertainty in how to treat these patients (Merrill et al. 2002). While this study did not explore the experiences of psychiatrists in treating patients with CODs, it does suggest that the structure and provision of pharmaceutically oriented mental health treatment is alienated from the realities of patient's everyday lives. Future studies are needed to better understand both provider and patient experiences of treatment for CODs.

Inconsistent access to mental health care and contentious relationships with health and social service institutions combined with economic instability to intensify mental distress. The local drug market provided the opportunity to self-medicate this suffering when legal avenues for obtaining psychiatric medications were unavailable or difficult to access. In this process, Susan and other participants developed a keen "pharmacological confidence" (Saris 2010) in choosing their own methods of chemical self-modulation. These dynamics fuel the creation and circulation of meanings that comprise the psychotropic imaginary.

However, it is important to recognize that the use of illegal drugs and black market psychopharmaceuticals to self-medicate is fraught with risk. In these situations, users have no way to know what substances they are actually receiving (i.e., the purity and dose of the drug) and risk arrest for use (Hanson et al. 2006a; Saris 2010). However, only a small number of participants (two) mentioned unwillingness or reluctance to purchase psychopharmaceuticals on the street because of uncertainty regarding the purity and dose of the drugs sold. This lack of caution is likely due to the weight of the psychotropic imaginary, the glut of pharmaceuticals in the black market economy, and the protracted process of obtaining these medications for mental illness through legal channels.

The combination of limited access to mental health care and this system's emphasis on pharmaceutical treatment of distress creates a complex state in which the conventionally conceived "drug problem" in the United States (i.e., the use of illegal drugs such as heroin) converges with "America's[11] other drug problem" (i.e., over-prescription and hyper-consumption of psychopharmaceuticals as well as non-compliance to prescribed medication regimens) (Applbaum and Oldani 2010).

[11] "America" refers to the United States of America.

These co-existing and inter-connected drug problems result in a flood of psychotropic drugs ("good" and "bad") on the streets and in the collective imaginary. However, this creates a paradox wherein people with CODs exist within drug-saturated environments, yet have restricted access to legally obtained psychiatric medications that might be safely used with medical supervision to treat their diagnosed mental illness. This restricted access mirrors limited access to psychiatric medications in the global south (Good 2010). Luhrmann (2010) observes that for community psychiatry clients, "stories of redemption are often accounts of forsaking the (bad) drugs and accepting the (good) medication" (180); the narratives described here underscore how the realities of drug availability and treatment dynamics complicate such redemption.

Conclusions

This analysis provides the opportunity to extend our understanding of psychiatric medication "compliance" by humanizing this experience as it occurs alongside heroin addiction in contexts of everyday life. Thus, this article contributes to "the advancement in medical anthropology from a prior focus mainly on the doctor-patient relationship towards the analysis of non/compliance as a dynamic, fluid and multi-stakeholder set of exchanges that occur within and beyond the clinic" (Applbaum and Oldani 2010, p. 120). This analysis also contributes to increasing conversation between psychological anthropology and the anthropology of illegal drug use by focusing on the complex inter-connections between psychopharmaceutical and illicit drug use at the junction of the self/imaginary. As we have stressed, people now live in a world saturated with psychopharmaceuticals. Psychological anthropologists provide critical knowledge of how the pharmaceutical imaginary associated with this saturation relates to subjectivity (Jenkins 2010a). Our expansion of the pharmaceutical self/imaginary to include the variety of psychotropic drugs that operate in the lives of people with CODs links psychological anthropology's focus on subjectivity to the long history of anthropological studies of illegal drug use that underscores the structural forces that shape the definitions, contexts, and lifestyles of illegal drug use. These perspectives are particularly important to unite when considering people with CODs since this population is highly vulnerable, difficult to access, and often alienated from treatment systems. Given the significant physical risks associated with mixing psychiatric medications and illicit drugs, the high stakes for fundamental conceptions of the self, and the increasing presence of psychotropic drugs in everyday life, there is an urgent need to better understand this experience.

The narratives presented here also contribute to critiques of the structure and delivery of mental health treatment. For some time, scholars have critiqued the biologization of psychiatry stressing the objectification of individuals through bio-determinist models of mental illness without addressing the sociocultural and political–economic contexts of their distress (Lovell and Scheper-Hughes 1986; Scheper-Hughes and Lovell 1986). The sole emphasis on psychopharmaceuticals to treat mental illness experienced by participants in this study reflects the continued

bio-centric focus of psychiatry despite the myriad contextual factors influencing the lives of people with CODs. Our focus on the subjective experience of this psychopharmaceutical treatment in relation to what comprises the psychotropic imaginary underscores not only the inadequacy, but also the dangers of pharmaco-centric psychiatric treatment. Participants in this study use the drugs available to them to attain their "normal" self, a self constructed in the context of addiction, despite the dangers of this use. Yet the biopsychiatric treatment they receive is alienated from this self, uncovering a fundamental paradox. Both psychiatrists and patients seek to achieve a "normal" patient self, yet their definitions of "normal" diverge dramatically. When the patient's "normal" hinges on the self that is constructed in relation to the complex dynamics of addiction, and treatment centers on the self as a biological subject, how is "successful" treatment defined? How can mental health treatment for people with CODs account for these disparate perspectives and treatment goals?

Consistent with previous research, the experiences recounted here strongly suggest that integrated addiction and mental health treatment is more effective than separate treatment systems (Drake et al. 2002) given the close connections between mental distress, addiction, and the use of a variety of psychotropic drugs to manage the self. These dynamics draw attention to the critical importance of a treatment approach that confronts the complex, inter-connected biological, psychological, sociocultural, and political–economic influences on CODs that shape the most basic experience of one's "true" self. Moreover, providers must recognize that many people who are addicted to illegal drugs such as heroin will likely continue this drug use alongside psychiatric medication treatment. This reality calls to attention the need for harm reduction approaches that do not center on the illusion of complete abstinence from heroin use. Heroin-assisted treatment is one such approach that has been proposed in response to critiques of methadone treatment and implemented elsewhere among chronic opiate addicts (e.g., in Switzerland) (Bourgois 2000; Drucker 2001; Kuo et al. 2000; Rehm et al. 2001), yet the ethics, safety, efficacy, feasibility, and meaning of such an approach for people with CODs simultaneously taking psychiatric medications is unclear. However, alternative approaches are in need of consideration. What this and other research makes clear is that when pharmaceutical interventions occur, they must be accompanied by psychosocial interventions and community social supports that address the struggles to achieve a "normal" self so inextricably entwined with addiction.

To conclude, to understand concurrent psychiatric medication and illegal drug addiction we must understand one's life as a whole (Alverson et al. 2001). Drug use is closely connected to complex contextual factors that are inextricably linked to one's sense of self. This article presents an exploratory effort to understand the complexity of psychopharmaceutical and illicit drug use in relation to the self and the sociocultural, institutional, and political–economic factors that constitute the psychotropic imaginary. Future studies are needed to further understand this phenomenon and its implications. Through these efforts, we can re-humanize the individuals who take these powerful drugs, but whose experiences are too often ignored or misunderstood.

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