ADDICTION RHETORIC: CONCEPTUAL METAPHORS IN CONVERSATIONAL ILLNESS NARRATIVES

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by

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DEDICATION

Dedicated to Diane Gail Patton, that is, Dr. Diane. Mom, you've earned a doctorate in Motherhood, still caring for me, and now my own children, while I've pursued my studies. There are no words. My love always.
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A very warm thank you to Dr. Ann Laurella Difrangia who suggested a study in addiction during a routine exam I had with her. She was always receptive to me as a human being, which led me to realize the importance of communication that expressed and responded to as much of the whole-person patient as possible during the doctor/patient interview. Thank you to Dr. Charles Misja, the participant doctor in my study, who took time and care to discuss addiction with me after allowing me to observe his interactions with patients. His willingness to help individuals with addictions and related problems runs deep, and I admire his patience and dedication to the individuals for whom he works. To his patients who allowed me to study their conversations: a tremendous thank you. From my observations of patients' need and desire to be well, and the tenacious human spirit that perseveres despite the odds, I hope to work within the field of addiction studies. Each individual who willingly permitted me a glimpse of his/her vulnerability and pain allowed me the opportunity to study more than addiction rhetoric. I saw first-hand how drugs and alcohol can damage one's sense of self, and also how, with proper care, one can rebuild wellness. This speaks to the awesome power of rejuvenation latent or active within each human being. I offer a genuine thanks to each
medical practitioner who strives to call forth a patient's unique will to engage this power of rejuvenation.

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CHAPTER 1

Introduction of Problem & Study

My research began three years earlier with a passing comment to my family physician: “I'm interested in health and illness and want to consider researching language within medical rhetoric.” I was comfortable with this doctor, with whom I'd been meeting the past decade. She was always open to hear stories of my life, to understand me emotionally and physically. While she, like other doctors, budgeted the valuable minutes we shared, she did so with a keen ability to interpret my utterances on emotional and physical well-being in symbiotic relationship. For example, I later picked up my medical records from her office because she had moved full-time into addiction work; there were many notes regarding anxiety written alongside my comments throughout the years during all sorts of visits. She had an ability to tie together the workings of my body in relationship to social situations in my life. For example, she listened to my complaints of a sinus infection and also heard the pains of having in-laws move from Russia to the States. At that session, she watched my two small boys bounce around the exam room and she seemed to understand more than I complained of, as evidenced when she suggested mothering wasn't always easy. With this fuller story in her mind, she counseled me as she was able. She seemed to take seriously my complaints of digestive problems. However, she encouraged me to seek counseling as a way to deal with stress and anxiety,
even as she also referred me to an internist. Interestingly, when I met with the internist, she listened to my narrative only to segue into a number of wasteful tests, going so far as to say that it would be good if I had HIV, which I did not, because then we'd know the root of the “problem.” She added that there were many good medications now for HIV. I realized then, as I realize even more now, that doctors' utterances shape the narrative shared with the patient. And I wanted to understand from a rhetorical perspective how this interaction worked.

I initiated this inquiry in a particular setting: a methadone clinic in the Midwest. I wanted to investigate conversation between a doctor and patient in the clinic for two main reasons. I wanted to understand how each conceptualized addiction and how each one's language demonstrated his conceptualization. Second, I wanted to study the doctor's and patients' conversations to see how responses between the doctor and patients operated. More specifically, I had experienced the role of my own emotion within the patient-doctor interview and the importance of my doctor's response to it. I wanted to investigate whether a doctor responded to his patients' emotions, the doctor is in fact male, how so, and to isolate the rhetorical effects on the conversational narratives.

I began to design a qualitative case study in which I would transcribe 20 conversations between one doctor and his patients, eight men and 12 women between the ages of 22 and 50. Each patient would be asked by the receptionist if s/he would be willing to participate when he scheduled his/her appointment. If so, before the session, s/he would be issued a consent form. I would meet weekly with the doctor to ask questions and discuss observations after audio-recording the conversations.
My study became a study of the rhetoric of addiction in which I investigated the doctor's and his patients' manner of thinking about addiction by their conceptual metaphors in their conversations. In this dissertation, I investigate the manner in which patients and their doctor speak of addiction. More specifically, my study shows how one doctor and twenty patients characterize addiction with their utterances of emotion, thought, and activity and with their responses to each other during conversations within patient-doctor interview sessions. I borrow Conceptual Metaphor Theory (CMT) from George Lakoff and Mark Johnson (1980), see below, and apply it to my data. Using CMT, I code the metaphorical expressions, or utterances, in my study as disease or illness experience. I find that the doctor typically speaks of addiction as a disease, and the patient typically speaks of addiction as a personal illness experience.

However, the doctor at times characterizes addiction as illness, and the patient at times characterizes addiction as disease, and these exceptions occur with certain patterns of response. In the typical conversation, modifications of the conceptual metaphors deployed by the doctor and patients suggest a change in how the participants respond to the topic addiction and to each other. Furthermore, with their utterances and responses, the doctor and patient ultimately construct a conversational illness narrative.

My study examines communication patterns within the doctor's and patient's narrative and demonstrates how, in the course of their narrative, the doctor and patient construct a rhetorical position along a spectrum of consensus and resistance. Along this spectrum, there are times when the patient and/or doctor seem to understand the other and respond, and there are other times when the patient and/or the doctor do not respond to
the other. When the doctor or patient fails to respond to the other, the conversation becomes one-sided and the listener may resist the speaker's conceptual frame and fail to work with him/her and past addictions.

In the context of my study, “addiction” is one's personal experience of mental and physical illness from chemically altering one's own consciousness. Therefore, my study of the rhetoric of addiction observes first and foremost that addiction is conceptualized by embodied experiences. One understands addiction from the particular lived accounts one has had with it. Clearly, the doctor's studies and the wider medical community with whom he associates frame his understanding of addiction. In contrast, the patient's on-going personal experiences with addiction frame his/her understanding, and s/he is informed by the doctor's perspective on his condition. Therefore, the patient is vulnerable and developing his/her sense of the disease, while the doctor is sure of what addiction is and what needs to be done. Furthermore, a patient's communities, including friends and family, affect his/her perspective, which can be at odds with the doctor's perspective. Because the patient is informed by others' perspectives and doesn't yet have a decided perspective on addiction, contradictory suggestions can cause confusion. As a result of their different positions with respect to illness, the doctor's and the patient's conceptual metaphors underlying these expressions are different.

My study demonstrates that the doctor and patients use different metaphors to express themselves. As stated above, the doctor typically speaks of addiction as a disease, and the patient typically speaks of addiction as a particular illness experience. Given these different characterizations, the doctor focuses on assessing the patient's body while
the patient expresses his/her emotions and thoughts as related to the experiences of his/her body. The doctor and patient speak of the patient's body, but their metaphors come from different conceptual frames. While the patient's utterances are primarily of his/her emotions and thoughts, the doctor's utterances are primarily about assessing the patient's body. As a result, the doctor's and patient's communication leads to ineffective care of the patient's whole body and mind and problems related to the patient's addiction(s).

**Conceptual Metaphor Theory**

Lakoff and Johnson's CMT is central to my research on patients' and their doctor's utterances because their theory suggests a way to understand each one's conceptual metaphors. Furthermore, their theory of conceptual frames and mapping helps me to explain how I understand the doctor's and patients' language as evidence for their thoughts and related emotions.

Current scholarship understands metaphor as a cognitive device (George Lakoff and Mark Johnson, 1980), rather than an element of style, as the traditional interpretation holds. As I detail below, conceptual metaphors are based on expressions that emerge from the words we speak.

In cognitive linguistics, conceptual metaphor refers to the understanding of one idea, or conceptual domain, in terms of another. Such domains can be any coherent organization of human experience; for example, the notion that up is good and down is bad, which I explain below. Furthermore, a conceptual metaphor uses one idea and links it to another to better understand that notion. Moreover, different languages employ the
same metaphors, and this has led to the hypothesis that conceptual domains correspond to neural mappings in the brain (Johnson and Lakoff, 1980). Conceptual metaphors are seen in language used everyday and shape the way we think and act. However, people are unaware of their conceptual metaphors and the effect their usage has on framing discourse.

In CMT, understanding is “embodied,” and this means that an elaborate system of conceptual metaphors lies at the core of our human mind, providing an underpinning for our imagining, knowing, acting, communicating, and creating. This system of conceptual metaphors, grounded in physical and social experiences, is a means by which one uses experiences of one thing to not only explain something else, but also to actually experience something else. In this way, metaphors shape one's experiences and in so doing generate meaning by providing coherence and structure to thought. A metaphorical structure of human thought suggests that metaphors are capable of providing new meaning to the past, to daily activity, and to what is hoped for in the future. Thus, metaphors have the ability to generate new realities. Lakoff and Johnson labeled this phenomenon “embodied metaphor” and it influences the way individuals' think and act.

This dissertation understands embodiment as the way in which one's emotions and experiential knowledge affect how one understands and comments on the world. For example, the statement “I am feeling up today,” reflects an individual's sense of his/her physical location from the Western perspective where God is on high. An individual's conceptual metaphors are cognitive devices because they aid communication in two predominant ways. First, one uses conceptual metaphors to express his/her
conceptualization of ideas. Second, one can better understand the speaker's point of view by paying attention to his/her metaphorical expression. Conceptual metaphors are thus linguistic tools that shape life experience in concrete, physical ways.

This chapter introduces my study of how the doctor and his patients conceptualize addiction. In this study of conceptual metaphors, the doctor and a patient respond to each's utterances and construct a narrative. Each conversation between the doctor and a patient is conceptualized as an illness narrative in my study. In the typical conversation, modifications of the conceptual metaphors deployed by the doctor and patients suggest a change in how the participants respond to the topic addiction and to each other. My study focuses on this rhetorical change and how it effects communication between the doctor and patients.

My project began as an inquiry into the rhetorical dimensions of communication between a doctor and patients regarding the treatment of addiction. What emerged from the initial inquiry is not only a study of health communication or medical rhetoric, but an investigation of socially constructed life narrative in which the conversational partners display conceptual metaphors to control and construct addiction and the patient's own identity in the context of addiction. To contextualize my research within a body of relevant scholarship, chapter two reviews studies in addiction, health and communication, metaphors in medicine, disability and communication, life writing and identity, as well as research in illness narratives within medicine.

In chapter three, I present my data and methodology, including my specific research questions and steps of analysis. Chapter four presents my findings and
represents my data analysis and warrants for the claims that follow. In chapter four, I present a summative tabulation of the data in my study and illustrate the most frequent utterances in my data, thought and then emotion, with an additional table. Two narratives are included in chapter four to illustrate the rhetorical patterns in my data. Chapter five interprets the findings in my study and illustrates the rhetorical patterns evidenced in the data by referring to the conversational narratives themselves. With the narratives, I show when the doctor responds to the patients' sense of self, which is communicated by the patient's utterances of emotion and thought. Additionally, I demonstrate when the patient and doctor construct a rhetorical position that persuades each to validate the other's conceptualization to some degree. In successful conversations, the doctor and patient linguistically move towards agreement rather than resistance. In the final chapter, I state the study's contributions and limitations, present a personal future research agenda, and suggest discussions to follow this research.
CHAPTER 2

Literature Review

My study of addiction rhetoric examines conversations between a doctor and patients in a methadone clinic as socially constructed illness narratives. Each one's responses in this conversation arise from embodied, or everyday, lived experiences which shape each's concepts. Lastly, both the patient's and doctor's narrative is rhetorically structured by their utterances of emotion, thought, and activity, as well as responses to each other. To be clear, the subject of narrative in these conversations is the body. The patient discusses his/her emotional and physical pains to the doctor, and the doctor listens and responds to the patient. However, the doctor tends to respond to what the patient says about his/her ill body, thus paying little attention to the patient's emotions. The patient's utterances on his/her emotional well-being express the patient's sense of self, which is his/her identity. The manner in which the doctor addresses or does not address the patient's identity is established and constrained by the fact that the doctor's focus is the body, despite patients' utterances that are frequently on emotions. When the narrative is controlled through the discipline of the doctor, or the manner in which he does or does not respond to the patient, then identity is also regulated. However, the patient can affect the doctor's discipline by the patient's manner of response to the doctor.
Given the situation and general patterns of the conversations studied in this dissertation, the relevant areas of research are studies in addiction, studies in health and communication, studies of metaphors in medicine, studies in disability and communication, studies in life writing and identity, as well as studies in illness narratives within medicine.

**Studies in Addiction**

As in studies of health, communication, disability and communication, recent scholars of addiction\(^1\) situate addiction in the context of wider cultural and environmental frames. Addiction is itself, in these studies, socially defined. Using social models of healthcare, researchers understand that definitions determine norms for being ill and well, and, therefore, frame identities of those diagnosed.

In his study of mental illness and addiction, Howard Kushner (2010) argues that addiction is not for a narrow population of “addicts” but is more appropriately understood as a syndrome that could affect many (p. 19). Kushner argues that mind-altering substances, including smoking, have been used as self-medication for a variety of ills throughout the centuries (p. 20). In fact, he claims, disorders of consciousness, including both major and minor psychiatric disorders, are rooted in interaction between culture and biology. Mental disorders cannot be understood outside of this interaction. He says, “[A]ddiction is one possible outcome of humans' drive to alter consciousness; what we label 'addiction' might be understood as a possible consequence of the human desire to

\(^{1}\) For relevant sources on addiction, see Caroline Acker (2010) and Michael Windle (2010), included in my references.
alter consciousness” (p. 20). Likewise, addiction medicine specialist Daryll Neil aptly notes that all people are addicts to the extent that learning itself requires that we master repeat behaviors that initiate reward systems in the brain (qtd. in Caroline Acker, 2010, p. 73).

Humans have used drugs of one sort or another for thousands of years. The early Egyptians used wine, individuals used narcotics from 4000 B.C., and Chinese used medicinal marijuana in 2737 B.C. In the nineteenth century, active substances were extracted from drugs and some of these newly discovered substances, morphine, laudanum, cocaine, were completely unregulated and prescribed freely by physicians for a wide variety of ailments. Additionally, such drugs were prescribed by physicians and patented and sold by traveling tinkers, or in drugstores, or through the mail. During the American Civil War, morphine was used freely, and wounded veterans returned home with it. By the early 1900s, an estimated 250,000 individuals were addicted to drugs in the United States.

The problems of addiction were recognized gradually and the use of narcotics and cocaine diminished by the 1920s. However, by the 1950s, there was increased use of marijuana, amphetamines, and tranquilizers, and in the 1960s it became more socially

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acceptable to use drugs, which led to lower legal drinking ages and decriminalization of marijuana in some states by the 1970s. However, the 1980s brought a decline in the use of most drugs, but cocaine and crack use soared. Additionally, the military became involved in border patrols for the first time.

Importantly, throughout the years, the public's perception of the dangers of specific substances changed. For example, the surgeon general's warning label on tobacco packaging gradually made people aware of the addictive nature of nicotine; and the recognition of fetal alcohol syndrome brought warning labels to alcohol products. Even prescription drugs and caffeine were investigated as addicting.

Conceptualizations of addiction have changed since they were first recorded. In the mid-20th century, withdrawal syndrome characterized addiction. Individuals were addicted when they were drug-dependent. Consequently, once withdrawal symptoms were gone, one was post-addicted (Acker, 1995). Today, Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV3) characterizes addiction4 with distinction

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3 Currently, the DSM-V is available; however, at the time of my study the DSM-IV version was in use only. The DSM-V takes into account environmental considerations associated with drug abuse and dependence, which illustrates contemporary social approaches in medicine. Furthermore, many more addictions are identified and classified. See http://www.psychiatry.org/dsm5 for details on the differences between the versions as well as the description of addictions in the DSM-V.

4 See the DSM-IV where addiction is described in the following manner:
   Substance Abuse Criteria
   Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period:
   Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household).
between drug abuse and drug dependence, stating that one cannot simultaneously abuse and depend on drugs but, rather, one is engaged in drug abuse or dependence. Drug abuse is characterized by individual's breech of social obligations with family and/or work, by legal problems, by breaking laws, and by interpersonal problems such as issues related to broken relationships with significant others in one's life. Such characterization is social;

Recurrent substance use in situations in which it is physically hazardous (such as driving an automobile or operating a machine when impaired by substance use)

Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct)

Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (for example, arguments with spouse about consequences of intoxication and physical fights).

Note: The symptoms for abuse have never met the criteria for dependence for this class of substance. According to the DSM-IV, a person can be abusing a substance or dependent on a substance but not both at the same time.

DSM-IV Substance Dependence Criteria

Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect or (b) Markedly diminished effect with continued use of the same amount of the substance.

Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance or (b)The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

The substance is often taken in larger amounts or over a longer period than intended.

There is a persistent desire or unsuccessful efforts to cut down or control substance use.

A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

Important social, occupational, or recreational activities are given up or reduced because of substance use.

The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or
one's drug use interferes with personal and at large communities. However, drug
dependence is characterized by physiological conditions such as the need to use more,
and more often; by withdrawal symptoms, such as the inability to stop using; by one's
psychological addiction, such as ceasing to engage with social activities; and by one's
harm to one's own body.

While the DSM-IV characterizes addiction as two separate states: abuse and
dependence, abuse being more social and dependence more physiological, my study
investigates the rhetoric of addiction to understand the personal, dynamic experience of
mind-body illness from altering one's own consciousness. Addiction, as it is characterized
by patients and their doctor in my study, is a disease affecting the body and mind, and it
is an illness experience unique to the person addicted. These characterizations are
discussed by patients and their doctor in a social context, and this context determines
what is acceptable and what is not. Therefore, my study is of the socially constructed
rhetoric of addiction.

Scott Vrecko (2010) argues that today one who is addicted is drug-independent,
and that addiction is less about the body-on-drugs then about general desires and risks of
returning to drug use. Furthermore, there are many kinds of addictions today, from
behavioral, such as eating and gambling, to psychological, such as obsessions, which, of

exacerbated by the substance, for example, current cocaine use despite
recognition of cocaine-induced depression or continued drinking despite
recognition that an ulcer was made worse by alcohol consumption.

American Psychiatric Association. 1994. Diagnostic and Statistical
Association. (pp. 181-183)
course, lead to behavioral addictions and often drug and/or alcohol addictions (p. 35). The DSM-IV characterizes addiction as a “chronic, relapsing brain disease,” and while this model frames addiction as a dysfunction of normal brain systems involved in reward, motivation, learning and choice, Vrecko and Howard Kushner (2010) merge biological research with social science. By so doing, they add to the above model, rather than dismissing the perspective as neurobiological reductionism.

For example, Kushner suggests an integrative “cultural biology of addiction,” which aims at encouraging a continuing dialogue between neuroscientists and those engaged in social studies of addiction. This cultural biology of addiction provides an alternative framework that brings together seemingly contradictory social-constructionist and biologically reductionist claims about addictions. Kushner argues historians, sociologists, and anthropologists of addiction collectively say classification of licit and illicit substances tell more about social norms and power relations than “psychopharmacological properties of substances” (p. 16). For example, alcohol prohibition and criminalization of narcotics and stimulants reflect dominant cultural values, not science (Levine, 1978; Kushner, 2006, p. 10 qtd. in Kushner p. 16).

Kushner frames the history of addiction within the first methadone clinic in 1965 in New York City. Then, individuals with addictions were thought to be incurable. He argues that addictionologists, and society in general, have failed to notice how addictive human behavior is; therefore, behaviors have been reconstructed as “addictions” (p. 17). Current scholarship recognizes that “addictions operate through a combination of cultural
and social constraints as they interact with biological mechanisms of substances and behavior” (p. 18).

In a similar vein, Vrecko contributes to cultural theorizations about the regulation of deviant forms of thought and behavior through an analysis of scientific accounts of, and approaches to, managing “behavioral addictions.” He argues that much cultural analysis assumes that biomedical formulations of addiction simply provide a scientific facade for forms of social control but that social change could be strengthened by biomedical descriptions of people, emotions, and behaviors emerging within theories, therapies, and popular science representations that frame behavioral addictions as brain diseases (p. 36). He argues against conceptualizing behavioral compulsions as diseases and therapeutic interventions as “treatments.” Rather, it is more accurate to describe addiction interventions used to produce better citizens, rather than to cure biological diseases, as “civilizing technologies.”

Vrecko claims that definition is a construct to purify and stabilize a condition for research, theory, and treatment, and any particular formulation of addiction and the practical conditions under which it develops are forgotten within a transcendent category. While definition is useful for research, it is harmful as it becomes a part of the ruling relations of society “mistaken as a neutral means for ordering social life and imposing

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5 Vrecko's notion of “civilizing technologies” are various means of fostering acceptable social behaviors, determined good or bad by society, in place of problematic behaviors resulting from cravings and desires. Importantly, his argument is for reconceptualizing such processes as civilizing technologies rather than treatments. Treatment has more of an institutional meaning, while civilizing technology suggests a process that all citizens engage in.
regimes of governance on individuals and groups” (Becker, 1963; Szasz, 1974; Bourgois, 2000; DeGrandpre, 2006 qtd. in Vrecko, p. 37).

Vrecko argues that behavioral addictions such as over-eating, sex, and gambling are problems from social and biological conditions. He concludes that addiction is a “hybrid' entity” (Latour, 1993) that combines a mixture of scientific, psychological, moral, technological, social and spiritual elements” (p. 37). Vrecko claims that by civilizing technologies, such as anti-craving medication and social therapy, people manifest states in which they are healthier and more able to adhere to responsibilities, obligations, and expectations of family and society. In these ways, they are better citizens. He argues against the possibility of another governing one's own will and instead for civilizing problematic cravings and desires. Conceptualizing the various means to this end as civilizing technologies carries a less institutional connotation than to name such processes “treatments.”

The above scholarship addresses addiction as a socially constructed phenomenon that is regulated by individuals' values, which reflect social norms of a time and place. The above scholars argue for ways in which society can understand individuals' physiological and psychological well-being. In the section below, scholarship in health and communication likewise argues illness is socially constructed, and how we understand disease is dependent, at least in part, upon communication practices.

**Health and Communication**
The following literature investigates perceptions of the patient and his/her arguments within the doctor/patient interview. In addition to Judy Segal's and Carol Berkenkotter's explicitly rhetorical studies in medicine, Arthur Kleinman's studies of patients' illness narratives as arguments demonstrate how medical meaning is constructed based upon the science of disease, the contestable nature of interpretation, and the social norms surrounding illness experiences. Segal (2005) notes a need in healthcare for a heuristic aimed at evaluating patients' illness claims, and Kleinman's work might be re-visited in response to her call. Therefore, Kleinman's attention to patients' cognitive styles, affective states, and verbal and nonverbal forms of communication serves as a heuristic useful for other healthcare providers.

Some literature in communication and health investigates how the patient is perceived and how the impression one has of the patient informs the perception one has of the patient's argument on his/her illness. In other words, one's narrative is socially constructed. From one's narrative, one communicates a sense of self, or identity. Medical rhetoricians Segal (2005, 2007) and Berkenkotter (2009), and psychiatrist and scholar in medical anthropology Kleinman (1988) examine perception within the patient-doctor interview.

For example, Segal (2005) offers one of the few rhetorical studies on persuasion in health and medicine. She argues that non-compliance is an “endogenous” feature of Western medicine because the biomedical model “denies the preliminary conditions that are necessary for persuasion to take place” (p. 138). Patients are expected to obey their doctor; however, Segal argues patients should be persuaded to adhere to their doctor's
recommendations. Additionally, she argues that patients share their narratives of illnesses to persuade the doctor of the patient’s illness experience.

Segal demonstrates how individuals with illnesses are influenced by “power of persuasion” (p. 138). For example, hypochondriacs are vulnerable to media hype, anorexics are susceptible to public scrutiny, and migraine sufferers are tainted with the history of the “migraine personality.” Segal explores persistent health conditions that resist conventional medical solutions and analyzes how patients and their illnesses are formed within the physician/patient relationship. She argues, the intractable problem of a patient’s rejection of a doctor’s advice can be considered a failure of persuasion, and the central point in care revolves around “issues of who is qualified to give advice and what are the warrants for taking it” (p. 134).

Segal examines the discourse of medicine in case studies and argues that illnesses are described in ways that limit patients’ choices and hinder their satisfaction. Furthermore, she investigates psychiatric conditions, infectious diseases, genetic testing, and cosmetic surgeries through the lens of rhetorical theory. Segal highlights the persuasive element in diagnosis, health policy, illness experience, and illness narratives. She also addresses questions of direct-to-consumer advertising of prescription drugs, the role of health information in creating the “worried well” and problems of trust and expertise in physician / patient relationships (p. 135).

Additionally, Segal (2007) argues for rhetorical analysis of patients' problems. She claims that analyzing types of arguments will focus attention away from categorizing types of patients. Doctors could focus on patients' arguments rather than evaluating
patients as difficult or malingering. She states, “My point is that, when physicians need to respond to contestable complaints, types of arguments make a more fitting object of study than types of patients. The goal of the study of arguments is to establish agreement among experts about what constitutes a good case for illness deserving care” (p. 229). Her focus is on the patient as a person who is suffering, rather than on the individual as a “difficult patient.” Segal explains her rhetorical approach is “[a] theory of interaction as persuasion, persuasion as argumentation and argumentation as a series of claims adding up, or not adding up, to a conclusion of illness” (p. 238).

Berkenkotter's *Patient Tales* (2009) adds to Segal's research on perception within the patient / doctor interview by employing rhetorical methods and discourse analysis to the case history narrative. She uses a multimodal research approach and attends to macro and micro levels of discourse analysis to contextualize the case history and semi-structured interviews with therapists and to triangulate the data. Berkenkotter studies two historical eras, the Asylum Age and the era of Biomedicine, arguing that in 250 years, two paradigm shifts occurred. In the first era, she argues that humanist notions foregrounded the world of meanings, including patients' narratives. In the second, that is the still prevailing biomedical era, empiricism foregrounded the world of matter, and evaluation of patients depends upon objective evidence. Thus, the two eras in the history of medical care are characterized as humanistic and scientific and are often thought to be at odds, presenting tension within medical practices where science and the humanities are wed (p. 98).
She studies the Asylum Age in the eighteenth and nineteenth centuries of England and Scotland as producing the earliest form of the case history narrative to show how the genre has acquired a conventional structure, style, and lexicon over the last 250 years and has become the standard form of reporting in medical and clinical psychiatry. The early case history was institutional record-keeping, and it recorded, in addition to patient's conditions, asylum patients' keeper's abuse. Berkenkotter's research leads to the second era of biomedicine where she argues, “[T]he case history in Freud's hands became a vehicle for representing the theory and methods of psychoanalysis, a new science of the mind” (p. 100). She illustrates how doctors have used patients' own words as an integral part of the case history, providing mental health providers language to diagnose and treat illnesses. Berkenkotter furthermore notes that the case history is not merely the psychiatrist's report but rather is a “double narrative” by which a patient tells his story and then, using reported speech, the psych professional creates a re-contextualized case history. This text is constructed from the patient's presentation, which is a narrative of the history of present problems. Additionally, one records the patient's observable bodily symptoms in this text that becomes part of the patient's medical record.

Unlike the above rhetorical studies that examine documents, Kleinman's anthropological research of illness narratives (1988) highlights the importance of response between doctors and patients. This work relates to my study on the doctor's and patients' utterances, responses to one another, and social construction of a conversational illness narrative. He argues that the doctor/patient interview is an exchange of arguments, and that “persuasion fails because the doctor is able to produce evidence of disease, but
unable to produce evidence of absence of disease” (p. 229). In this way, Kleinman complicates the practice of diagnosis and illustrates the importance of listening to patients; however, he argues that patients may fail to persuade the doctor because they are too willing to say “I'm sick as no one else has been before” (p. 229). He calls this an argument of uniqueness which fails because doctors expect illness experiences to fall within the conventions of nosology. Interestingly, he notes that patients, regardless of whether they realize it, are active participants within socialized norms. In other words, patients and doctors communicate with one another in ways that each assume the other will find acceptable, and when patients declare they are sick in a different way, that is, a way unexpected by the doctor, then the patient risks the doctor's rejection of the authenticity of the patient's condition. However, my study shows that the patient persuades the doctor to reconsider the patient's condition in some cases. This occurs when the patient responds in a manner that engages the doctor, as demonstrated and explained in chapters four and five.

The patient has to present a sense of self, his/her thoughts and emotions, that the doctor finds credible for responsiveness to occur between them. However, mentally ill patients often do not have credible ethoi. Patients who continue to suffer and incessantly declare their illness, despite doctors' tests that show no abnormality, are often considered psychologically ill. Kleinman studies such patients who have exhausted resources of biomedicine, though they continue with disorders affecting their bodies, said to be a result of mental problems. In Kleinman's research of patients with psychosomatic disorders, or physical problems resulting from psychological distress, he argues that
patients have failed to persuade their doctors of their illnesses (p. 232). In such cases, he argues that patients should therefore make stronger arguments. Kleinman argues that patients' arguments could improve with strong reasons presented to their doctors, and then their illness claims would be more thoroughly addressed (p. 235).

In Kleinman's work with patients and their chronic illnesses, the “reality” of pain is under investigation. The patient claims his/her pain, but tests fail to diagnose a disease or other reasonable causes. Therefore, treating the patient's pain is problematic. In such a situation where the doctor cannot explain the problem and the patient cannot accept that there is no problem, neither the doctor nor patient has the perspective to respond to the other. Elaine Scarry notes the tension between a patient and the doctor in such a situation:

For the person in pain, so incontestably and unnegotiably present is it that 'having pain' may come to be thought of as the most vibrant example of what it is to 'have certainty,' while for the other person it is so elusive that 'hearing about pain' may exist as the primary model of what it is 'to have doubt.' Thus pain comes unsharably into our midst as at once that which cannot be denied and that which cannot be confirmed. (Elaine Scarry, 1985, p. 4).

Kleinman describes psychosomatic disorders as personal problems of identity and relationships. He argues that patients' pain is a real result of emotional problems.

[The patient's disorder is a] physical idiom of distress and a pattern of behavior that emphasizes the seeking of medical help […] it is a] sociophysiological continuum of experience: at one end are cases in which patients complain of bodily ailments in the absence of any pathological bodily processes […] at the
other end are cases in which patients who are experiencing disordered physiology of medical or psychiatric disease amplify beyond explainable levels their symptoms and the impairment in functioning those symptoms create, usually without being aware of their exaggeration. (p. 57)

According to Kleinman, there are acceptable ways of describing pain and suffering; indeed, the way a patient communicates his/her experience of pain enables the doctor to understand his/her personal illness experience.

Interestingly, Kleinman's study considers the ways a patient delivers his/her illness narrative in order to persuade the doctor, and others in his/her life, of his/her illness. He studies the patient's cognitive style, affective state, and verbal and nonverbal forms of communication. He argues that doctors contribute to somatization by confirming patient's suspicions and medicalizing personal or interpersonal problems, but ignoring the stress that caused the complaints. Additionally, families encourage certain forms of complaints. For these reasons, and others, a patient feels pressure to convince others of his/her pain and will not accept psychosocial explanations.

Kleinman argues scientists resist discussing the meaning of pain, a subjective entity. Furthermore, “the science of pain must include social science interpretations together with biomedical explanations. It must bring to bear knowledge of the economic, political, and social psychological sides of pain” (p. 73). Importantly, Kleinman observes the limits of interpretation and notes that validity of an interpreted narrative relies on correspondence to reality, coherence, usefulness in the context of a person's problem, and, most important for the clinician, the aesthetic value of the patient's narrative.
My study understands addiction as a mental and physical disorder and extends Kleinman's work with patients' pain and communication with their doctor. My study adds the notion from Conceptual Metaphor Theory that speakers' utterances arise from one's conceptual frame, which is shaped by mental and physical situations such as time and place. Furthermore, one's embodied situation affects one's conceptualization and resulting utterances. Communication between a doctor and patient depends upon each's response to the other. The patient's utterances of thought and emotion express his/her sense of self and illness to the doctor, and the doctor's perspective of the patient depends upon his interpretation of the patient's identity. The doctor's and patient's communication is contextual and depends upon two rhetorical principles in this study: conceptualization and persuasion to respond to the other.

**Studies of Metaphor in Medicine**

In my study, I follow CMT's argument that conceptual metaphors arise from individual's frames of understanding. One understands the world by both his/her reasons and his/her emotions. I maintain the value of metaphor as a cognitive device that reveals the manner in which one conceptualizes the world in which he lives. My research on metaphor comes from a value-less domain. Rather than arguing for or against the use of metaphor in communication between the doctor and patient, I argue, using CMT, that conceptual metaphors arise from one's embodied condition. I study utterances in order to understand the social construction of the conversation, how conceptual metaphors are deployed and implicated in the construction of what becomes an illness narrative.
Metaphors have been studied in research on health and communication and two predominant arguments exist: metaphors aid communication in revealing ways to understand concepts, or, metaphors needlessly, or even intentionally, conceal understanding of disease. Here again, the manner in which one interprets metaphor depends upon the social situation. That is, a myriad of factors follow from the degree of personal attachment one has to the illness and the doctor and the manner in which one interprets the communication experienced with the doctor concerning the illness.

The following studies of metaphor argue that metaphors shape understanding, rather than arise from a conceptual frame, and serve as a communication tool that enables patients to understand disease by a more familiar concept. Susan Sontag argues illness should be discussed in “literal” terms because metaphors conceal aspects of disease, which rends patients more vulnerable than if they had a clearer understanding of their illness.

In the following four studies of metaphor and pulmonary disease, cancer and genetics, as well as medicine in general, scholars demonstrate how metaphors shape understanding. In the first study, doctors use metaphors to help patients understand their health. Rhetorician Sara Newman and physicians David Longworth, Alejandro Arroliga, and James Stoller from The Cleveland Clinic Foundation investigate how pulmonary physicians use metaphors to enhance communication with their patients (2002). They argue: “[m]etaphors can facilitate communication because they render new concepts in familiar terms” (p. 376).
In the following study, Geraldine van Tongeren (1997) argues that scientific facts do not originate from passive observation of reality; imagination helps the unknown become knowable. Furthermore, established metaphors can inhibit nuances because metaphors highlight and hide aspects of a given concept. Language frequently used may no longer help one understand the experience of their bodies and the disease. Metaphors in medicine are understood as cognitive and communicative instruments, argues Tongeren (p. 132). She analyzes texts from recently published medical handbooks and reveals what kind of metaphors are used to structure certain medical concepts. Metaphors enhance communication by providing a frame of conceptualization, but a different frame would result in different meanings, she states (p. 133). Tongeren's research demonstrates how doctors' and patients' communication practices are subjective and yield particular, socially situated meanings. This aspect is particularly valuable to my research because it highlights how individuals interpret concepts and make meaning depends upon many factors and meaning itself is subjective.

How individuals perceive concepts affects the meaning of their experiences. For example, if one thinks of language as suggestive of truths, they will perceive what is said about their illness as part of what is true for them. However, if one perceives language as a tool to communicate objective Truth, then they will expect language to effect the reality of disease. Understanding that one's truth depends on one's conceptual frame changes the

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6 I believe “Truth” is constant and objective. However, my point here is that individuals' perception of Truth is subjective. For example, the universe exists, but I can only see a fragment of it, and my understanding depends upon many factors including my experiences walking, breathing, looking up into the sky, imagining what is beyond the stars, and believing in God.
argument philosophers have had since the time of Aristotle about whether metaphors reveal or conceal truth. This argument continues to be important as individuals seek meaning of their illness experiences, particularly as they consider how their lives fit into their conceptualizations of the world.

According to Sontag, the healthiest way to be ill is to use literal language to explain the disease. Sontag studied cancer metaphors to explain the feeling she had of being shamed and silenced when she had cancer. She argues that metaphors can render disease physically and socially mortifying and that metaphors shape public perception of neoplastic diseases (p. 130). She means by this that metaphors veil the reality of what it means to have cancer in concrete, real ways. She goes so far as to argue that silencing discussion of illness, with metaphors, is a conspiracy (p. 130).

Metaphors suggest that illnesses have symbolic meanings, and some scholars think that this is important because it helps individuals to question, and in some cases to realize, life meanings. For example, medical historian Barbara Clow (2001) studies Sontag's book, *Illness as Metaphor* (1978), and counters Sontag's claim that diseases should be discussed “literally.” Importantly, Clow claims that one cannot strip illnesses of symbolic meanings, and metaphors must be studied in context to understand their implications. Clow argues that when communicating about one's experience with disease, symbolic language benefits literal language by expressing emotions and other embodied experiences. She notes that language used to discuss embodied knowledge transforms the disease, and can also contribute to medical policies (p. 115).
Metaphors depict underlying conceptualizations, and these can be problematic. Clow disagrees with Sontag's observation that the ill are silenced by others' uses of metaphor, and she argues that any life experience can be an occasion for assigning fault, not only cancer. People are not silenced or disgraced by the metaphors used in discussing their illnesses; rather, because of fear of a bad diagnosis, people may hesitate to talk about their diseases. To Clow, metaphor is not the problem but one's cultural uses and applications of metaphors that depict problematic underlying conceptualizations.

My study is concerned with metaphors as these express individuals' thoughts and emotions regarding addiction. Thoughts and emotions reflect social norms, however, and one's personal utterance reflects the values of a given society, as well. With this in mind, research by rhetorician Celeste Condit (2009) is relevant to my study because she argues that one's metaphors communicate one's emotions and depend upon social norms. One's metaphors are interpreted against the “appropriateness” and value of things.

For example, Condit analyzes dynamic feelings, or those that include more than one emotion, associated with metaphors used to discuss genes and form genetic policies. She argues that metaphors are social, rather than cognitive, and in her study of interviews with non-geneticists about preferred metaphors for gene-environment interaction, she found that dynamic emotions were involved. She determined which metaphors were used, particularly whether the metaphors “virus” or “disease” were used rather than “map” or “blueprint.” Condit argues that social scientists should analyze metaphors for the emotions associated with a concept because emotion is as important as reason in the process of constructing meaning. Emotion works as a rational analogical structure, by
which she means that components of metaphors align to components of an object. Therefore, according to Condit's analysis, reason and emotion work together and metaphor expresses both emotion and reason.

My study agrees with CMT that emotion and reason are interrelated and affect one's conceptual frame. However, my study argues from CMT that conceptualization gives rise to metaphors, that metaphors are conceptual and as such are cognitive rather than merely communicative tools. The use of metaphor is ubiquitous and a part of everyday language, and we can understand how meanings are socially constructed by listening to one's utterances. Additionally, new conceptual patterns can emerge by responding to utterances in ways possible only with greater understanding of the other's frame of understanding.

**Studies of Disability and Communication**

Recent scholarship in disability studies is increasingly interested in patients' own narrative accounts as a more accurate and telling depiction of disability that empowers individuals' with impairments. For example, Rosalyn Darling (2013) researches how society's views of one who is impaired effects how disability is conceptualized. She adds to social models that understand disability as socially constructed rather than an inherently biological condition, with her argument that disability has become a normal form of human variation. Historically, disability was seen as deviance from ability and appearance norms of Western society; however, over the past several decades, disability has been re-conceived as a normal form of human variation, like race or gender. Darling
investigates how people have incorporated their disability into their self-definitions, which she claims are their identities. Her focus is on individuals with disabilities who tend to be associated with differential treatment in a variety of social situations, such as African American children living in poverty.

In her examination of literature on disability, she finds that the scholarship claims people with disabilities often have a poor self-concept that follows from stigmatizing attitudes in society. However, Darling claims that not all with disabilities view themselves negatively. She works from George Mead (1934) and Herbert Bloomer (1969) and their human communication theory. According to their theory of symbolic interactionism, individual attributes like thought and self-concept derive from one's interactions in society. Darling studies role-taking between individuals with and without disabilities in conversation and notes how this process affects identities.

Addiction is often considered mental illness and therefore a disability. Impaired populations are marginalized by social constructs that categorize expertise, disability, and self. The following research argues that doctors' positions of expertise lead to classifications of impairments that dissuade patients from worthy senses of selves. As a result, patients accept their doctors' narrative as their own and fail to recognize the possibility of another perspective.

Social constructs that categorize expertise, disability, and the self are based on larger social themes that exist by the norms and values of a given culture. For example, such norms and values are expressed in language, social policies, including laws, and in expectations people have for interpersonal relationships, such as how we should respond.
to one another, what is appropriate to discuss, and what is better left unsaid. Ellen Barton (1996) researches disability as a sociocultural construct that is partially established and maintained by language. In her analysis of a variety of discourses of disability, she finds that expertise is a dynamic, multidimensional construct, negotiated interactively among speakers in medical encounters. In the disability narratives she studies, multiple dimensions of expertise exist among the physician, patient, and the patient's family. Furthermore, “[T]he discursive practices of narrative often establish, reflect and maintain larger social themes” (p. 313). Expertise-based conflicts arise because both patients and doctors are oriented towards expertise, though patients often reserve themselves during the doctor/patient interview, and because there are multiple dimensions of expertise over the span of the medical encounter between patients and their doctors. Her findings contrast with “a static construct of asymmetrical expertise within the institutional discourses of medicine” (p. 318). Rather,

the actual interactions and narratives of families and physicians point to the need for more complicated constructs of expertise as multidimensional and dynamic: negotiated expertise can be collaboratively developed and cooperatively maintained, and the expertise of families is not always ignored. (p. 318)

She argues that ultimately any description of medical encounters has to complicate its concept of expertise to include: physician expertise, family expertise, and their negotiation in context.

As mentioned, an individual's conceptualizations of his/her world reflect social norms, and the importance of individuals' self-concepts is often under-appreciated in
medical communities concerned with healing one's body. Scholar of identity and disability, Anne Hunsaker-Hawkins (1999) highlights the importance of patients' self-concept and its role in being well. She studies what she coins “pathographies,” illness narratives that are both autobiographical and biographical accounts of disease. She argues that one's illness narratives express mythic thinking, and by “myth” she means formulative constructs that organize the way patients understand their illness, how they interact with medical institutions, and how they write their narratives. Patients order illness experience by such myths, and she argues that myths can be enabling or disabling and they can be medically “syntonic or dystonic” (pp. 21-24). When syntonic, myths are adaptive, useful, help recovery or adjustment, and ameliorate suffering. When dystonic, myths are compatible with Western medicine but may not help the ill.

My study argues that utterances reveal and challenge notions of addiction and that the doctor's and patient's narrative is co-constructed in a process of utterance and response. In this way, the patient and doctor can break the pattern of marginalization and socially construct a narrative that more aptly responds to the realities of addiction for a given patient.

**Life Writing and Identity**

Studies in life writing and narrative demonstrate that identity is socially constructed within narratives. The significance of narrative is therefore personal and communal because individuals express themselves from how they internalize their culture. More specifically, individuals position themselves in their culture and express
themselves as a response to their culture's norms and values. Identity is formed by narrative in social context, according to John Paul Eakin (2008). Therefore, the social and personal are indivisible. Sidone Smith and Julia Watson (2010) argue that life writing, or writing that contextualizes a person's experiences in a time and place, is socially constructed. Sara Newman (2013) and Thomas Couser (2010) add that narrative written by those who identify as disabled offer insights that others writing about them cannot provide. All argue that one's narrative is shaped by the socio-historic moment, including one's physical environment and social norms. These elements help to forge narrative identity. My research extends these bodies of work by looking at medical conversation as life writing with narrative that is socially constructed between a doctor and the patient. Furthermore, the doctor regulates the patient's identity by his responses or lack of responses to the patient's thoughts and emotions.

From these studies, I have developed a perspective based on conversation as an illness narrative constructed by the doctor's and patient's responses to the other. I work from Smith and Watson's definition of life narrative and extend their definition by adding that the doctor's life, perception of his experiences, and the patient's life, perception of his/her experiences, cooperate in construction of their singular conversational narrative. The patient's life as it is affected by addiction is the subject, but only in part. The patient's narrative identity is affected by the conceptual metaphors that arise from the doctor's embodied experiences treating addiction. The ensuing responses between the doctor and patient result in a co-produced illness narrative. In this conversational narrative,
therefore, the subject includes aspects of both the patient's and the doctor's lives, as each relates to addiction, and as each relates to one another's characterizations of addiction.

Eakin investigates identity and considers what identity is and how it affects one's narratives. Ultimately, he argues that one's “narrative identities,” by which he means the manner in which one represents himself, become aspects of one's identities. In his studies of autobiographies, he claims that narrative identity is “the version of ourselves that we display not only to others but also to ourselves whenever we have occasion to reflect on or otherwise engage in self-characterization” (p. xiv). Furthermore, he argues that by means of one's narrative identity, one communicates a sense of self that is considered normal or abnormal. Eakin asserts that one's narrative identity evolves with socialized norming standards. He argues, “narrative is not merely something we tell, listen to, read, or invent; it is an essential part of our sense of who we are” (p. viii).

Narrative identity changes, and there is always potential for re-conceptualizing a sense of self. Eakin argues that one's identity is shaped by one's life in and as a body across time, and narratives help “anchor our shifting identities in time” (pp. x-xi). I add to Eakin's study by examining the context patients and their doctor inhabit when dealing with addiction. In my study, the subject of the narrative is the body, and identity, one's thoughts and feelings, is established and constrained by that fact. When the narrative is controlled by the doctor's disciplinary expertise, expression of identity is also regulated. Controlling one's sense of self, or utterances of thoughts and emotions, by the doctor's responses to patients adds to Eakin's claim that the regulation of narrative identity is a potential threat to individuality rather than a cooperative effort between individuals: “If
narrative is indeed an identity content, then the regulation of narrative carries the possibility of regulation of identity—a disquieting proposition to contemplate in the context of our culture of individualism” (p. 33). Eakin goes so far as to ask: “What is expected of this individual, as manifested in this self-narration, for him or her to 'count as' a person?” (p. 34). In my study, regulation of patients' identities is as subtle as failing to respond to patients who don't present to the doctor in a manner that is acceptable.

Speakers together shape an oral narrative within which identity is controlled by the dynamic of power between individuals. Like Eakin, scholars of life writing Sidonie Smith and Julia Watson (2010) argue that identity is constructed by narrative, and their work informs my definition of narrative and my understanding of identity in relationship to narrative. In my study, I understand narrative as conversation and identity as one's thoughts and feelings. I investigate the manner in which patients express their thoughts and feelings in their conversational narrative with the doctor. Smith and Watson use the narratological distinction between the narrating and narrated self and argue that the “I” of autobiography is a multiple production, not only literally through publishers and paratextual editors but, more subtly, in the form of ideological or psychological alter-egos.

Smith and Watson argue “self, life, writing” is autobiography, and add to this definition: “[I]f life is expanded to include how one has become who he or she is at a given moment in an ongoing process of reflection, the concept of the autobiographical as a story requires more contextualizing.” They study life writing within historic, geographic, and generic contexts. Additionally, they distinguish between life writing “as a
general term for writing that takes a life, one's own or another's, as its subject” and life narrative,

a general term for acts of self-presentation of all kinds and in diverse media that take the producer's life as their subject, whether written, performative, visual, filmic, or digital. In other words, we employ the term life writing for written forms of the autobiographical, and life narrative to refer to autobiographical acts of any sort. (p. 4)

From this perspective then, the self is socially constructed and in symbiotic relationship to the other to whom it responds and is responded to. The self, importantly, is not separate from society. Thomas Couser (2011) informs my argument on the socially constructed nature of selves in the patients' and doctor's narrative. Couser argues that the singular pronoun of narrative “need not speak in splendid isolation from others” (p. 239). Rather, the individual speaks intimately from his/her everyday, bodily experiences and can intimately and realistically forge community bonds and foster communal sensibility with others who are suffering, particularly when they suffer from shared illnesses. Furthermore, in his studies of disabilities, Couser argues: “[A]utobiography has considerable potential to counter stigmatizing or patronizing portrayals of disability because it is a medium in which disabled people may have a high degree of control over their own images” (p. 78).

In addition to his claims on the relationship between the social and individual, Couser suggests that current memoirs are written by “somebodies,” those with conventionally accepted bodies, and “nobodies,” those whose bodies are not
conventionally normal. As the wording implies, the one group has cultural presence and the other does not. Regardless, he argues that there is a cultural preoccupation with having and being a body, and people are interested in others' embodied experiences. He examines the “odd body” and the potential ensuing physical and/or mental catastrophe that one narrates. In recent times, individuals have told their own stories about their disabilities; however, in times past, one did not voice his/her own problems. Rather, others' objective studies accounted for the conditions of a disease. For example, it wasn't until the 1990s that substance abuse memoirs suggested that addiction could be considered a disability (p. 230). My study works from Couser's argument that one's narrative is informed by the intricate operations of one's body. Patients' identities are based on their thoughts and feelings communicated so far as enabled by the responsiveness of the doctor in their conversation.

The above research contributes to my argument about the construction of conversational illness narratives and identity. The subject of the narratives in my study embraces the patient's and the doctor's life with addiction. The patient's problems and the doctor's way of treating these shape the conversation, and depend upon the particular responses that occur to patients' utterances on their thoughts and emotions. The rhetorical responsiveness in the doctor's and patient's narrative depends on one's sense of self as it is communicated by the patient and received by the doctor.

**Illness Narratives in Medicine**

The following studies of illness narratives in medicine demonstrate the value of “narrative knowledge” for medical providers and patients alike. Narrative knowledge is
an appreciation of a patient's mind and body and an empathetic manner of responding to patients that fosters patients' deeper responses and allows the medical provider to assess the patient's emotions and thoughts along with his/her disease. In this way, patients and doctors cooperate towards communication practices that positively affect wellness.

Doctors have used narratives as resources to appreciate patients' own abilities to heal by identifying with their illness in personal, relevant ways. For example, research from medical anthropologists and physicians such as Rita Charon (2002, 2006) and Arthur Frank (1993) demonstrates how illness narratives help patients relate to others and foster empathy. Frank argues, “The ill person who turns illness into story transforms fate into experience; the disease that sets the body apart from the others becomes, in the story, the common bond of suffering that joins bodies in their shared vulnerability” (p. xi). In Charon's extensive study, she argues that narratives show that those with illnesses care for others, beyond that they are in need of other's care-giving. Furthermore, sharing one's illness narrative is a way to express one's voice, to feel heard, and, therefore, to have compassion and listen to others. Through their illness narratives, patients may feel more open to doctors and doctors may understand patients more individually. Charon argues that illness narratives improve outcomes between patients and medical providers (2002, 2006).

Additionally, narratives can serve as a means whereby medical providers adopt the patient's perspective in order to better understand the patient's illness experience. Charon (2006) argues that doctors should write narratives from their patients' perspectives. In this way, narrative can serve as a bridge between the ill and well:
Until my impressions were expressed in language, I did not know what, in fact, I knew about the patient. [...] and yet my acts of guessing at the patient's situation and trying imaginatively, to make sense of her behavior had some profound dividends. The hypothesis acted like a prosthetic device or a tool with which to get to the truth, like a crowbar or a periscope will enable you to see under a rock or over a wall. Also, this narrative act helped me to get closer to the patient. My writing exercise invested me in learning of her true plight instead of blaming her or suspecting her of malingering. (p. 6)

Charon became empathetic about writing narratives from her patients' perspectives. She argues that narratives compliment scientific elements of healthcare by expressing ordinary human experiences that surround pain, suffering, and dying. With a better picture of the human affected by illness, a doctor may be better able to address individual patient's ailments. Charon says it is an “extreme pleasure that my thinking complicated thoughts and being attuned to complex ways of language can translate into control of my patients' bodies” (p. 191). Therefore, through her work, Charon argues that narrative thinking empowers the doctor to more effectively treat patients.

Based on research of narrative from the twentieth and twenty-first centuries, narrative knowledge is a way of understanding an individual's life, and, by it, one seeks the particular meaning of another's experience(s). Charon (2006) describes narrative medicine in the post-positivistic era, 1980s and forward:

Unlike scientific knowledge or epidemiological knowledge, which tries to discover things about the natural world that are universally true or at least appear
true to any observer, narrative knowledge enables one individual to understand particular events befalling another individual not as an instance of something that is universally true but as a singular and meaningful situation. (p. 9)

According to the biomedical model, disease involves universalized and generalized facts that transcend particulars. In contrast to this, narrative knowledge attempts to illuminate the universal human condition by the particular conditions of a life.

Sociological studies on medical practices and communication have found that in American medicine doctors controlled what could be talked about and how by regulating turn-taking, interrupting, asking questions and expecting “right answers.” Once doctors saw what they were doing, they made changes. These changes heralded in patient-centered care for the first time since post-WWII when there had been an explosion in biomedical research. According to research on doctors teaching doctors, training in medical schools aimed to provide communication skills, though these were seldom taught effectively. Charon also notes that changes didn't happen easily or promptly because of professional dominance, regressive authoritarianism, and issues of greed.

However, medical practitioners increasingly realized the need to understand patients and human predicaments, and there has been a steady rise in studies related to the humanities, moral philosophy, and bioethics. Researchers in the humanities have proposed that doctors accomplish a number of tasks including: expand clinical and moral imaginations, reflect on the care of the sick, develop readerly skills to follow patients'


narrative threads, enter into patients' worlds: adopt multiple and contradictory points of view to see how he experiences it, identify images and metaphors, recognize temporal flow of events, follow allusions to other stories, tolerate ambiguity in patients' stories, and foster the ability to be imaginatively transported to wherever the patient's story goes (p. 195).

In Frank's (1993) study of patients' narratives, he finds that patients tell of a loss of self-recognition because of their illness experiences and need to regain a sense of self. Working with narrative, doctors and patients can identify a patient's lost self-concept and construct alternate narrative identities. Inherent in the doctor's and patient's communication processes is the need for change and the need to accept having changed. In his research on patients' narratives, Frank finds themes related to how one has changed by his illness. Patients express themes of: “illness as epiphany,” “who I have always been,” and “who I might become” (p. 48). He claims the patient's conceptualization of who s/he is relates to who s/he has been and will be and is brought to a head in the face of illness. Thus, the study of illness narratives is the study of the social construction of identity and the ways in which one changes and develops additional senses of selves:

Illness narratives are not illnesses, but they are a significant means for studying the social construction of illness as a rhetorically bounded, discursively formulated phenomenon. Reflexively and sometimes prescriptively, illness narratives invoke change, based on understanding illness as a moment at which change is especially possible. (p. 41)
I add to the above research of illness narratives with my study of conversation as “rhetorically bounded” and socially constructed illness narrative.

**Conclusion**

This chapter presents literature that contextualizes my study. Studies in addiction provide the social frame of my study, as my study examines conversation between a doctor and patient as a socially constructed illness narrative. Furthermore, the narrative is rhetorically structured by the doctor's and patients' utterances of emotion, thought, and activity, as well as responses to each other. Lastly, each one's responses arise from embodied, or everyday, lived experiences that shape one's conceptualization.

Studies in health and communication argue that doctors' perceptions of patients affects their perceptions of patients' illness arguments. Studies in metaphor and medicine argue that metaphors can aid communication by helping patients understand their conditions, or they can conceal literal meanings of disease. In studies of disability and communication, scholars argue that identity is regulated. Such control of patients' senses of selves occurs by the nature of the give and take in the discourse shared between patients and doctors. Furthermore, social constructs such as values and norms categorize expertise, disability, and self. As a result, patients are dissuaded from a worthy sense of self and patients accept the doctor's perspective. Research on life writing and identity illustrates identity is within narrative and socially constructed with personal and communal implications. Studies in illness narratives argue that narratives are a means by
which patients can cooperate in the process of communicating with their doctors and
obtaining wellness.

My study of the doctor's and patients' utterances begins with my argument that the
doctor conceptualizes addiction as disease and patients conceptualize addiction as illness.
Importantly, my argument is based on the understanding that metaphor is conceptual, or
cognitive, which means that one's frames of understanding follow from one's embodied
everyday life. The patients' and their doctor's utterances within a conversation construct a
narrative that communicates the patient's sense of self. My research identifies patterns of
response that rhetorically positions conversations. In this way, my research of the doctor's
and patients' conversation on the nature of addiction adds to the above research on
medical rhetoric, health and communication, and life writing.
CHAPTER 3

Methodology and Data

I designed a qualitative case study in a private, not-for-profit, regional methadone clinic, hereafter identified as the “Center.” The Center's purpose is to provide comprehensive treatment, prevention, and housing services for addictive and compulsive behaviors and disorders. The Center has been serving its patients in the Midwest since 1974 and coordinates primary and behavioral health care with a philosophy that no one treatment regimen cures substance abuse, no one miracle drug cures all ailments. At the Center, the doctor and patient begin their interactions based on a treatment plan developed during patient in-take that serves as a “blueprint” for how the doctor and patient should respond to the patient's addiction(s) and related problems. Healthcare providers assist patients through the recovery process from counseling, medical treatment, to housing by using the treatment plan designed at the time of intake.

The Center is one of only 10 regional methadone clinics in a midwestern state offering methadone maintenance and detoxification treatment for opiate addiction. The Center argues that methadone is the single most effective treatment for those addicted to opiates, and they provide methadone maintenance as a daily routine, which some patients continue on for the rest of their lives. In addition to methadone treatment, the Center has an intensive outpatient program, adult counseling, and mental health services. In 2009,
there were 5,048 patients seen in the adult behavioral health programs, and over 60% of these patients made under $5,000 in the year 2009. According to the Center, addiction affects individual's family members, friends and colleagues, and addiction can occur at any point in the cycle of a life. Medical providers at the Center have helped individuals with addictions and mental health disorders for over 36 years.

During 2011-2012, I documented communication between one doctor and 20 different patients during appointment sessions that lasted on average 10 minutes. Participants in my study included a certified psychologist and medical doctor, and 20 different patients seeking medical treatment for addiction. Specifically, my study included eight men and 12 women aged between 22 and 50 with an average age of 30. I did not collect racial, social / class, and ethnic data on patients. While such demographic information may have helped to explain some of my linguistic findings, my focus was on the patient's language. I isolate patients' conceptual metaphors, as explained below, and analyze how these alone suggest a patient's sense of self and understanding of addiction. An additional step in future research may be to collect demographics and investigate if and how so these aspects of one's embodied condition effects patients' way of thinking about themselves and addiction.

Patients were notified that I would be there and offered the choice during scheduling of their appointments to allow me to be present or to decline. After they made an appointment and the administrative scheduler issued a consent form, I met them at the beginning of their session with the doctor. After they signed the release, I recorded their
discussion with the doctor in order to investigate how patients with addiction and their doctor co-construct an illness narrative by their conversation during treatment sessions.

The Center's mission statement identifies the importance of treating the individual patient’s illness; however, in the same mission statement, addiction is described as a disease. Thus, the Center's rhetoric frames addiction as both disease and illness experience. As I found in the data and saw here in the mission statement, patients' and their doctor's utterances on thought, emotion, and activity employ the conceptual metaphors of disease and illness experience when discussing addiction and treatment. Because individuals understand addiction as both disease and as unique illness and my study explains how conceptual metaphors arise and inform language among individuals dealing with addiction(s), Conceptual Metaphor Theory (CMT) is an effective lens for analysis in my study. As I discuss in detail below, the manner in which I code for

Contemporary Lakoffian CMT proves particularly useful in analyzing the doctor's and his patients' conceptual metaphors in this dissertation. Lakoff and Johnson's theory is based on cognitive linguistic evidence that the ordinary conceptual system with which humans think about and discuss the world is metaphorical in nature (1980, p. 4). Accordingly, Lakoffian theory bridges binaries between theories of language as literal or metaphorical; rational and objective (thus, Truth) or subjective; and, finally, language as either “scientific” or pertaining to the humanities.

CMT developed in the 1980s when George Lakoff and Mark Johnson's empirical research on conceptual metaphor responded to a deficit in linguistic and philosophical views on “meaning” and Western culture. They were interested in the role of metaphor in understanding one's self and world. In times past, they argued, metaphor had been perceived peripherally, but that, in fact, metaphor was key to understanding the ways people construct meaning. Lakoff and Johnson's research followed from their rejection of any notion of objective or absolute truth and related assumptions. Instead, they argued that meaning is made through human experience and understanding. Their approach in Metaphors We Live By is experiential, and their studies focus on issues of language, truth, and understanding in the context of the everyday.
metaphors is based on CMT but uses Norman Fairclough's notion of “force of utterance.” Simply put, in each conversation I coded all phrases that held the doctor's and patients' semantic meaning. These phrases are metaphorical expressions and are described as attributing metaphors in CMT. Such phrases were coded as activities, thoughts, or emotions. The doctor and patients characterized addiction with utterances that support two main structural metaphors: *addiction is disease* and *addiction is illness experience*. See below for an account of how I proceed with the coding and analysis of my data.

As my study investigates how patients and their doctor uniquely conceptualize addiction and how their utterances serve as linguistic evidence for their embodied understandings, the following research questions guide my study:

1. How does the doctor / patient talk about addiction vis-a-vis language used to discuss activities?
2. How does the doctor / patient talk about addiction vis-a-vis language used to discuss emotions and thoughts?

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10 “Force of utterance” is Norman Fairclough's (1992) notion that a sequence of sounds consists of meanings and episodes. The force of utterance is the semantic meaning, the conceptual or cognitive sense a speaker communicates within the context of the discourse. Investigating the doctor's and patients' force of utterances in this way allows me to connect utterances to conceptual metaphors: the word or phrase is understood as a sign that communicates one's underlying conceptualization. The expression communicates a way of understanding that is socially situated and embodied.
3. How does the patient / doctor respond to the other's utterances characterizing addiction?

4. From embodied experiences with addiction, what identities (or senses of selves) do patients narrate to their doctor?

In order to answer my research questions, I gathered data by recording and then transcribing conversations between patients and their doctor. I also attended addiction club meetings among medical providers and luncheons with the participating doctor and his colleagues, and discussed addiction with the participating doctor after each weekly observation. My primary data consists of 20 audio-recorded patient-doctor interactions during doctor appointments. I transcribed these audio-recordings immediately following my observations, averaging 30 lines per conversation for a total of 670 lines of transcription.

**Description of Method of Analysis**

As mentioned above, in the course of gathering my data for this study, I began to see two predominant conceptual metaphors: *addiction is disease* and *addiction is illness experience*. My analysis relies upon an understanding of Conceptual Metaphor Theory (CMT). More specifically, in my study, the doctor's and patients' utterances are understood as two levels of conceptual metaphors.\(^{11}\) All utterances are in themselves

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\(^{11}\) My study is concerned with all utterances that relate to the concept addiction. I do not investigate phatic utterances, by which I mean language used for general purposes of social interaction that does not convey information pertaining to the discussion of addiction. For example, phrases such as “Hi, doctor,” are not included in the data corpus studied here.
attributing metaphors and support one of the two structural metaphors.\textsuperscript{12} Attributing metaphors are both the markers and carriers of the two structural metaphors that dominate the rhetoric of addiction in this data set.

From initial observation, I define the two most prominent conceptual categories that emerged from the data collected and test these categories against 20 conversations between the participating doctor and 20 different patients. After initial reading of my data corpus, I define the first category of structural metaphors as illness experience. In this category, the patient's conceptualization of addiction is based on his/her unique embodied experiences and his/her particular social conditions, such as relationships with family, friends, and community, as well as his interactions with medical providers. The second category is defined as disease. In this category, the doctor's conceptualization of addiction is based on universal, general facts on “normal” and “abnormal” bodily activity that transcend the particulars of the patient's personal illness experience and against which objective symptoms of physical pathology are measured. The patients' and doctor's utterances in this dissertation are categorized by the above structural metaphors.

\textsuperscript{12} According to Lakoff and Johnson, “The most fundamental values in a culture will be coherent with the metaphorical structure of the most fundamental concepts in a culture” (p. 22). They illustrate this principle by the value of UP demonstrated in spatial metaphors. The following structural metaphors indicate the Western conceptualization of good being up: MORE IS UP / GOOD IS UP. These CMs arise from numerous metaphorical expressions such as “the future will be better” and “your status should be higher in the future,” which express values embedded in the culture (p. 22). Metaphorical expressions in Western culture systematically cohere to the value of good being up and more. In this study, structural metaphors, disease or illness, are articulated across the corpus by the attributing metaphors.
Based on my definitions of the structural metaphors *disease* and *illness experience*, I investigate how pervasive the doctor's conceptual metaphor of disease is and, likewise, how often patients conceptualize addiction as an illness experience. To these ends, following CMT, I study the doctor's and patients' attributing metaphors to determine how often each is referring to *disease* and *illness*. Importantly, I find that there are times when the patient characterizes addiction as disease, and the doctor characterizes addiction as illness experience. In the course of their conversation, the doctor and patient respond to each other's metaphors with the attempt to relate, but their value systems do not cohere and cannot relate in systematic ways. This is a direct result of the doctor's embodied experience as one who observes patients' bodies and aims to regulate the body with methadone and patients' embodied experiences with addictions and the host of related problems each one faces.

In order to isolate the attributing metaphors that support each structural metaphor, I conducted the following steps of analysis:

1. I isolated each t-unit that is an utterance characterizing addiction.
2. I identified the force of the utterance characterizing addiction; for example, addiction is x (activity), addiction is y (thought), addiction is z (emotion). These codes are, in effect, the attributing metaphors categorized in the next step.
3. I developed categories of attributing metaphors by sorting t-units *illness experience* and *disease*. The following categories emerged for *illness experience*:
   - Acting Body, which is an expression of pain, of doing harm or doing good
   - Reflective Thought
Emotional Response

The following categories emerged for disease:

Body Acted On

Expected Bodily Response, to medication, drug use, and not using drugs.

The table below illustrates four utterances, two from the doctor and two from a patient.

<table>
<thead>
<tr>
<th>CONCEPT</th>
<th>Patient Utterances</th>
<th>Physician Utterances</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDICTION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structural Metaphor</td>
<td>ADDICTION IS ILLNESS</td>
<td>ADDICTION IS DISEASE</td>
</tr>
<tr>
<td>Code Category</td>
<td>Acting Body</td>
<td>Body Acted On</td>
</tr>
<tr>
<td>Attributing Metaphor</td>
<td>ate a bag of poppyseed bagels</td>
<td>will assess your levels (of dope)</td>
</tr>
<tr>
<td>Structural Metaphor</td>
<td>ADDICTION IS ILLNESS</td>
<td>ADDICTION IS DISEASE</td>
</tr>
<tr>
<td>Code Category</td>
<td>Reflective Thought</td>
<td>Expected Bodily Response</td>
</tr>
<tr>
<td>Attributing Metaphor</td>
<td>Don't make no sense to me</td>
<td>(with the upped methadone) Cravings, pain should decrease</td>
</tr>
</tbody>
</table>

Table 1: ADDICTION CONCEPT MAP

4. After coding my data, I tallied the frequency of characterizations and counted the instances, per category, by which the doctor and the patient each employed the conceptual metaphors disease and illness experience.

5. I made a second pass through my data and coded for boundaries between disease and illness experience. In so doing, I examined to what extent each conceptual metaphor dominated and addressed how addiction was characterized by the conversation as a whole. With study of the doctor's and patients' responses
to each other, I found patterns that account for the rhetorical position in the conversation.

In my analysis, the structural metaphors *disease* and *illness experience* are supported by attributing metaphors. These utterances, or attributing metaphors, pair the concept of addiction with other concepts that I have coded as categories related to activity, thought, and emotion. As explained above, utterances characterizing addiction in ways related to the attributing metaphor activity support the structural metaphor *disease*, and those utterances related to the attributing metaphors emotion and thought support the structural metaphor *illness experience*.

**Summary**

This dissertation understands the doctor's and patients' utterances as conceptual, which means that the doctor's and patients' language arises from what each understands as the truth, which is likely based on the individual's embodied, everyday experiences. Thus, truth is perceived as subjective and informed by objective evidence in one's life.

The doctor and patients discuss addiction as both illness and disease. This happens in the course of their conversation as each responds to the other. In this way, the doctor's and patients' utterances construct rhetorical positions informed by the experience they have talking with one another. By applying Lakoffian Conceptual Metaphor Theory (CMT), my study understands that one's every experience affects his/her conceptualization, and this conceptualization is represented in language, as in the doctor/patient interview.
Lakoff and Johnson question whether words and sentences have standalone meanings and argue that context and people shape conceptualizations. As explained in my introduction, Lakoffian theory holds that conceptual metaphors are systematic inference patterns from one conceptual domain to reason about another conceptual domain, which they call mapping. Such mapping is not abstract or arbitrary but based on “bodily experiences in the world.” Because cultures have unique perspectives on the world and experience within it, conceptual metaphors reveal these assumptions. Lakoff and Johnson argue that one's conceptual metaphors arise from one's socially situated reality:

In short, metaphor is a natural phenomenon. Conceptual metaphor is a natural part of human thought, and linguistic metaphor is a natural part of human language. Moreover, which metaphors we have and what they mean depend on the nature of our bodies, our interactions in the physical environment, and our social and cultural practices. (pp. 246-7)

In my study, the doctor's and patients' unique cultures and related assumptions meet, and the focus of my research is how the doctor and patients construct conversational narratives by responses to the other.

CMT proved useful in my study of the doctor's and patients' language as a way to explain the doctor's and patients' conceptual frames, related to their metaphors, and understand the unique perspectives that arise from their roles as “patient” and “doctor.” My study is also concerned with the communication of one's sense of self, and with CMT identity can be understood as contextual and changing.
Western thought often splits mind and body, but Lakoff and Johnson argue for an experiential gestalt in which direct activity follows conceptualization. This approach to meaning-making is pragmatic in my study where patients' activities: using drugs, following the doctor's orders, and expressing their pain, directly corresponds to their utterances of personal illness experience. Thus, patients' conceptualizations of addiction effect their behaviors. Likewise, the doctor's conceptualization of addiction effects his prescription of methadone and other meds as well as the manner in which he responds to patients. Furthermore, the doctor's activities follow his interpretation of the patient as one who is addicted. CMT is useful in my study because experiential gestalts relate concrete and abstract, mind and body, and thought and language.

Additionally, CMT helps me explain why subcultures use different metaphors. Because they have different embodied experiences, individuals from different cultures have different conceptualizations and may have different priorities. For example, a patient dealing with addiction values feeling better. Though s/he wishes to feel well, his/her activities may or may not lead to actually being well. The doctor's sense of wellness is a body balanced with methadone. His metaphors express disease with utterances on how often the patient's body acts well or unwell. Patients do not always express a sense of being well while taking methadone. Patients' metaphors express personal illness experiences with utterances on how s/he feels and thinks about his/her life. The doctor and patients express their characterizations of addiction, but they fail to relate because of different conceptualizations. Their differing conceptualizations arise from unique embodied experiences with addiction, as explained above.
As a student of language and communication, rather than a medical doctor or counselor, my objectives are to analyze the doctor's and patients' conceptual metaphors, which are identified by the specific utterances the doctor and patient use to characterize addiction. My study is designed to investigate addiction and treatment as a public discourse, and in this study I am not concerned with psychological issues involved in effective communication. Thus, the rhetoric of addiction is characterized by the physical body responding to problems related to addiction(s), which includes emotions, thoughts, and activities. Importantly, I argue that one's mental state is a physical condition, and this is supported by Lakoffian CMT that draws together the body and mind with an explanation of embodied, everyday experiences.

In the following chapter, I present my data analysis and the findings in my study. I represent the findings with a summative table and discuss the structural metaphors disease and illness. Additionally, I present a table illustrating the most frequent attributive metaphors in my study, thought and then emotion. By tabulating utterances of emotion and thought, I illustrate rhetorical patterns evidenced in my data and further discuss these in chapter five where I present interpretation of the results in my study.
CHAPTER 4

Findings

Structural Metaphors Disease and Illness

Throughout the data corpus, the doctor speaks of addiction predominantly as disease and patients speak of addiction predominantly as illness. These conceptual metaphors are supported by 285 utterances analyzed in this study. Of these utterances, 79 support the structural metaphor disease and represent 28% of all relevant conceptual utterances. Of the total utterances, the structural metaphor illness arises from 206 utterances, or 72%. Patients characterize addiction as illness over four times as often as the doctor.

Further, what emerges from the primary coding is that the doctor's utterances are characterized most often as disease, and he has 77% of all disease utterances. Additionally, from the primary coding, patients have only 23% of all utterances on disease. The doctor characterizes addiction as disease over three times as often as patients.

As explained in chapter three, phatic utterances or language used for general purposes of social interaction, rather than to convey information or ask questions, was not included in my study. For example, when phrases such as “excuse me, um, I don't know” are merely filler given the context of the conversation, such phrases were not included in the data corpus.
The doctor speaks of *addiction as illness* in 19% of all the utterances over the course of 20 conversations. The doctor and patients speak of addiction as *illness* a total of 72% of the data, but the doctor has only 39 utterances and 19% of these utterances of *illness*. In contrast to the doctor's fewer instances in the data with which he expresses addiction as *illness*, patients' 167 utterances give rise to the conceptual metaphor *addiction is illness*. Patients' speak of *illness* 81% of the time in my study.

The conceptual metaphors *disease* and *illness* are represented in the summative tabulations\(^\text{14}\) presented below. In this table, the categories for the concepts *disease* and *illness* represent attributive metaphors that give rise to each structural metaphor. These attributive metaphor categories are explained in what follows.

**Summative Table**

![Table 2: Summative Analysis](image)

**Totals by Attributive Metaphors**

\(^{14}\) In tabulating my data, I rounded numbers with decimals, unless categories were equal and rounding would total higher than 100%. In one instance, the category was only equal to a decimal and is so indicated.
The doctor and patients characterize addiction by their attributive metaphors, a process through which each one's utterances follow from one's conceptual scheme that arises from embodied, everyday experiences. This process is Conceptual Metaphor Theory and has been applied to the data in my study by which metaphors are categorized to explain what I mean by disease and what I mean by illness experience. For example, the doctor's and patients' attributive metaphors are represented by the following coded categories, as illustrated above and described in chapter three. When the doctor and patients speak of addiction as disease, their utterances are coded as attributive metaphors of Body Acted On and Expected Bodily Response, including response to medication, drug use, and no drug use. When the doctor and patients speak of addiction as an illness experience their utterances are coded as attributive metaphors of Acting Body, including pain expression, doing harm or good, Reflexive Thought, and Emotional Response. Each of these categories represents metaphors that attribute meaning to their respective structural metaphor, disease or illness. The following statistics illustrate the findings in my study:

- **Body Acted On** = 28 utterances, 24 from the doctor and four from patients, and 35% of the total utterances for the structural metaphor disease
- **Expected Bodily Response (to medication)** = 22 utterances, 17 from the doctor and five from patients, representing 28% of all the utterances on disease
- **Expected Bodily Response (to using drugs)** = Eight utterances, six from the doctor and two from patients, and only 10% of the disease metaphors
Expected Bodily Response (to not using drugs) = 21 utterances, 14 from the doctor and 17 from patients, which represents 27% of the disease category

Acting Body (pain expression) = 18 utterances, all from patients, and represents nine percent of the data

Acting Body (doing harm or good) = 25 utterances, one from the doctor and 24 from patients, and 12% of the attributive metaphors on illness

Reflexive Thought = 108 utterances, 28 from the doctor and 80 from patients, representing over half of the metaphors for illness at 52%

Emotional Response = 55 utterances, 10 from the doctor and 45 from patients, and 27% of the total metaphors on illness

Reading the Results

The doctor speaks of actions he takes regarding treatment of the body and what he expects the body to do in response to his prescription of methadone. He characterizes addiction as a physical problem that he can regulate by the correct dosage of methadone. For this reason, the doctor has an average of 70% of all attributive metaphors giving rise to Body Acted On. For example, the doctor says things such as, “We know what will happen if you don't stay on methadone.” When the doctor speaks to the patient with attention to that patient's individual illness experience, then the doctor's metaphors support the structural metaphor illness experience in my study. This occurs with 10% of the total utterances on addiction is illness. Of these, the majority of the doctor's attributive metaphors are on thought. For example, he comments: “I think you are at a
high risk for relapse,” expressing how he perceives the patient will respond. Conversely, patients’ metaphors speak to experience in and as a body. Patients often tell how they feel, think, and what addiction has meant in their lives. Comments such as, “I'm not feeling well,” for all sorts of reasons, permeate the data corpus, as do expressions such as, “I thought I could stop using, but I realized” along with other utterances that communicate how patients think about what they have done. Patients also express how they feel about what they have done, such as: “I feel awful; there's no enjoyment from the high, nothing but guilt.” However the paradox continues on as patients use and hurt their senses of selves because of their addiction(s). They harm not only their bodies but their emotions and thoughts in regards to how they feel and think of themselves.

While the results in my study demonstrate that the doctor speaks of addiction as disease and patients speak of addiction as illness experience, both also respond to and with the other's structural metaphor. In general, patients characterize addiction as a personal illness experience in which they experience aching joints and back pain, as well as emotional pain such as anxiety and depression, for example. Patients' utterances characterize pain with discussion of physical and emotional ailments. For example, patients complain of insomnia and sexual dysfunction as it affects their bodies and they mention how their physical troubles make them feel emotionally. Patients' pains come from using drugs and also cause them to use drugs.

On the other hand, the doctor's utterances characterize the patient's addiction experience as a physical problem. To the doctor, the patient's problems stem from an “off-kilter” body that can be regulated by methadone. The doctor and patients conceptualize
addiction differently. Patients embody their addiction and related problems, and the
doctor observes patients' bodies. The doctor's perspective is valuable because he is able to
observe patterns in patients over time. However, his perspective is limited because the
doctor does not live the manifold ailments that uniquely affect each patient. The doctor's
limited perspective maintains a diagnostic focus. Based on this focus, he does not often
respond to the patient's individual utterances characterizing addiction for that one patient.

Because each patient is unique and the doctor himself changes over time, each
conversation presents a particular social situation. Within each socially constructed
correspondence, the doctor and patient respond to each other as they could not at any other
time. My study examines these contextual utterances with the understanding that the
doctor and patients are affected by each other's ways of speaking about addiction in the
moment.

The doctor's and patients' responses to one another are antistrophic. I address
Aristotelian antistrophos in my concluding chapter six as an area of research to be
continued in the future; however, I briefly refer to it here in order to demonstrate how the
notion relates to my study of the rhetoric of addiction. An antistrophos is a response or
correspondence to a preceding utterance. Antistrophos has always involved a rhetorical
act of calling and responding, in religious practices and public speaking, for example. It
is a compelling technique for persuading groups to respond to a voice calling out a way
of conceptualizing the world. In my study, the doctor's call is that addiction is disease;
while patients' call addiction is illness. My study is concerned with the manner of
response to these different, though relatable, calls.
The doctor's attributing metaphors typically frame addiction as *disease* and patients' attributing metaphors typically frame addiction as *illness experience*; however, because each is influenced by the other speaker, it is reasonable to expect that the doctor and patients characterize addiction as both *illness experience* and *disease* at points in the conversation.

Furthermore, according to CMT, conceptual metaphors arise from embodied, everyday experiences, including one's cultural values and norms. It is understandable, then, that the doctor employs a *disease* conceptual metaphor. The *disease* concept is informed by the biomedical model in healthcare that privileges diagnosis based on objectivity, which the doctor is immersed in from his medical training and healthcare community. The doctor's embodied knowledge of addiction arises from his experiences regulating patients' bodies and assessing their physical needs as a group. The *disease* concept of addiction affects patients' bodies in uniform ways, such as with symptoms of withdrawal, appetite, and cravings for illicit drugs.

To patients, addiction is *illness experience* based on one's own interpretation of the sensate experiences of the body. *Illness* is comprised of what one experiences first-hand. Patients' home communities, including family, friends, peers at work and/or on the streets and in the neighborhood influence how a patient learns to respond to life situations. Thus, the concepts *disease* and *illness* are socially constructed.

Understanding that conceptualization depends on the social environments in which one functions day to day leads to an interesting intersection of meaning-making between the doctor and patients. Each interlocutor comes from a different vantage point,
but in the process of communicating with each other, the doctor and patients inform one another on how addiction and related problems operate in individuals' lives. My study shows that the doctor and patients express rhetorical positions by their utterances and also suggests that those positions develop in response to the other's utterances in their conversations.

The doctor's and patients' conversational narrative is constructed by each one's utterances. The doctor's and patients' utterances arise from meanings each suggests within their socially situated conversation. The rhetorical position of their narrative develops as a result of their responses to each other that develop a stance of agreement or resistance. Examining the utterances in the conversation provides a way of unraveling why resistance and/or agreement occur. For example, when patients speak of personal emotions without also speaking of their thoughts, the doctor tends not to respond because his typical response of acting on the body to improve the patient's illness experience does not easily fit into the patient's utterances of emotions. Rather, the conversation is more an expression of the patient's way of feeling and doesn't invite the doctor's diagnosis as readily as when the patient also expresses his thoughts, which the doctor can correct in a manner such as he corrects the patient's body. Ultimately, as a result of the interaction of the doctor's and patients' attributive metaphors, each conversational narrative maintains a position that moves forward from addiction and related problems or instances of resistance.

**Illness Conceptual Metaphor and Rhetorical Patterns**

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The highest frequency for the structural metaphor *illness experience* occurs with the attributive metaphors emotion and thought. From the doctor's and patients' utterances of emotion and thought, they establish a rhetorical position in their conversation. Based on patterns of these utterances, described further on in this chapter, their conversational illness narrative progresses or fails to.

In the following table, I represent the highest frequency of attributive metaphors Emotional Response and Reflective Thought for the structural metaphor *illness*. I arrange the frequency of patients' utterances on emotion from highest to lowest. The conversations are ordered from the most to the least patient utterances on emotion. I compare the doctor's and patients' number of utterances for emotion in each of these conversations. I then compare the doctor's and patients' number of utterances on thought, and demonstrate how many utterances of thought occurred in conversations ordered from high to low utterances on emotion. I present the frequency of attributing metaphors of emotion and thought to illustrate first that patients have more utterances of emotion, as has been presented, and next to begin discussion on the relationship between patients' and the doctor's utterances of emotion to patients' and their doctor's utterances on thought, both within their own expressions and in response to one another's utterances.
Patients' utterances of emotion are frequently accompanied by their attributive metaphors on thought. In the following three conversations, four, five, and 20, patients' emotion and thought utterances are no more than three apart. In conversation four, patients have five utterances and nine percent of emotion utterances in relationship to seven utterances of thought and six percent of thought utterances. In conversation five, patients have four utterances of emotion and seven utterances of thought; and in conversation 20, four utterances of emotion and three utterances of thought. In conversations: three, eight, nine, 16, 18, and 19, patients equally have three utterances of emotion, representing five percent of the total utterances of emotion per conversation. However, of these conversations, patients' have one utterance of thought in the third conversation, five in conversation eight, eight in conversation nine, and three in conversation 16. Only in conversations 18 and 19 is there an equal amount of thought utterances, seven, over twice the frequency of utterances of emotion in the conversation.

Table 3: Attributive Metaphors: Emotion & Thought

Patients' utterances of emotion are frequently accompanied by their attributive metaphors on thought. In the following three conversations, four, five, and 20, patients' emotion and thought utterances are no more than three apart. In conversation four, patients have five utterances and nine percent of emotion utterances in relationship to seven utterances of thought and six percent of thought utterances. In conversation five, patients have four utterances of emotion and seven utterances of thought; and in conversation 20, four utterances of emotion and three utterances of thought. In conversations: three, eight, nine, 16, 18, and 19, patients equally have three utterances of emotion, representing five percent of the total utterances of emotion per conversation. However, of these conversations, patients' have one utterance of thought in the third conversation, five in conversation eight, eight in conversation nine, and three in conversation 16. Only in conversations 18 and 19 is there an equal amount of thought utterances, seven, over twice the frequency of utterances of emotion in the conversation.
In fact, of these conversations, all but number three have more utterances of thought than emotion. Among these conversations, there is an average of four thought utterances, just one more than the three emotion utterances in each conversation.

In my study, thought and emotion utterances are not necessarily both present. For example, in conversation 12 there are seven patient utterances of emotion and no thought utterances. There are also times when patients express more than double thought utterances than emotion utterances, such as in conversation two where the patient has eight thought utterances to three utterances of emotion.

The doctor responds to patients more often than he initiates utterances of emotion and thought in conversations. Also, the doctor responds to patients' utterances on emotion more often when patients' emotions are elucidated by their utterances of thought. As I have stated above, patients have higher instances of expressing emotions and thoughts, and in 16 of the 20 conversations, the doctor does not have an utterance of emotion. In six of the 20 conversations, the doctor does not have an utterance of thought. However, the doctor responds to patients' with utterances of reflexive thought 26% of the time. In conversation 16, the doctor has the highest frequency of utterances of thought with six, and no utterances of emotion. In some instances, the doctor responds with utterances of emotion and not utterances of thought. For example, in conversation 12 the doctor has two utterances of emotion and zero utterances of thought, which is uncharacteristic of his responses to patients. Conversation 11 is also uncharacteristic of the doctor's utterances as he has four utterances of emotion and three of thought, while the patient hasn't any utterances of thought or emotion.
Based upon the frequency of utterances on thought and emotion, the doctor's focus is diagnostic and patients' focuses are emotional. The doctor responds to patients with utterances that characterize addiction as *illness* an average of 20% of the time, and the remaining 80% of illness metaphors in my study come from patients. The doctor's *illness* utterances are most often thought, as stated above. The doctor's thought utterances are different from patients' thought utterances. The doctor's attributing metaphors on thought respond to why he thinks the patient's physical and emotional well-being will improve with the use of methadone. Patients' attributive metaphors of thought and emotion characterize addiction as their personal *illness experience*. Their utterances are specific expressions of personal feelings and thoughts the patient relates to addiction. As such, their utterances vary more than the doctor's and depend upon social factors with high variables such as age, life-style, family and community influence, and gender.

For example, the doctor's utterances on thought are often questions on why the patient has gone off methadone or wishes to do so. The doctor's thoughts are rarely on the patient's own illness experience. Rather, the doctor's utterances of thought evaluate the patient and his use of medication or drugs. For example, “I don't have an issue with your getting [hormone injections]”; “I'm not judging you [for relapse]; you're gonna do a good enough job judging yourself”; “The issue is the marijuana. You don't really know what you're getting.”

The patient's utterances of thought give rise to *illness* by expressing the experience the patient has had with addiction: “I'm between a rock and a hard place”; “I get that you're a doctor. I don't know what to do. I'm not sleeping, and that makes
everything so much worse”; “I just can't live no more like this. In my head, it's just not worth livin’”; “Ain't nothing like being dope sick; I cannot go through that again.”

Patients' thoughts relate to the patient's emotions and elucidate why the patient thinks as s/he does. Patients' 45 utterances of emotion illustrate the gamete of emotions a patient dealing with addiction feels: “I've been praying to feel better”; “[after using] You can't enjoy it; you feel like the worst. The guilt”; “I was afraid”; “I just want to eat”; “This is like crazy, feels crazy”; “I don't ever want the nightmare to come back”; “I just want to feel myself, what it feels like to be clear and not on anything.” Patients' emotions are central to their experience and provide a fuller picture that helps one understand why a person would intentionally use drugs that harm the body. Patients “call” addiction by their own illness experiences, and together with the doctor's responses to patients, an *antistrophic* conversational illness narrative takes form.

**The Doctor's Characterization of Addiction**

As noted above, the doctor characterizes addiction as disease 77% of the total utterances on disease. The doctor has the most utterances in Body Acted On, followed by Response to Medication, 22 times and 77% of the time this attributive metaphor appears. The doctor speaks to the patient about what can be done to the body. He says things such as “we will assess your levels” and “bring you down / take you up” on methadone dosing. The doctor speaks to the patient as a body, but he doesn't as often ask the patient how he feels about methadone treatment. He asks patients “what sort of support group do you have,” in order to gauge an estimation of the social networks that will help keep the
patient taking methadone as prescribed by driving the patient to the clinic, for example. However, the doctor does not express utterances that could evaluate the patient's own willingness, based on his emotions and thoughts, to stay on methadone.

For example, in the first conversation in my data corpus, the patient responds with emotion once, thought twice, and body acted on three times. The doctor, however, has no response to the patient's utterances. The doctor speaks of symptoms grounded in physical outcomes because this is the aspect of the patient's body that he can measure. He is unresponsive in this first conversation because the patient's body was assessed and found to be on drugs, which ties the doctor's hands from issuing her methadone treatment. Additionally, the patient denies having used illicit drugs. Therefore, the doctor cannot speak to acting on the patient's body or assessing the patient's body, and the doctor is not persuaded to respond to the patient's thoughts and emotions, which are primarily of excusing her assessment based on having eaten poppyseed bagels that gave her a “false positive” on her drug test. The problem between the patient and the doctor based on this narrative is that the patient cannot receive methadone because of having used drugs, and the doctor cannot understand the patient's reasons for having used because he is unresponsive to her emotions and thoughts.

The doctor doesn't typically respond to patients' thoughts and emotions. As stated above, the doctor characterizes addiction as illness experience 19% of the total utterances on illness. The doctor has 26% of the total 108 utterances on thought, and the doctor has 18% of all utterances on emotion. This indicates that the doctor speaks of thought and emotion in response to patients on an infrequent basis. This fact is important because it
leads to inquiry on when and why the doctor responds to patients with utterances that are characteristic of illness.

Though not frequent in my data corpus, when the doctor's utterance of emotion responds to the patient's individual condition, the patient is persuaded to engage emotionally with the doctor. For example, the doctor says, “Sounds like something's terrifying you”; “You look good. You're wearing lipgloss, and your affect is brighter.” In both cases, the patients told the doctor how they were feeling, and it was better because of the doctor's prescription of methadone. In other instances, the doctor expresses his emotions on how the patient responds to what is happening to the patient's body. When the doctor asks a patient what the patient thinks will happen if she goes off methadone and does nothing to counter her addiction, she says she doesn't know. The doctor says, “That's a terrible answer.” The doctor's utterances of emotion are on how the patient handles her prescription of methadone, which invites a positive and/or negative response from the patient, depending on whether the patient resists or agrees with the doctor.

However, the doctor doesn't often gauge patients' thoughts and emotions in his assessment of patients' bodies because patients' characterizations of their own illness experiences are varied as a result of their social situations, such as age, life-style, family, community, and gender, as I stated above. However, there are instances in which the doctor responds to patients' emotions and/or thoughts in the course of his explanations of why methadone will improve a patient's particular physical and/or emotional state(s). In this way, the doctor demonstrates attention to a patient's illness experience, which is persuasive to a given patient.
The following narrative\textsuperscript{15} demonstrates when the doctor can identify with the patient and when the patient seems likewise to identify with the doctor. At such times, the doctor and patient construct a narrative that conveys a sense of mutuality and ease. When this is the case, the doctor tends to repeat the patient's comments. However, the doctor ultimately leads the patient to a diagnostic focus, rather than fostering the patient's deeper understanding of his emotions and thoughts.

For example, in conversation nine, the patient and doctor are both direct-speaking men, about middle-aged, and attractive. The patient speaks of emotion three times and the doctor has five utterances on emotion. The patient has eight utterances on thought, and the doctor hasn't any. The patient expresses confidence in the doctor's ethos, and this persuades the doctor to respond. The patient and the doctor build emotional responsiveness with their utterances, which illustrates that the patient expresses thoughts with his emotions and the doctor responds with his emotions related to the effectiveness of methadone treatment. The patient is persuaded to share his emotions with the doctor who chuckles at his comments and nods with affirmation as the patient speaks. However, as is typical to the manner of the doctor's response, in conversation nine when the patient expresses his emotions, the doctor does not respond to the emotional problems. Rather, the doctor responds with prescription of methadone that abbreviates the patient's expression of thoughts and emotions related to his problems with addiction.

\textsuperscript{15} Each narrative that is sustained for the purposes of illustration and discussion in chapters four and five appears in the appendix in the order in which each conversation appears in this dissertation. Many, though not all, of the expressions presented earlier in chapter four come from the narratives later included in these two chapters. These phrases are included as demonstrations of the manner of utterances patients and the doctor express.
As their conversation begins, the doctor and patient discuss the patient's recent stints in the hospital for his arms, which both had infections from hypodermic needles. The patient begins with the fact, “I was in the hospital.

The doctor repeats: “You were in the hospital.” The patient adds to the drama of the situation with another fact and says he was in the hospital twice so that “they” could open him up and search for the needle, which wasn't found.

“They kept pulling meat out. It's still in there.” The doctor repeats that they couldn't find it. However, the patient segues to more emotional response as the conversation continues. He expresses his thoughts and feelings related to the brutal facts. He tried to kill himself last Christmas. The doctor doesn't ask why he attempted suicide, but the patient offers his emotions about his actions. The patient says that he felt miserable on methadone because he wanted to eat all the time and he “ballooned up to two-hundred pounds.” The patient expresses how much he doesn't want to be fat; this emotional fact relays the patient's sense of self as an attractive middle-aged man. This detail adds to the patient's strong sense of self, evident from the beginning of the conversation in the direct way in which he communicates details to the doctor. In the middle of their conversation the patient says, “I ain't never been clean.” He adds, “I do ungodly, stupid amounts of drugs.” The doctor doesn't ask why, and the patient's vulnerability becomes more evident as the narrative progresses. However, the doctor does not respond to the patient, and the patient seems to become more vulnerable as he expresses his emotions with increased concern. The doctor says that the patient is in danger of losing his arm, a fact that turns the talk away from the ways the patient feels about his situation and onto an assessment
of the body. The patient says that he's out of control and it has to end. The conversation does not address the reasons for the patient's behavior, and the patient does not communicate self-reflection. The doctor's communication with the patient is friendly but fails to redirect the patient's thoughts into a more self-critical and realizing mode. A segment of the transcript is below to illustrate the rhetorical patterns identified above.16

<table>
<thead>
<tr>
<th>P: They found [the needle] on the X-ray but couldn't find it when they opened me up. [Talk about drugs, dosages, and effects. Last Christmas the patient tried to kill himself.]</th>
</tr>
</thead>
<tbody>
<tr>
<td>I quit takin' [prescription drug]; it really screwed me up, and I just went crazy.</td>
</tr>
<tr>
<td><strong>DISEASE:</strong> The patient discusses his body in a matter of fact manner that provokes the doctor's response.</td>
</tr>
<tr>
<td>D: Do you have a psychologist now?</td>
</tr>
<tr>
<td><strong>DISEASE:</strong> The doctor asks a fact-based question to assess what treatment the patient has received, but the doctor doesn't follow up on the patient's statement that he &quot;went crazy.&quot;</td>
</tr>
<tr>
<td>P: I was going to Akron General [hospital]. The [medicine] helped, but I <strong>just wanted to eat</strong>, eat all the time, I ballooned up to two-hundred pounds. And I <strong>just felt so miserable</strong>. Ya know what I mean?</td>
</tr>
<tr>
<td><strong>ILLNESS:</strong> The patient begins to address his emotions related to his experience with methadone. He poses a rhetorical question to the doctor to relate his feelings with the doctor.</td>
</tr>
<tr>
<td>D: So, if I'm hearing you right, when you were on [medications] you don't use as much or you don't use at all—</td>
</tr>
<tr>
<td><strong>DISEASE:</strong> The doctor speaks to the patient as a body and doesn't assess the patient's sense of self:</td>
</tr>
<tr>
<td>P: No. I ain't never been clean. But I <strong>kept it under control</strong>, somewhat, you know. To most people, it would be a major drug problem.</td>
</tr>
<tr>
<td><strong>To me it was pretty low-key.</strong> I'm just, I do ungodly, stupid amounts of drugs.</td>
</tr>
</tbody>
</table>

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16 The conversation excerpts included here and in the next chapter are coded by underlined utterances of disease and bold utterances of illness. Additionally, the utterances coded illustrate key points of my discussion of the doctor's and patients' conceptualizations and responses to each other. I have not coded here all of the disease and illness utterances, as was done for my data analysis represented in tabulations above.
I use by myself.

**ILLNESS:** The patient discusses his situation by reflecting on what he does and how it may seem to others.

D: So, [nurse] was telling me that you just finished a course of antibiotics for that arm.

**DISEASE:** The doctor doesn't ask why the patient uses or how he feels about his addictions; instead, the doctor states a fact to move the conversation from an emotional focus to a diagnostic focus.

P: No, for both of ’em.

They cut this one open, then I had to go back for the other arm.

It was like a golfball and it was startin' to streak.

They cut it open (other arm) and drained it.

It was lookin' better until I went on another streak and then they swelled up.

It was better, now it's lookin' huge. [Talk about antibiotics and embarrassment for his mother to know the recurring situation.]

**DISEASE:** The patient discusses his body and how it has been acted upon.

**ILLNESS:** At this point, the patient again returns to an emotional focus.

I've had drug problems since I was eleven, but it's never been this bad.

I just can't live like this no more.

If I don't take myself out of the environment, I'm gonna kill myself.

D: Well, the first thing you're gonna do is be in danger of losing that arm.

P: I know.

It's gotta end.

I'm outta control.

It's crazy.

As the above section demonstrates, the doctor speaks to the patient as a body and doesn't often ask the patient his/her thoughts and/or emotions. The doctor, therefore, does not assess the patient's sense of self in regards to addiction and/or treatment. However, when the doctor speaks of patients' emotions and thoughts, he tends to lead the conversation to a diagnostic focus and away from patients' emotional focuses. In an antistrophic manner, the doctor's response to patients persuades some patients to re-conceptualize addiction as disease rather than as they have conceptualized addiction as a
matter of their personal emotions and thoughts. Even when patients are persuaded to the
doctor's conceptualization of addiction, patients' responses illustrate what addiction has
felt like and so seemed like to them. Patients' emotions and thoughts inform their
conceptualization of addiction.

The Patients' Characterizations of Addiction

Unlike expectations for what their bodies are capable of doing, which comes more
often from the doctor, patients' embodied, everyday realities are the sources of knowledge
from which they speak. For example, when expressing pain, patients say such things as:
“I'm having trouble letting go”; “I just went crazy”; “I have two tattoos of heaven and
hell because I know people in both places.” Patients provide the details from which their
personal experiences with pain can be known. For example, with metaphors coded Acting
Body, patients' utterances express how their bodies have been harmed: “I stopped coming
[to clinic] because it's a constant battle”; “I smoke marijuana because of the anxiety”;
“I've been cutting [myself] since I was thirteen”; “I do ungodly stupid amounts of drugs.”
Their attributive metaphors here show what their illness is like for them by utterances that
communicate what their pain has led them to do, in and as a body.

As stated above, patients characterize addiction as illness 81% of my data corpus.
The highest category of attributing metaphors for patients was Reflexive Thought, and
they had 74% of the total utterances on thought. Patients had 82% of the total utterances
on emotion in the data. Patients express their emotions related to their thoughts in most
conversations, including the example below, even when they also speak of addiction as
disease. Furthermore, even when patients speak of addiction like disease, their utterances are personal response to medication and drug use, which depends entirely on their own thoughts and feelings. On the other hand, the doctor follows the medical model and characterizes addiction as disease with physical outcomes and general conditions for all patients.

Patients' utterances on disease lend themselves to discussion of how they are feeling and thinking. As stated above, patients characterize addiction as disease 23% of the total utterances on disease. Of these attributive metaphors, patients' utterances were highest in responding to not using drugs 33% of the data, and in responding to medication with 23% of the data. These utterances lead into discussion of addiction and why patients felt as they did and what they thought about these emotions. For example, patients' utterances such as, “I'm going into withdrawal” and “You assessed my levels,” which are utterances that characterize addiction as disease, also relate to patients' personal illness experiences.

When patients' utterances are disease-like, patients may speak like the doctor in order to persuade him to respond to their need, particularly if it is for more methadone, which the doctor would normally agree to. However, as in the conversational example to follow, number 11, the patient is not given more methadone. This conversation demonstrates the ironic nature of the doctor's and patients' utterances when the patient speaks of addiction as disease and the doctor speaks of the patient's illness experience.

In conversation 11, the patient and the doctor share a diagnostic focus, and both also express their emotions. The doctor is emotional about prescribing methadone, which
he believes can significantly help those dealing with addictions. The doctor offers four utterances of emotion, and the patient does not respond to with emotional utterances in this conversation. The doctor also has three utterances of thought, while the patient hasn't any.

In this conversation, the doctor has to lower the patient's methadone, which makes both the doctor and the patient uncomfortable. The patient does not trust the doctor, and the doctor is unusually reticent. For example, the doctor begins by addressing the patient with the doctor's own emotions: “I wanted to talk with you today so that we can get on the same page cuz I've never met with you before.” The patient responds that he and the doctor met once before. The patient continues not to receive the doctor's gestures of reconciliation. For example, the doctor says that he knows lowering the patient's methadone has been difficult for the patient. When the doctor says that they can lower the dose and then talk, the patient asks,

“Talk about what? What do you want to talk about? Just get to the point.” The patient is furious because he thinks that he has been functioning perfectly at the exorbitantly high dose of methadone prescribed for him over the years. However, the doctor tries to explain “from a physical perspective” how dangerous the patient's dosage is. The patient refuses to understand because in his embodied experience the dosage seems good. Interestingly, the patient uses the doctor's technique of rhetorical questions to state this opinion: “Why am I functioning perfectly? I'm not sleeping [during the workday]; I'm working; I'm not in a comma. What's the problem? I haven't had a dirty urine in years; leave well enough alone.”
The doctor responds with emotion, saying that he needs an accurate reading on the patient's methadone levels, and if he gets a too-high reading he'll “go through the roof.” He asks the patient if that makes sense, which is interesting because the doctor rarely asks patients non-rhetorical questions regarding their thoughts and emotions. In this instance, the doctor depends on the patient's trust. Additionally, the doctor empathizes with the patient because he thinks methadone is the best way to treat the addiction disease. By the end, the doctor responds by asserting his ethos. “My job, [patient's name], is to manage this from a medical standpoint but also to keep the addictive side of you in check.” Therefore, the doctor's ethos usurps the patient's pathos as the doctor concludes: “I think the addictive side is in check, and I think you're doing well.” However, the patient doesn't feel well about the change in his medication, and the doctor does not persuade the patient to the doctor's perspective. The following excerpt from the conversation illustrates how the doctor and patient characterize addiction as disease.

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<table>
<thead>
<tr>
<th>P: Talk about what?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you want to talk about?</td>
</tr>
<tr>
<td>Just get to the point.</td>
</tr>
<tr>
<td>I heard, someone said, you want to drop me to X.</td>
</tr>
<tr>
<td>For what reason?</td>
</tr>
</tbody>
</table>

*DISEASE:* The patient characterizes addiction as a disease for which he's been using high doses of methadone. He is not receptive to the doctor's suggestion that they discuss why he needs to change his medication regime. The patient is not willing to share his thoughts and feelings about his illness experience, which he thinks is under control.

<table>
<thead>
<tr>
<th>D: This is great.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is why we need to talk.</td>
</tr>
<tr>
<td>Let's do this right—</td>
</tr>
</tbody>
</table>

*ILLNESS:* The doctor here expresses his emotions “This is great.” He thinks he and the patient need to talk in order to understand why methadone levels should be lowered.
P: Why am I functioning perfectly?
I'm not sleeping, I'm working, I'm not in a comma.
What's the, you know [problem]?
I haven't had a dirty urine in years; leave well enough alone. [Talk about when they will test for an accurate count of the methadone in patient's system.]
I don't agree, but i'll do it for [his counselor].

DISEASE: The patient discusses his bodily functioning, and he disagrees with the need to change.

D: Okay. I think that's reasonable.

We need an accurate reading.
If I get another [2.5 level of methadone above normal] I'll go through the roof.
Does that make sense?

ILLNESS: Again, the doctor here comments on his thoughts and what he believes they need “an accurate reading.” He expresses his emotion and asks if that makes sense to the patient.

P: No. Why do I feel fine?

I'm working, doing fine.
What's gonna happen with that?

ILLNESS: The patient demonstrates his emotional concerns.
D: Anything could happen.
You could get sick, go to the hospital, medication interactions.
I mean, it's too high.

DISEASE: The doctor diagnoses the situation, and the patient is displeased.

P: Okay. Whatever.

D: This is what we're here to talk about,
this is why you're here.

P: No. I was forced to talk before I get my medicine. That's why I'm here. I feel trapped.

The above discussion demonstrates how patients respond with their thoughts and feelings when they characterize addiction as disease. Furthermore, when patients characterize addiction as disease, their utterances are often personal responses to medication and drug use. This differs from the doctor who characterizes addiction as disease by physical outcomes and general conditions. In some cases, when the patient
characterizes addiction as disease, the doctor characterizes addiction as illness because he recognizes potential harm to the patient's body that the patient himself does not.

For this reason, the doctor's utterances are often about what the patient needs to do, or not do, in order to be free from addiction and related problems. When he refers to what the patient should not do, he often does so using second person point of view, which places the responsibility on the patient alone. For example, when the doctor discusses that the patient stop the use of drugs or otherwise destructive behaviors that lead to the patient using drugs he says: “You gotta stop it”; “You've got to control yourself”; “You should not stop the medication.”

However, the doctor more often discusses what the patient should do that would lead to positive symptom outcomes; in such instances he often speaks of the patient taking methadone or doing behaviors that lead the patient back to the regime of self-regulation that includes methadone and frequent visits to the clinic. Additionally, when the doctor speaks of what the patient should do to improve his health, the doctor uses first-person point of view and says: “We will continue on methadone”; “We'll get you up to a targeting dose”; “We have to keep the addictive side of you in check”; “We need to manage all this stuff together.” The responsibility for the patient's wellness is distributed between the patient and the doctor in cases when utterances for Body Acted On are affirmative and support the disease conceptual metaphor.

Because in many conversations the patient seeks the doctor's assurance that methadone can and will fix his/her body, the doctor's distribution of responsibility for wellness is rhetorically effective. Furthermore, the patient is encouraged when the doctor
affirms the patient's positive behavior and resulting wellness. For example, the doctor says in response to a patient who is happy on methadone, “Sounds like you can't live without methadone”; and to another, “Your life's changed, huh?”; the patient responds that she should have taken methadone earlier, “I would have been so much better.” In both instances, the patient expresses gratitude to the doctor and methadone, which work cooperatively to fix the patient's body. In these conversations, the doctor and patient engage effective antistrophic responses, and the patients are persuaded by the doctor's conceptualization of addiction as disease that affects the patient's body.

The doctor's expectations for the body in response to not using drugs provide reasons for why the doctor prescribes methadone. The doctor speaks of body sweats, insomnia, anxiety, chronic pain, and feeling sick, and patients attest to these discomforts. Still, some patients express a desire to try different meds or none at all because the patient is not the agent; rather, he is being acted upon and relies on the one by whom the action is decided and enacted, the doctor. For example patients say: “You want to drop me [lower methadone dose]”; “You think I should stay on methadone, but it makes me so jittery”; “You will check me; my mom used to check my arms for holes, you know.” These patient assumptions reflect the patient's sense of self is in direct relationship to the doctor. One patient explains that he expects his body to be more creative when he is off methadone. As an artist, this patient would like to try another medication to see how his body responds but is nervous. The doctors says, “If you can handle a little bit of discomfort, you're gonna be fine.” Through this utterance, the doctor and patient construct consensus that observes a mutual expectation for the body to need medication and for the change of
meds to cause discomfort, but, as long as the patient remains on medication, he will be “fine.”

However, in some conversations, such as in conversation 11 presented above, the patient is not in agreement with the doctor's prescription of methadone, and the patient's utterances express dissatisfaction with the doctor and his treatment. For example, the doctor asks a patient why she wants to decrease her dose of methadone. After she says that she doesn't know, the doctor responds, “You're going to experience withdrawal”; “We know exactly what will happen [implying relapse]”; and, “You're at incredibly high risk for relapse. Just like a diabetic, you have to take your meds.” The doctor expects the body to need methadone and to respond favorably to it, provided the patient uses the medication correctly, meaning the doctor's prescribed dosage and frequency. So, when a patient expresses her dissatisfaction with her bodily response while taking the doctor's prescription of methadone, “You gain so much weight cuz everyone's in the freakin' kitchen,” the doctor is defensive and incredulous. He says that it can't be the methadone. Because the patient thinks that it can be and has experienced something that tells him it is so, the patient resists the doctor.

**Rhetorical Patterns of Doctor and Patients**

As I have discussed above, utterances of emotion and thought have rhetorical effects on the conversational narratives in my data corpus. The doctor responds more often than he initiates utterances of emotion and thought, and his responses are more frequent when patients' thoughts elucidate their emotions. Furthermore, based upon the
frequency of utterances, the doctor's focus is diagnostic while patients' focuses are emotional. Because of their unique intentions, the doctor and patients have different thought utterances. The doctor's thoughts are on why the patient's physical and emotional states will improve with methadone. Patients' thought utterances express their emotions related to their personal illness experiences. As such, patients' thoughts are more varied than the doctor's as they are informed by social factors such as age, life-style, family and community influence, and the patient's gender.

Additionally, the doctor and patient structure their utterances differently. The doctor's utterances of thought are often rhetorical questions as to why the patient desires to be off methadone treatment, implying that methadone is the patient's means to wellness. Patients' statements of thought relate to how they feel on methadone, or with addiction, and therefore wish for this or that to happen. The doctor's utterances of emotion are often used to persuade patients to the doctor's diagnostic focus. The doctor's utterances on emotion aim to persuade patients to engage with him and his view on the usefulness of methadone. As a result, this leads patients to respond positively or negatively to the doctor, based on the patient's own thoughts and feelings about addiction and methadone. When patients' utterances are of disease, patients' utterances continue to follow from their thoughts and feelings. When the doctor's utterances are on what the patient needs to stop doing, he uses “you,” but when the doctor affirms the patient's behavior(s), he does so with the first person “we.” The doctor expresses a shared sense of responsibility for the patient's wellness in such cases.
The findings in my study affirm my hypothesis that the doctor conceptualizes addiction as disease, and the patient conceptualizes addiction as his own illness experience. Patients' conceptualizations of addiction are personal and arise from everyday embodied emotions and thoughts. However, sometimes the patient conceptualizes addiction as disease, and sometimes the doctor conceptualizes addiction as illness. This means, then, that in such cases patients respond to how their bodies behave, and the doctor responds to addiction in a personal manner by his thoughts and feelings. Interestingly, patients respond to addiction from their personal thoughts and emotions, whether the patient conceptualizes addiction as disease-like or illness-like, and the doctor responds to addiction as a disease that should be treated with methadone, a method he is passionate about.

These rhetorical techniques affect the antistrophic natures of the doctor's and patients' conversations. For example, in conversation 11 the patient conceptualizes addiction as disease. The patient has a high frequency of utterances on thought, and the doctor responds with utterances of emotion. This conversation illustrates how the doctor is emotionally responsive to patients who express thoughts related to their emotions on using methadone.

From the findings stated in this chapter, I turn now to chapter five for further discussion and interpretation of the above rhetorical patterns in my study. I interpret conversational narratives in order to consider the ways in which the doctor and patients construct their utterances. Furthermore, from interpretation of the data, I determine how the interactions between the doctor's and patients' utterances result in the progression of
their conversational narrative. I interpret the doctor's and patients' conversation as *antistrophic* in nature because each aims to call out their conceptualization of addiction as disease and/or illness, which follows from the doctor's and patients' embodied everyday realities. My study on the rhetorical effects of the doctor's and patients' conversations is an important step in assessing the effectiveness of communication between the doctor and patient. In order to advance towards interpretation of the findings in my study, I turn to chapter five.
CHAPTER FIVE

Discussion

In chapter five, I interpret how the doctor's and patients' conversational illness narratives operate rhetorically and why this should matter. As chapter four demonstrated about the data in my study, the doctor and patients construct a rhetorical position through their conversations that persuades or fails to persuade the other to respond. Their conversations are constituted by the interlocutors' responses, which makes the rhetoric of addiction about the ways in which one fails or succeeds in eliciting response. Furthermore, in the ways that the doctor and patients call and respond to each other, their conversation is antistrophic and persuades the other to conceptualize addiction by one's own conceptualization. Lastly, in the process of their call and response, the doctor and the patient can be persuaded by the other, which can affect a sense of addiction as both illness and disease.

In the following chapter, I analyze the findings on emotion and thought utterances presented in chapter four with additional narrative illustrations from my data corpus. Furthermore, I submit that in conversations where the doctor responds to the patient's sense of self, communicated by the patient's utterances of emotion and thought, the patient and doctor construct a rhetorical position that persuades each to validate the
other's conceptualization to some degree. As a result, the conversation moves towards agreement rather than resistance.

As mentioned in chapters one and three and developed by the findings in chapter four, my hypothesis is that patients' and the doctor's specific utterances uniquely characterize addiction. The speakers' language reflects an understanding of addiction, which conceptualizes addiction most often as one's own illness experience. In contrast, the doctor tends to characterize addiction more often as “disease.” Together, through their attributive metaphors and responses to each other's, the doctor and patient socially construct an illness narrative. This singular, joint effort demonstrates the doctor's and patients' essential understanding of “addiction” and the ways in which they communicate with one another in order to effect agreement or instances of resistance.

The doctor and patients characterize addiction on a continuum of disease and illness experience. This continuum ranges from conceptualizing addiction as a broken body to conceptualizing addiction as an embodied, personal illness experience. The differences inherent along this spectrum move from physical and in-common with all people who are addicted, to emotional and socially-situated, as only a unique individual can experience the disease. As the doctor and patients discuss addiction, therefore, their utterances suggest limited and unfinished meanings. For example, when the doctor asks patients to consider hypothetical situations whereby they might not use illicit drugs, patients are unable to envision hypothetical situations with accuracy, and say so, expressing willingness only to communicate an understanding of current bodily pain. This conceptual phenomena is directly related to the difference in the doctor's and the
patients' predominant conceptual metaphors. Patients' knowledge is embodied and everyday, and the doctor's knowledge comes from looking at a variety of patients on most days. Therefore, the doctor can see beyond a given patient's plight by comparing it to other patients, but the patient's experiential knowledge is of his/her own illness. Both the doctor and the patient offer valuable knowledge, and each relies on the other's response to knowledge for the narrative to effectively develop.

In order to investigate my hypothesis, I asked the following research questions:

1. How does the doctor / patient talk about addiction vis-a-vis language used to discuss activities?
2. How does the doctor / patient talk about addiction vis-a-vis language used to discuss emotions and thoughts?
3. How does the patient / doctor respond to the other's utterances characterizing addiction?
4. From embodied experiences with addiction, what identities (or senses of selves) do patients narrate to their doctor?

Using the above research questions enabled me to isolate how the doctor's and patients' utterances characterized addiction and how these characterizations of addiction operated in the context of their conversation which constructed a narrative whole. For the first and second questions, I identified utterances on activities done to the body, more characteristic of the doctor's predominant conceptual metaphor *addiction is disease*, and I also identified utterances on thoughts and emotions, more characteristic of the patients' predominant conceptual metaphor *addiction is illness experience*. Furthermore, these first
two questions relate to the ways in which the doctor and patients state claims to what addiction is like.

With the third and fourth research questions, I studied patients' emotions and thoughts as senses of selves presented to their doctor. I found that when the doctor responds to patients' sense of self, communicated by patients' utterances of emotion and thought, then the patient and doctor construct a rhetorical position that persuades each to validate the other's conceptualization to some degree. As a result, the conversation moves towards agreement rather than resistance.

The doctor and patients persuade each other to respond in a two-fold manner. First, the patient responds with his thoughts in addition to his emotions. Second, the patient agrees with the doctor's prescription of methadone. Typically, the patient responds in this manner when the doctor responds to the patient's thoughts and/or emotions with the doctor's own thoughts. Often, the doctor's thoughts relate to the usefulness of methadone. When the doctor relates his thoughts on methadone to the patient's sense of self, his emotions and/or thoughts, then the patient responds more effectively to the doctor. In this way, a patient feels understood and respected by the doctor.

Importantly, I have found in my study that patients often speak of their illness experience before they hear the doctor speak about addiction. Therefore, the patient may express utterances that obstruct the doctor from a desirable response. This happens when the patient is highly emotional and resistant to methadone treatment. When the conversation begins in this way, the doctor responds defensively. He may assess the patient's body, as he does with utterances on the body acted on 86% of the times in which
the doctor characterizes *addiction as disease*. However, when the conversation sets the stage for ineffective rhetorical response between the patient and doctor because of the highly emotional manner the patient began or because of the patient's rejection of methadone, then the doctor is likely not to respond at all to the patient's emotions and/or thoughts. For this reason, 64% of the time, patients' emotions are not responded to, and 48% of the time patients' thoughts are not responded to.

Now that I have outlined the ways in which the conversations operate in a rhetorically persuasive manner, the remainder of this chapter presents narrative demonstrations which model how persuasion operates between the doctor and patients. I enumerate this singular process in a three-fold way to explain how the doctor's and patients' responses work to persuade the other. My study's findings presented in chapter four serve as the basis for my three-fold claim below:

a. Patients have to express their thoughts and emotions for the doctor to respond to their senses of selves.

b. In order to persuade the doctor to respond, the patient has to state his/her thoughts *with* his emotions, and the patient has to state a position compatible with the doctor's sensibilities on the usefulness of methadone.

c. When the patient is highly emotional and does not express his/her thoughts clearly, s/he obstructs the doctor's response to the patient's thoughts and/or emotions.

*Part One of Claim*
Patients have to express their thoughts and emotions for the doctor to respond to their senses of selves. The doctor responds to patients with questions and statements that genuinely engage the patient's emotions and/or thoughts. However, the doctor's frequent use of rhetorical questions does not respond to patients as individuals with personal illness experiences. Instead, the doctor's rhetorical questions are often statements demonstrating that he perceives addiction as disease.

For example, in conversation 12, as referred to in chapter four, a patient communicates the paradoxical desire to be sober, despite his awareness that he depends on drugs. While the doctor calls for the patient's affirmation for methadone, he does not provoke the patient's reflection on underlying reasons for drug abuse. Ironically, the patient refuses to be sober, even if this choice costs him his life. The patient is in his upper 50s when he meets with the doctor. He has a history of severe drug abuse but has remained on a steady dose of methadone for over a year. The doctor asks the patient how life would be without methadone, and the patient says it would be the same as before, “I'd be shootin heroin, and that's never good.” The patient continues to explain that he's “seen that video before, and it always finishes badly.” He says that he cannot go through that again or he'll shoot himself.

The doctor says, “Sounds like you can't live without methadone.” He continues, asking, “What would have to change for you to think that you don't need methadone to live?” The patient says everything, and he begins his next utterance specifying what he means by “everything.” He comments on sweats at night, aching joints, and his mental state. He determines that the cycle of withdrawal and heroin use is so terrible to him that
he would choose death. Indeed, he says that he cannot live without methadone. Ironically, as the patient continues talking with the doctor who is very receptive, the patient expresses an abrupt shift in his own narrative on addiction. If the patient didn't have methadone, though he says he couldn't live with illicit drug abuse, he would find and use dope:

“'It's straight to the dope boys [...] There's no question what will happen. Ain't nothing like being dope sick. I cannot go through that again. But the first thing I would do, would be to go buy me some. I just would.”

The doctor asks the patient, “If you weren't dope sick, and not on methadone, would you still use?” However, the patient refuses to reflect on a life he has not lived. He says that there are too many hypotheticals and living sober is not what is going to happen. Through this response, the patient blatantly refuses to consider situations other than he is in. The doctor's attempt to question the patient's activities shows a desire to foster the patient's ability to self-reflect, but in his attempt he never asks the patient about his thoughts and feelings related to drug abuse. In this way, the doctor does not respond to the patient's sense of self and therefore fails to persuade the patient into a responsive dialogue. Therefore, the patient cannot reconcile what he wants to do with what he sees himself doing. The following portion of the transcript of conversation 12 shows how the patient and doctor characterize addiction and rhetorically interact:

<table>
<thead>
<tr>
<th>ILLNESS: The doctor responds to the patient with an utterance expressing thought that relates to the patient's expressions of emotion and thought.</th>
</tr>
</thead>
<tbody>
<tr>
<td>D: That's based on previous behavior, your life-video, your consequences, ahhh—</td>
</tr>
<tr>
<td>P: Ain't nothin' like being dope sick. I can not go through that again.</td>
</tr>
</tbody>
</table>
But the **first thing I would do** [without methadone] would be to go buy me some [dope].

I just would.

**ILLNESS:** Though the patient's utterances are on his refusal to endure the way he felt dealing with addiction, he thinks he would continue the addictive pattern. The patient's ambivalence is a result of conflicting emotions: wanting not to go through the withdrawal, etc., but not willing to endure a sober life, either.

D: Alright.

P: Never been able to stop before.

D: So, **if you weren't dope sick, and not on methadone, would you still use?**

P: There's too many hypotheticals. 

**That's not what's gonna happen.**

I can't answer so many hypotheticals.

D: One of the reasons I brought that up, [patient's name], is because when you came in, you were off methadone.

**ILLNESS:** The doctor continues to respond to the patient's sense of self and presents an alternative for the patient. However, this is not a persuasive proposal to the patient because he cannot identify himself with sobriety.

P: Yeah, well, one of the dope boys came up to the hospital and took care of me, too, so. You pay enough, and somebody'll take care of ya.

D: **Why didn't somebody give you methadone?**

**DISEASE:** The doctor asserts methadone could have provided the patient's relief.

P: They never told me that.

I should'a asked 'em.

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**Part Two of Claim**

In order to persuade the doctor to respond, the patient has to state his/her thoughts with his emotions, and the patient has to present a position on methadone compatible to the doctor's. In conversation 14, also referred to briefly in chapter four, the patient does not agree with the doctor's prescription for methadone. She does not express her thoughts and emotions, and the doctor responds to the patient with shallow rhetorical questions that state his conceptualization of addiction as disease.
The doctor begins by asking, “What can I do to help?” The patient responds to the doctor by saying that she doesn't know what he can do to help. As the conversation continues, the doctor demonstrates a sense of certainty and the patient expresses insecurity. For example, the patient says that she needs something for stress but she does not want to be on methadone. This is a red flag for the doctor who views methadone as the best response to the diseased body, as it keeps the body in a sort of stasis without illicit drugs. The doctor asks why the patient doesn't want to be on methadone. The patient doesn't respond with specific thoughts related to her emotions, and the doctor does not provoke the patient to further response. Instead, he says she will continue drug abuse by his rhetorical question: “What do you think's gonna happen?” When the patient says she doesn't know, the doctor says, “That's a terrible answer. We know exactly what's gonna happen.” The doctor does not respond to the patient's sense of self because she does not express her thoughts and emotions and agree with his stance on methadone.

The patient shifts her sensibilities as she listens to the doctor's perspective. The patient asks the doctor if he thinks she should stay on methadone. He says that in his “experience and clinical judgment, you're at an incredibly high risk for relapse. It just goes from there.” Next, the doctor turns the narrative: “So, you had a lapse in judgment. It happens, okay. But, to make a decision to go down on your dose, I would advise against it.” In this way, the doctor reframes the patient's desire to get off methadone as a mistake. He begins to end the conversation by suggesting he and the patient meet again in a month and “see how life's changed for you.” By his dismissive approach, the doctor does not respond to the patient's thoughts and feelings concerning treatment. As a result,
the patient has no alternative to the doctor's characterization of addiction as a disease he can fix with methadone.

The doctor asks the patient: “Do you think you have a disease, [patient's name]?” She says she does; however, when the doctor asks if it is like diabetes, she says no, that addiction is nothing like diabetes because she doesn't wake up and want a piece of cake. She wakes up and wants a shot of heroin. “Right. From my perspective, disease is something that's off-kilter in your body. And what's off-kilter in your body, in opiate dependency, are opiate receptors. So, just like a diabetic, you have to take your meds.” The conversation ends with this metaphor of addiction as diabetes, which the patient does not respond to again, though by her silence she seems to accept. The doctor and patient do not construct a responsive rhetorical position in this narrative. Instead, the doctor's conceptual metaphor prevails over the patient's thoughts and feelings. Below is an excerpt from their conversation that illustrates how patient 14 is led to the doctor's diagnostic focus.

<table>
<thead>
<tr>
<th>D: Do you think you have a disease, [patient name]?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P: Uh-huh.</td>
</tr>
<tr>
<td>D: Do you think it's like diabetes?</td>
</tr>
<tr>
<td>P: My disease?</td>
</tr>
<tr>
<td>No. It's nothing the same.</td>
</tr>
</tbody>
</table>

**DISEASE:** The doctor's rhetorical questions state that the patient's addiction is a disease. The patient at first resists. The doctor's following thought utterance states that addiction is disease.

<table>
<thead>
<tr>
<th>D: I think they are.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P: I don't.</td>
</tr>
</tbody>
</table>

I don't wake up and think I want a piece of cake,

but I do wake up and think I want a shot of heroin.

**ILLNESS:** Because the patient considers her addiction from an embodied, everyday perspective, she understands concrete differences between her addiction experience and diabetes. The
D: Right. From my perspective, disease is something that's off-kilter in your body.

And what's off-kilter in your body, in opiate dependency, are opiate receptors.

So, just like a diabetic, you have to take your meds.

and there is behavior associated with that: the cravings and all that stuff.

DISEASE: To the doctor, disease is “something off-kilter in your body” but to the patient, the detail of desire makes addiction different from other diseases.

In the following example conversation where the patient does not agree with the doctor's prescription of methadone, the patient is more effective in persuading the doctor to see addiction as the patient does. Rather than failing to communicate the patient's own emotions and merely following the doctor's conceptualization of addiction as disease, as illustrated by conversation 14 above, in the following example, the patient communicates how he feels and thinks about methadone so that the doctor responds to the patient.

In the last of my examples provided as illustrations of the second part of my claim on the rhetorical persuasiveness of the conversational narrative, patient 20 expresses his desire to get off methadone because he is an artist and feels that being on methadone has “disintegrated my flame a bit, if you will.” In this narrative, the patient expresses what he feels with direct relationship to what he thinks. This rhetorical move is persuasive to the doctor and causes him to respond to the patient's sense of self, even though the patient does not agree with the doctor's prescription of methadone. Furthermore, the patient suggests another drug in place of methadone that could be what he calls his “parachute,” or a medication, other than methadone, that would be taken to counter his addiction. By the patient's proposal of another medication to balance what the doctor perceives as an “off-kilter” body, the patient successfully persuades the doctor to agree with his argument.
and respond. The patient persuades the doctor because he expresses his emotions with reasons for his behaviors and because the patient's perspective includes medication.

For example, patient 20 continues by saying, “I'd like to just feel myself, what it feels like to be clear and not on anything.” The patient expresses his emotions, and he continues with explanation of what he thinks: “I’ve heard there's been success in coming down [from other patients], just as long as I do it correctly.” Next, the patient addresses the doctor with a rhetorical question, hoping for the doctor to confirm: “If that's done correctly, can I come down from this without feeling awful? I mean, I can handle a little bit of discomfort, but.” The doctor affirms that the shot is a very good idea, and the narrative proceeds from there. In this example, the doctor affirms the patient's perspective, allowing him to do what he feels, and thinks, would be better for him. The doctor is persuaded to respond to the patient's sense of self by the manner in which the patient presents his emotions related to his thoughts and because the patient agrees with the doctor's use of medication to be sober. In the excerpt below, the patient's utterances of emotion are tempered by utterances of thought.

<table>
<thead>
<tr>
<th>P: <strong>I wanted to lower down</strong> [methadone dose]; it's the only thing that's helped me with opiate addiction, because of things going on in my life, it would just be a nightmare.</th>
</tr>
</thead>
<tbody>
<tr>
<td>And, uh, it's getting to the point where <strong>the medicine's keeping me from going further</strong>.</td>
</tr>
<tr>
<td>You know, I'm an artist.</td>
</tr>
<tr>
<td>And it's kinda disintegrated my flame a bit, if you will.</td>
</tr>
<tr>
<td><strong>ILLNESS:</strong> The patient begins with utterances expressing what he desires (lowering methadone), but with hesitation born from thoughtfulness of the positive change methadone has had in his life.</td>
</tr>
<tr>
<td><strong>D:</strong> Are you attributing your decreased ability to be creative, is that your “flame,” and decreased energy to methadone?</td>
</tr>
<tr>
<td><strong>ILLNESS:</strong> The doctor responds to the patient by restating what he hears from the patient, and in...</td>
</tr>
</tbody>
</table>
Part Three of Claim

When patients express too-high emotion disconnected to thoughts and without concession to the doctor's prescription of methadone, the doctor does not respond to the patient's thoughts and emotions. As a result, the doctor and patient do not persuade each other to validate the other's conceptualization of addiction, and rather than consensus the conversational narrative develops as an instance of resistance.

For example, in conversation 16, the patient begins by telling the doctor that she is tired all the time and so she is taking her methadone at night. The doctor says it can't be the methadone but “we can't have you tired.” The doctor demonstrates by his use of “we” that the problems are shared and he and the patient will work something out. In the beginning, it seems that the patient takes the doctor's response as encouragement to further express her emotions. As the narrative progresses, however, it is evident that the patient doesn't need the doctor's validation to continue to share what she feels. She speaks as though uncaring to whom she speaks. As she continues to express her emotions, she
does so without thought utterances, and the doctor does not respond. Still, the patient continues dramatically expressing herself. She says how she fell asleep in her soup and birthday cakes because she felt exhausted by the methadone. The doctor's reply defends the higher dose of methadone, which was to block the patient's reception of “perks,” or illicit drugs that she continued using. The patient's brazen approach to the doctor reaches a climax as she asserts: “I don't know. You're the doctor.” The doctor does not respond to the patient's thoughts and emotions against the usefulness of methadone.

The conversation continues as the patient says when her baby screams it sounds like a busted speaker. She wants to see a neurologist for her head because she feels crazy. The doctor doesn't ask her about this. Rather, he returns to his concern about methadone and asks why she wants to go off it. The patient responds that while on methadone she eats too much and drives when she's too tired. She fears that she may wake up on the wrong side of the road, or that she may even start a fire in the kitchen. In response, the doctor simply says: “That's not the methadone. Maybe it's your head.” The doctor uses the patient's own words to dismiss her thoughts and feelings. The doctor does not respond to the patient's sense of self, and the patient does not respond to the doctor's prescription of methadone. Both remain rhetorically incompatible, and the conversation does not move forward. For example, in the instance below the patient expresses strong emotion, and the doctor remains focused on diagnoses based on the functions of her body:

<table>
<thead>
<tr>
<th>P: This is like crazy, feels crazy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ILLNESS: The patient feels crazy, but doesn't say why or further provide an utterance of thought to elucidate her feeling for the doctor.</td>
</tr>
<tr>
<td>D: Why do you want to stay off X?</td>
</tr>
<tr>
<td>Are you sleeping?</td>
</tr>
<tr>
<td>DISEASE: The doctor assesses the patient's body.</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>P: I sleep for two hours then I go into the kitchen.</td>
</tr>
<tr>
<td>Does anyone talk to you about this?</td>
</tr>
<tr>
<td>Everyone talks about it in the waiting rooms, the way <strong>you wander around on methadone.</strong></td>
</tr>
<tr>
<td>Everyone goes into the kitchen.</td>
</tr>
<tr>
<td>They tell you this, ever hear these stories?</td>
</tr>
<tr>
<td><strong>You gain so much weight cuz everyone's in the freakin' kitchen.</strong></td>
</tr>
</tbody>
</table>

| ILLNESS: The patient avoids reflective thought on her emotional state and instead focuses on a highly dramatic scene of patients wandering in a kitchen. There is not substance from which the doctor can respond, other than in defense of his prescription of methadone to all these patients. |

In other conversations, such as conversation 19, the patient expresses his emotions and the doctor responds to the patient's sense of self. Unlike the above example, in conversation 19, the doctor and patient construct a rhetorical position that is responsive to each other. Though the patient is primarily talking about his emotions, and the doctor is primarily gathering information related to how the patient can sustain his treatment of methadone, the doctor responds to the patient's sense of self and the patient is accepting of the doctor's methadone prescription.

As stated above, when the patient utters his/her emotions and thoughts and agrees with the doctor's methadone treatment, then the doctor responds. Additionally, when the doctor responds effectively to a patient's sense of self, then the patient feels understood and respected by the doctor, as is illustrated in the following conversation where the patient concedes with the doctor.

The conversation begins with the patient saying that work is miserable and he wants to have an antidepressant to help with depressed moods. The patient discusses his emotions at length and justifies his drug use by his bad moods. In this way, the patient
sees concrete relationship between his emotions and thoughts. The doctor doesn't further inquire about the patient's moods, but he allows the patient to speak of his depression at length. For this patient, the doctor's silent attention confirms his care. The doctor asks questions to assess the patient's body and conceptualize the patient's treatment such as how much he uses, what medications the patient needs, and how he will pay for his treatment. The doctor tells the patient that if he doesn't stay off the illicit drugs, attend small groups, and pay for medication, the patient's “spot” will be given to another patient. The doctor's language is colloquial, and he says things such as, “I'm not sayin' that to be an asshole.” The doctor expresses closeness to the patient in talking to him with direct and candid honesty. However, by telling the patient that he will need “this stuff for the rest of his life, but if I don't see ya, I'm gonna give your spot to someone else,” the doctor communicates a contradictory message. On the one hand, he responds to the patient's emotions by legitimizing the patient's request for mood-altering meds; however, by failing to respond more to why the patient experiences such painful emotions, the doctor short-circuits the patient's response.

The doctor and the patient validate one another's conceptualization elsewhere in a partial manner in conversation 19. For example, as they discuss addiction, the doctor demonstrates empathy by his thought utterances in response to the patient:

| P: [Doctor and patient talk about addiction.] | I miss it [drugs] because anytime something goes wrong, you know how to fix it, at least in your eyes. |
| **ILLNESS:** The patient expresses his emotion with his thought. |
| D: Because you know how to survive—how to get something to feel normal for four hours? |
| **ILLNESS:** The doctor's rhetorical question re-states what the patient says as the doctor understands it. |
| P: You don't realize it, but you are surviving. |
I try everything. **It's about the effort, up to the individual.**

Then, **other times, it doesn't matter what I do.**

**ILLNESS: The patient reflects on what he does to control himself.**

The urge comes, the craving, you get it in your head, then forget it. But you gotta keep yourself in check.

I mean I gotta keep myself in check. I try and stay busy.

**DISEASE: The patient acknowledges addiction as a disease out of his control, and yet he tries to control himself, to “stay busy.”**

In the above conversation, each responds to the other's claim and adds to his utterance. For example, the patient says that he misses drugs he had used to fix his problems, and the doctor rewords the patient's comment by suggesting that the patient knows how to “survive—how to get something to feel normal for hours.” This is the doctor's way of addressing the body, but in a manner that relates to the patient's emotions. The patient adds to the doctor's claim by saying, “You don't realize it, but you are surviving.” Each speaker adds to the other's claims and they together develop explanation of what addiction is. In this way, the doctor and patient rhetorically construct a position on addiction that is centered on response to one another's utterances. The doctor listens to the patient's emotions and thoughts and responds to the patient's sense of spiritual self. The doctor asks the patient to explain his tattoos of heaven and hell that cover both of his arms. “I know people in both places,” the patient says. The doctor nods and says “interesting,” responding to the patient by the doctor's own sensibilities.

In my last narrative illustration of this chapter, the doctor and patient build rapport by means of the patient's honest self-reflection and the ability each shows to re-visit problems and in ways validate the other's conceptualization to some degree. The following conversation six demonstrates how a patient can persuade the doctor with her
utterances of emotion when these are related to the patient's utterances of thought.
Additionally, conversation six shows how the doctor responds to the patient's sense of
self in a rhetorically effective manner that, in this case, evokes mutual empathy between
the patient and doctor.

The doctor and patient share a diagnostic focus and agree on the usefulness of
methadone. The patient wants to raise her methadone dose, but the doctor resists because
the patient is using marijuana. The patient begins with an argument for the harmlessness
of marijuana. In reply to the doctor's claim that marijuana is not a pharmaceutical
substance and therefore one doesn't know what is in it, the patient says that she's been
going to the same person for 10 years and “knows” what she's getting. The doctor
switches into more technical language, but then switches to common talk to which the
patient responds.

“We have different cannabinoid receptors. One that is the big one that everyone
wants to hit, and the other one that does some strange stuff.” The patient says that she
doesn't know what to do, and this confession leads the patient to expressing her emotions
in relationship to her thoughts.

“Sleep is a huge issue. I've been in care since I was fourteen. I have serious
anxiety issues.” She continues self-reflecting on the problems for which she uses illicit
drugs. She says that she doesn't have a doctor willing to give her medication when she
continues to use marijuana, but she is between a rock and a hard place because of her
anxiety and inability to sleep. She asks if the doctor understands and indicates by this
question her desire for the doctor's validation. Before the doctor responds, she continues
to express her pain: “I'm waking up miserable. So, I don't know what to do. At this point, I'm about ready to stop comin' here because it's a constant battle.” The patient communicates her emotions and thoughts with a throw-in-the-towel attitude that seems to strike a chord with the doctor. The doctor asks how long she's been coming to the Center. He says that methadone is not a cure-all and that marijuana doesn't help the patient's condition, either.

After the doctor responds to her emotions, the patient's tone lightens and she speaks less defensively. The patient interjects here, asking, again, on what research the doctor makes his claim. This time, though, the patient says, “excuse me for asking,” with a lighter and more respectful tone. She continues, “I get that you're a doctor, […] but if you give me something that helps the anxiety, I won't smoke the marijuana.” The doctor chuckles. As a result of their rapport, the doctor issues the patient methadone, and the patient listens to the doctor's orders. The following excerpt demonstrates a pivotal point between the doctor and patient as they re-see addiction by the other's conceptualization.

<table>
<thead>
<tr>
<th>D: Is this your first go-around with methadone?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot of your symptoms are overlying.</td>
</tr>
<tr>
<td>You have some withdrawal from the methadone; then, you get chronic pain and anxiety — the methadone's not a cure-all.</td>
</tr>
<tr>
<td><strong>DISEASE:</strong> The doctor assesses the patient and her use of methadone.</td>
</tr>
<tr>
<td>P: I understand that, trust me, I understand that.</td>
</tr>
<tr>
<td>D: The marijuana doesn't help either.</td>
</tr>
<tr>
<td>I know you think so, but it doesn't.</td>
</tr>
<tr>
<td><strong>DISEASE:</strong> The doctor continues to assess the patient's body.</td>
</tr>
<tr>
<td>P: What research are you going by, excuse me for asking.</td>
</tr>
<tr>
<td><strong>ILLNESS:</strong> The patient's thought utterances challenge the doctor:</td>
</tr>
<tr>
<td>D: There's research out there at a medical library.</td>
</tr>
<tr>
<td>You don't know what you're actually getting.</td>
</tr>
</tbody>
</table>
P: Want me to bring some in, then you can check it out.

D: No. I don't.

P: Okay. I don't know how else to resolve that issue.

D: What I'm saying is that I trust the makers of [prescription drugs]—

P: Right. I get that you're a doctor,

but I get to some point where I've told them [other doctors] repeatedly, if you give me something that helps the anxiety, I won't smoke the marijuana.

Of course, that's never happened.

*ILLNESS: The patient's thoughts are clear and offer understanding from the doctor's perspective. By her argument, the doctor is persuaded to respond effectively to her.*

Because the doctor conceptualizes addiction as a disease of the body that cannot be cured, one that will continue making one sick, he sees methadone treatment as a responsible way to manage one's diseased body. However, patients characterize addiction more dynamically from their experiences with the disease as it affects their minds and spirits. Additionally, their personal histories of making what many feel are self-destructing choices, results in feelings of inadequacy and insecurity in one's sense of self. Patients often feel unable to trust themselves, just as the doctor seems unwilling to trust the patient. In response to patients' more dynamic expressions of illness experiences, the doctor offers methadone. Some patients are more and some less satisfied with this solution.

In order for the rhetorical position to be authentically responsive, the doctor and patient have to understand each other to some degree. When the doctor fails to respond to the patient's sense of self as presented in his thoughts and emotions, then the patient's fuller, embodied problems related to addiction(s) are left untreated. This results in resistance to the doctor as well as resistance to the truth of the patient's illness.
experiences. As a result, the seed of addiction remains in place and in a matter of time will develop further problems related to drug use.

**Conclusion**

As seen above in the conversational narrative illustrations, when the doctor responds to patients' utterances of emotion and thought, the patient and doctor construct a rhetorical position that persuades each to validate the other's conceptualization to some degree. This moves their illness narrative forward from addiction-related problems and towards agreement, rather than resistance. Consensus is two-fold and relies on the patient's utterances of thought and emotions as well as the patient's compatibility to the doctor's view on methadone. When the patient presents his/her thoughts and emotions as such to the doctor, the doctor responds with his thoughts on the usefulness of methadone. Furthermore, when the doctor's response to the patient appeals to that patient's particular emotions and thoughts, the doctor is persuasive to the patient who feels understood and respected.

However, the conversation can be an instance of resistance and fail to move forward from addiction and related problems. Such rhetorical failure occurs when the patient speaks first and negatively about methadone treatment, which sets the doctor in a defensive mode where he is less likely to respond to the patient's thoughts and emotions with affirmation. Additionally, if the patient is too emotional and fails to simultaneously submit his/her thoughts, the doctor often does not respond to the patient.
Of the above six conversations interpreted for their rhetorical persuasiveness, three demonstrate a position of rhetorical persuasion between the doctor and patient and three do not. Conversation 12 illustrated how the patient wanted to be sober while also depending on methadone. In this conversation, the doctor did not engage the patient's self-reflection. The patient was unable, and/or unwilling, to consider the hypothetical situation of being sober posed by the doctor. Patient 12 persuaded the doctor to respond because the patient was fully dependent on methadone; however, the doctor did not persuade the patient to respond with the patient's thoughts and feelings. In conversation 14, also an illustration of ineffective response, the patient was anxious and expressed the desire to be off methadone. However, the doctor didn't respond to her thoughts and feelings and instead usurped the patient's vulnerability with his position on methadone. Lastly, in conversation 16, the patient was highly emotional and unreasonable and failed to foster empathy from the doctor in large part because of her position against methadone. His response to her emotions uses her own words concerning problems with her head, which closed the narrative from developing resolution for the patient.

Of the three conversations that develop a responsive rhetoric between the doctor and patient, patient 20 is the only one who expresses a desire to be off methadone. Though usually the doctor is unresponsive when patients obstruct his primary treatment option, patient 20 suggests another medication that might have a more positive affect on him. The patient expresses his thoughts with his emotions and agrees with remaining on meds. For these reasons, the doctor is responsive to him, and both he and the doctor construct a narrative that moves forward from the addiction problems.
methadone as well as other medication for his moods. The doctor responds positively to the patient's thoughts and emotions with the doctor's reflexive thoughts on the patient's tattoos of heaven and hell. The second example of successfully persuading one another to respond is demonstrated by conversation six as the doctor and patient agree on methadone but together face the problem of the patient continuing to smoke marijuana. They build rapport between them as they engage reflective thoughts on the pitfalls of methadone, marijuana, and treatment of addiction all together.

In each of the conversational narratives, the doctor is sure how to best treat the body, and when patients move the doctor to empathy, he responds to them as individuals and both an emotional and diagnostic focus emerges. However, when the patient opposes the doctor's way of conceptualizing addiction as a disease of the body that requires methadone, then the doctor is unresponsive to the patient's sense of self.

From the above narrative demonstrations, I conclude with two additional claims. First, the patient's utterances are persuasive and even sound like the doctor's language when s/he wants the doctor's approval, and the doctor's utterances are persuasive and even sound like the patient's when he assumes he has the patient's approval. This demonstrates that the doctor's and patients' objectives are unique. The doctor aims to persuade the patient to trust him and do as he says. On the other hand, the patient expresses his/her thoughts and emotions because of personal need to be responded to and/or to receive methadone. In my study, patients who struggled to self-disclose their illness experiences were more persuasive in communicating embodied illness experiences that suggested a desire to move forward and be well than patients who sounded like they
were playing soundbites of the doctor's own discourse. It was evident in some cases when
the patient did not discuss his/her emotional problems that s/he wanted a medication in
order to continue not to have to deal with his emotions and thoughts.

Second, when the patient and doctor respond to one another, they build rapport
between them. Rapport enables the narrative to move forward because the patient self-
reflects on his/her embodied knowledge with addiction when the doctor calls the patient
to consider his experience as a disease. The doctor self-reflects on his conceptualization
of addiction as a disease when the patient's emotions are communicated in direct
relationship to the patient's thoughts that lead to actions related to drug addiction. When
the conversation flows in this way, the doctor is responsive to the patient's illness
experience. Therefore, in the process of constructing their illness narrative, the doctor and
patient together realize what addiction is as it is embodied by a given patient.

In the above chapter, I have interpreted six conversational illness narratives from
the 20 in my data corpus. These examples have demonstrated the rhetorical nature of my
study. Again, the rhetoric of addiction is about the ways in which one fails or succeeds in
eliciting response. The rhetorical call and response between the doctor and patients is
antistrophic because it is a responsive technique aimed at persuading the other to
conceptualize addiction as disease and/or illness. The doctor and patients demonstrate
that their conceptualizations of addiction exist on a spectrum and are continually
influenced by life experiences, including their discussions with one another. Therefore,
their embodied understandings can change through the rhetoric of addiction established
by their conversational illness narratives. However, this occurs when the other is
persuaded to see addiction in particular ways. The above claims have indicated the manner in which each successfully or unsuccessfully persuades the other to respond to addiction. In chapter six, I conclude my dissertation with discussion of the contributions and limitations of my research.
CHAPTER SIX

Contributions and Limitations of my Study

Contributions

In this final chapter of my dissertation, I discuss my study's contributions, limitations, and the need for further discussion within the fields of rhetoric and composition; addictionologists studying communication practices, such as doctors, counselors, and therapists; scholars of language studying mental illness and disability; and narrativists studying narrative and medicine. Disability, addiction, mental health, and language scholars have studied how language affects individuals’ social status and what it means to be “ill.” It has been argued that disease is defined by language, which my study illustrates. Furthermore, my study demonstrates how conversation is rhetorically constructed by a doctor's and his patients' responses, which arise from different conceptualizations of addiction.

My study contributes to understanding how conversational illness narratives operate rhetorically and why this should matter. My data and analysis demonstrated in chapter four and my interpretation of the study's findings in chapter five are stated below as a recapitulation of the claims in my dissertation. After all, these are the central contributions that support my argument that the doctor and patient construct a position by means of their conversations that persuades or fails to persuade the other to respond.
Furthermore, my study argues that conversational illness narratives are constituted by interlocutors' responses, which means the rhetoric of addiction involves, among other issues, the ways in which one fails and/or succeeds in eliciting response.

First, I found that the patient has more frequent utterances of emotion, and the doctor has less frequent utterances of emotion. Second, patients' frequent utterances of emotion are often associated with frequent utterances of thought. Third, the doctor has a diagnostic focus in response to the patients' emotional focus. And, fourth, the patients' utterances characterize addiction by means of their thoughts and emotions. Furthermore, a conversational illness narrative is antistrophic when the doctor responds to the patient's mind, body, and soul, to the degree warranted by the patient's utterances. For example, in order to persuade the doctor to respond, the patient has to state his/her thoughts with emotions, and the patient has to state a position that is agreeable to the doctor's sensibilities regarding the usefulness of methadone. Additionally, the doctor responds to the patient's thoughts and/or emotions with the doctor's own thoughts, but this process is obstructed when the patient is highly emotional and does not express his/her thoughts clearly.

By the end of my analysis and after interpreting the claims in my study, I present two concluding claims. The first, patient's utterances are persuasive and reflect the doctor's language when s/he wants the doctor's approval, and the doctor's utterances are persuasive and even sound like the patient's when he assumes he has the patient's approval. This demonstrates that the doctor's and patients' objectives are distinct. The doctor aims to persuade the patient to trust him and do as he says. On the other hand, the
patient expresses his/her thoughts and emotions because of personal need to be responded to and/or to receive methadone.

My second conclusion is that when the patient and doctor respond to one another, they build rapport between them. Rapport enables the narrative to move forward. When the doctor calls the patient to consider his experience as a disease, then the patient self-reflects on his/her embodied knowledge with addiction. S/he considers if the thoughts and feelings s/he has and has had regarding addiction is relatable to the doctor's conceptualization of *addiction as disease*. As a result, the rhetoric of addiction involves a dynamic of persuading the doctor and the patient to respond to one another. The doctor responds through his utterances characterizing addiction as *disease*, and patients respond to the doctor through utterances characterizing addiction as *illness*. However, in the process of communicating with one another, the doctor and patients characterize addiction as both *disease* and *illness*. Their response is critical to enabling a conversational narrative to move the patient forward and past addiction. The above claims follow from patterns that arose throughout my data corpus.

Now, I address the contributions of my study in light of narrative studies. In this dissertation, I have argued that patients' and their doctor's conversation is an illness narrative. In so doing, I have demonstrated how patients communicate personal emotions and thoughts in a clinical setting with their doctor. As demonstrated in chapter five with my interpretations of the doctor's and patients' conversations, I extend research on life writing. My study of conversation as narrative investigates how “personal” narratives can be oral and social. In this way, I add to current literature, presented in chapter two, on
narrative and illness. My study argues that conversational illness narratives are co-constructed by the doctor's and patients' utterances, characterized as conceptual metaphors in this study.

Furthermore, my research complements illness narrativists Charon's and Frank's research and adds to their findings that empathy is not constant within conversational narrative. There are instances when understanding the other occurs and times when it does not, and the degree of responsiveness between speakers determines this effect. More specifically, the doctor's and patient's empathy depends upon the rhetorical dimension of their interactions, as discussed above. The doctor is persuaded by the patient's emotional control and demonstration of thought. The patient is persuaded by the doctor's response to his/her sense of self communicated by the patient's utterances on his/her thoughts and emotions. This manner of response determines whether the doctor's and patients' narrative is rhetorically successful.

My study of patients' and their doctor's conversation as illness narrative illustrates how addiction is socially constructed and uniquely embodied by the context of each speaker and his/her response to the other speaker. The conceptualization of addiction exists on a spectrum, a spectrum which moves from illness to disease and is dependent upon social norms, which are shaped by doctors' understandings of their patients' actual experiences with addiction. Therefore, studying the rhetoric of addiction informs society how to accommodate individuals' with addiction(s) and extends existing research in language within narrative, rhetoric, and medicine by looking closely at the exchange of patients' and their doctor's conceptual metaphors within their conversational narratives. In
this way, it is possible to understand conceptualizations arise from social contexts such as one's communities, gender, economic situation, etc. and effects one's thoughts and feelings as much as one's physiological make-up. The body and the mind manifest states of being that determine conceptualizations and effect how addiction is perceived. The doctor and patient communicate from particular vantage points and respond to one another with degrees of empathy that determines the success of their conversation.

I have shown in my study of addiction rhetoric that conceptual metaphors emerge in conversational illness narratives and tell of the manner the doctor and patient understand addiction and related problems. I add to research by Judy Segal on rhetorical problems in medicine that the patient's embodied experiences are valuable and telling. Patients should be encouraged in medical encounters shared with their doctors to give voice to their thoughts and feelings that arise from their embodied experiences. Like Segal's, my research on the rhetoric of addiction follows a social model approach, by which I argue that illness is constructed within a broader cultural context. Rather than perceiving addiction as merely a physical fact, patients' and their doctor's metaphors demonstrate how problems related to addiction are physical, as the body is addicted, and also socially constructed because the doctor's and patients' communication frames notions of disease and disseminates these notions into society. In particular, my study adds to rhetorical research how “addiction” as a concept is constructed by a doctor's and his patients' conceptual metaphors and how their responses to one another develop a conversational illness narrative. By examining metaphorical expressions that tell what one thinks, feels, and how one conceptualizes addiction in and as a body, I contribute to
investigations on how the patient's embodied illness experience is expressed, received, and responded to by his/her doctor in the context of addiction.

Furthermore, I contribute to research in medical rhetoric and writing studies by demonstrating how existing frames of understanding illness narratives can be applied within the context of the doctor/patient interview in addiction. My study extends work done with written illness narratives in disability studies by illustrating ways in which illness is told and understood between patients and their doctor. I add to existing research on written illness narratives with my study of conversation. Therefore, my research of conceptual metaphors in conversations between a doctor and patients demonstrates the rhetorical patterns of response that lead to agreement and/or resistance between the doctor and his patients. This dissertation shows that conversations between a doctor and patient can be understood as illness narratives, and that in doing so there are important rhetorical findings. While the doctor and patients do not conceptualize addiction similarly, they are able to communicate and reach agreement in a rhetorical process I have depicted in this study. In continuation of this study with additional research on antistrophos, the rhetorical patterns of call and response discovered here could be further investigated.

My dissertation adds to scholarship in addiction from Howard Kushner and Scott Vrecko (2010). They argue for conceptualizing social change and social regulation that redefines disease and manages behaviors by therapeutic interventions as “civilizing technologies” rather than “treatments.” My research adds to theirs by affirming that the ways patients and their doctor conceptualize addiction leads to particular ways they
conceive of treating it. Therefore, medical providers' and patients' language has the power to define addiction by their manner of responses. Furthermore, language used in response to addiction and related problems enters into social spheres and shapes the ways in which society understands addiction. This means the ways that a doctor and patient communicate affects treatment for the patient involved directly and also for other patients in contact with the doctor and/or the patient who has come to conceptualize addiction in particular ways. For example, others may be affected such as future patients with whom the doctor may work and peers or those in mutual communities with the patient. Beyond this, language used to describe addiction problems and treatments spreads throughout society, such as in medical communities and out into mainstream society.

**Limitations and Need for Further Discussion**

My study does not investigate treatments and recovery. Rather, my study offers linguistic evidence to support that patients need to talk about their thoughts and emotions related to addictions. When the doctor responds to patients' emotions and thoughts, the conversation tends to lead to improved conditions for the patient. The manner in which patients characterize their pain redefines some current conceptions of addiction that are inaccurate generalizations. Listening to what people suffering with addictions have to say about their illness experiences allows medical providers to re-conceive what addiction really is, noting that addictive behaviors change depending on a number of factors such as time, place, and person. Addiction is not a category requiring protocol treatments but a dynamic, day-to-day way of life. To successfully address the problem of addiction
requires degrees of patience and attention to understand the whole-body effects drugs have on individual patients. While quantitative studies on addiction have identified at-risk populations, considering class, race, age, and socio-economic positions of those with drug problems, my study addresses the importance of the rhetorical position constructed by the doctor and patient.

However, there have been some limitations in my study. Most of the limitations in my study can be summarized by a small sample size and short duration of study. I was the only investigator for this research project and therefore the above claims come from my interpretation of the data. However, my study has been transparent in that I defined each code and set methods up in a replicable manner. Most importantly, my focus is on narrative meaning, which is contextual, living, and so also subject to change. The results of my study are suggestive rather than strictly objective. For example, I urge doctors and patients to consider that language tells important facts about embodied states of mind that affect our illness experiences and define our diseases.

There is certainly a need for further discussion of communication between doctors and patients, both inside and outside of the context of addiction. Rhetoricians may extend my study by investigating whether gender affects discourse between doctors and/or patients. Another consideration is to investigate patients in particular socio-economic situations and research if, and how so, socio-economic situations affect the ways in which patients internalize addiction problems and use language to communicate. An interesting avenue of continued research is to gather data and categorize it by marked differences in patients' and/or doctors' embodied states. This may include gender and class and also
aspects such as race, sexual preference, religious worldview, and family conditions, such as having children, or not having dependents, for example. Additionally, other scholars may further the research I have presented in this dissertation by using different methods such as interviewing patients and/or doctors, asking for patients to write narratives, or surveying doctors across the country. In so doing, one could collect important data for analysis to explain how individuals conceptualize addiction based on their everyday, lived experiences.

In the course of my study, I considered rhetorical research in antistrophos and dialectic but ultimately decided that to move critically into these concepts would prove beyond the scope of my study. According to Gu Yun-Sang (2011), the ‘structure of calling and response’ began in the beginning of Western philosophy. Aristotle says in The Rhetoric that “rhetorics is the counterpart (antistrophos) of dialectics” (1354a). Yun-Sang argues that counterpart means something that stands adverse or is the opposing piece (isostrophos), but that it originally meant contrapuntal procession in music. That is, ‘antistrophos’ means an ‘answering strophe’ in a form of response or correspondence for the preceding ‘strophe (strophē).’ Therefore, he argues, that rhetoric can be considered a technique (techne) of argument in response to dialectics, as an answer to dialectics. With the argument that rhetoric is antistrophic in nature, there are possibilities for future research in addiction and responsiveness between medical practitioners and patients. For example, in the future, I may investigate the doctor's and patients' treatment plans developed during patient in-take. I may compare these documents to the conversational narratives in my study in order to investigate particular utterances in each and the manner
in which addiction is characterized in writing versus in the oral form of conversation. The act of writing may take more or less account of particular characterizations of addiction; i.e.: patients' physical states and/or emotional complaints, which may affect responsiveness between medical practitioners and patients.

I have discovered that conversational narratives exhibit a foundational call and response. In order to further investigate this finding, I would take my 20 conversational units, divide them into quartile segments, and analyze the manner of utterances from the beginning to the end of each conversation. Then, I would compare these utterances across the data corpus, noting the ways in which the patient and doctor rhetorically engaged “call and response.” For example, the patient tells how he feels and how he thinks. The doctor, on the other hand, asks if the patient has experienced withdrawal from a lowered dose of methadone. Taken together, the patient here calls to the doctor who then responds to the patient. I am interested in whether their conversational narrative develops an antiphonal reply which characterizes addiction. By antiphonal reply, I refer to Greek choral lyric poetry whereby a short sentence is sung by two alternating groups. Furthermore, the consideration of antiphonal reply may be a pragmatic frame for interpreting how the doctor's and patients' utterances harmonize, despite their differing conceptual metaphors, and despite the juxtaposing instances when the conceptual metaphors change for a given speaker.

While I have not developed discussion of antistrophos in this dissertation, I have observed the way in which it explains rhetorical patterns in my data and therefore provides a base for future research. I am interested in pursuing a project that investigates
the oral tradition of call and response as it relates to Aristotelian rhetoric as *antistrophos* to dialectic. Particularly, I would consider call and response as it relates to the ancient Judeo-Christian oral tradition in worship practices and Aristotle's characterization of rhetoric as *antistrophic*. I am intrigued by the rhetorical nature of calling and responding that has always been a compelling technique in persuading groups to respond to a voice calling out a way of conceptualizing the world, whether that voice is defining by their conceptualization God, Truth, or, in my study, addiction.

**Conclusion**

Now that I have completed my study, I urge doctors to do two things while working with patients and addictions. First, I encourage doctors to pay closer attention to how patients' express, or fail to express, their emotions and to respond. Second, I urge doctors to respond to the patient's mind, body, and soul, even beyond what is directly communicated by patient's initial utterances. In other words, I'm calling doctors to elicit patients' emotions and thoughts and to use these responses to their rhetorical advantage in persuading the patient towards whole-body wellness.

Obviously, the doctor works with patients more effectively when s/he listens carefully to the patient's thoughts and feelings and responds in a manner that affirms the patient's sense of self in a positive way. However, unresponsiveness cannot be eliminated altogether between a patient and doctor, and there will not always be the possibility for consensus between them. Yet, when the doctor responds to the patient and affirms the patient's sense of self, the patient may be encouraged to forego the addiction and follow
the treatment plan. Furthermore, being attentive may give the patient the impression that the doctor genuinely cares. Feeling encouraged, the patient may better explain his problems. With a clearer understanding of the illness experiences affecting the patient, the doctor can better help him.

Addiction cannot be remedied by simply understanding patient's metaphors, by speaking a magic metaphor that communicates hope, or by identifying the social norms that generalize dynamic problems related to addiction. My research and the research of others does not purport to solve deep-seeded problems related to drug abuse. However, my study offers linguistic evidence demonstrating how utterances characterize addiction and how these utterances function from one's conceptual metaphors. Therefore, understanding communication between doctors and patients is a way in which we may better understand addiction.

Furthermore, by studying individuals' conceptualizations of addiction and how these become public discourses, it is evident that social messages define addiction. For example, the way in which a Center describes addiction in their brochures, or the manner in which practitioners explain problems related to addiction that the patient his/herself may experience. Therefore, it is of utmost importance that scholars and medical providers listen to language carefully and understand the significance of research on communication practices between doctors and patients. Furthermore, doctors may wish to re-examine their uses of conceptual metaphors of “disease” and treat illness as more of a whole-body, personal illness experience. At the least, doctors may realize that patients'
language communicates how they conceptualize their own illness experience. Thus, it is important to pay attention to patients’ and their doctor's conversational illness narratives.
P: I was in the hospital.

D: You were in the hospital.

P: Twice. They opened [middle of arms where he shoots drugs] me up and tried to find the needle, but they couldn't find it.

They just kept pulling meat out. It's still in there.

D: Couldn't find it?

P: They found it on the X-ray but couldn't find it when they opened me up. [Talk about drugs, dosages, and effects. Last Christmas the patient tried to kill himself.]

I quit takin' [prescription drug]; it really screwed me up, and I just went crazy.

D: Do you have a psychologist now?

P: I was going to Akron General [hospital].

The [medicine] helped, but I just wanted to eat, eat all the time,

I ballooned up to two-hundred pounds.

And I just felt so miserable.

Ya know what I mean?

I don't want to be fat. I've been the same size for years, and I would eat just to eat.

D: So, if I'm hearing you right, when you were on [medications] you don't use as much or you don't use at all—

P: No. I ain't never been clean.

But I kept it under control, somewhat, you know.

To most people, it would be a major drug problem.
To me it was pretty low-key.

I'm just, I do ungodly, stupid amounts of drugs.

I use by myself.

D: So, [nurse] was telling me that you just finished a course of antibiotics for that arm.

P: No, for both of 'em.

They cut this one open, then I had to go back for the other arm.

It was like a golfball and it was startin' to streak.

They cut it open (other arm) and drained it.

It was lookin' better until I went on another streak and then they swelled up.

It was better, now it's lookin' huge. [Talk about antibiotics and embarrassment for his mother to know the recurring situation.]

I've had drug problems since I was eleven, but it's never been this bad.

I just can't live like this no more.

If I don't take myself out of the environment, I'm gonna kill myself.

D: Well, the first thing you're gonna do is be in danger of losing that arm.

P: I know.

It's gotta end.

I'm outta control.

It's crazy.
APPENDIX B

Conversation eleven

D: I wanted to talk with you today so that we can get on the same page
cuz I've never met with you before—

P: You were in the room with Dr. Nick when he arbitrarily dropped me [lowered methadone dose].

D: I know this has been difficult for you,

and I want to address that.

We can stay at [upped level of methadone but not high enough to patient] for two weeks,
and then we can talk again.

P: Talk about what?

What do you want to talk about?

Just get to the point.

I heard, someone said, you want to drop me to X.

For what reason?

D: This is great.

This is why we need to talk.

Let's do this right—

P: Why am I functioning perfectly?

I'm not sleeping, I'm working, I'm not in a comma.

What's the, you know [problem]?

I haven't had a dirty urine in years; leave well enough alone. [Talk about when they will test for an accurate count of the methadone in patient's system.]
I don't agree, but I'll do it for [his counselor].

D: Okay. I think that's reasonable.

We need an accurate reading.

If I get another [2.5 level of methadone above normal] I'll go through the roof.

Does that make sense?

P: No. Why do I feel fine?

I'm working, doing fine.

What's gonna happen with that?

D: Anything could happen.

You could get sick, go to the hospital, medication interactions.

I mean, it's too high.

P: Okay. Whatever.

D: This is what we're here to talk about,

this is why you're here.

P: No. I was forced to talk before I get my medicine. That's why I'm here.

I feel trapped.

D: My job, [Patient's name], is to manage this from a medical standpoint

but also to keep the addictive side of you in check.

I think the addictive side is in check,

and I think you're doing well.
Appendix C

Conversation Twelve

D: So, what would life be like if you didn't have methadone?

P: Same as before.
I'd be shootin' heroin,
and that's never good.
I've seen that video before, and it always finishes badly.
D: What video is that?
Your life-video?
P: Yeah. Getting arrested, end up in the hospital, rip ya off,
give you something so good that it knocks you down.
I can't go through with that again.
I'll just shoot myself.
I've been there too many times. I can not do that again.
D: Sounds like you can't live without methadone.
P: Probably not. At least for now. I know, yeah, at least for now.
D: What would have to change for you not to think that you don't need methadone to live?
P: Probably everything.
Sweats at night, joints aching. In my head, it's not worth livin', as far as going through all that again [cycle of withdrawal and heroin use].
I can't live without medication.
It's straight to the dope boys, some of 'em will drive to my parents' house.
There's no question what will happen.
D: That's based on previous behavior, your life-video, your consequences, ahhh—

P: Ain't nothin' like being dope sick. I can not go through that again.

But the first thing I would do [without methadone] would be to go buy me some [dope].

I just would.

D: Alright.

P: Never been able to stop before.

D: So, if you weren't dope sick, and not on methadone, would you still use?

P: There's too many hypotheticals.

That's not what's gonna happen.

I can't answer so many hypotheticals.

D: One of the reasons I brought that up, [patient's name], is because when you came in, you were off methadone.

P: Yeah, well, one of the dope boys came up to the hospital and took care of me, too, so.

You pay enough, and somebody'll take care of ya.

D: Why didn't somebody give you methadone?

P: They never told me that.

I should'a asked 'em.

D: [After more talk about hospital experience and drugs:] Tryin' to know something about you, [patient's name].

P: Yeah. Yeah.
Appendix D

Conversation Fourteen

D: What can I do to help?

P: I don't know.

I need something for the stress.

D: [Dosing talk and discussion of boyfriend home from jail, which will help in taking care of their baby.] You want to decrease your dose of methadone, why?

P: I don't want to be on it.

D: As you go down on your dose, you're going to experience withdrawal.

What do you think's gonna happen?

P: I don't know.

D: That's a terrible answer.

We know exactly what will happen.

P: So, you don't think I should go down?

D: If you were my daughter or sister, after what just happened [she did heroin and lost her take-home methadone doses],

in my experience and clinical judgment, you're at incredibly high risk for relapse.

It just goes from there.

So, you had a lapse in judgement.

It happens, okay.

But, to make a decision to go down on your dose,

I would advise against it.

Why don't we meet again in a month and discuss how life's changed for you.

P: [Patient asks about getting her take-home methadone back and dosing.]
D: Do you think you have a disease, [patient name]?

P: Uh-huh.

D: Do you think it's like diabetes?

P: My disease?

No. It's nothing the same.

D: I think they are.

P: I don't.

I don't wake up and think I want a piece of cake,

but I do wake up and think I want a shot of heroin.

D: Right. From my perspective, disease is something that's off-kilter in your body.

And what's off-kilter in your body, in opiate dependency, are opiate receptors.

So, just like a diabetic, you have to take your meds,

and there is behavior associated with that: the cravings and all that stuff.
Appendix E

Conversation Twenty

P: I wanted to lower down [methadone dose]; it's the only thing that's helped me with opiate addiction, because of things going on in my life, it would just be a nightmare.

And, uh, it's getting to the point where the medicine's keeping me from going further.

You know, I'm an artist.

And it's kinda disintegrated my flame a bit, if you will.

D: Are you attributing your decreased ability to be creative, is that your “flame,” and decreased energy to methadone?

P: Yeah. But at the same time, I don't wanna, I don't ever want the nightmare to come back.

I was told about a shot you get monthly, so when you use the opiate blockers keep you from the high.

I know when I was in jail it was easier to quit smoking because I knew it wasn't possible, um, and I think that would be like my parachute.

And, at the same time, I could have a sober mind.

I'd like to just feel myself, what it feels like to be clear and not on anything.

I've heard there's been success in coming down, just as long as I do it correctly.

If that's done correctly, can I come down from this without feeling awful? I mean, I can handle a little bit of discomfort, but.

D: If you can handle a little bit of discomfort, you're gonna be fine, if you can handle feeling a little bit of discomfort.

I think the idea of the shot is a very good idea.

P: Yeah.
D: We need to get you completely off of opiates, including methadone, for five days, um, then we'd need to give you [name of injectable medication].

I give X to those in the ER who stop breathing after overdosing on opiates and within seconds the opiate receptors are displaced.

It's a competitive antagonist.

If you have any opiates in your system, it will put you into instant withdrawal—

P: The other thing i'm taking, ah, my mom is into a lot of rayke and herbal things, she's turned her and her boyfriend's life around, she mentioned milk thistle for my liver, and i want to check my liver for enzymes—

D: Yeah, we're gonna do that anyways.

P: Okay. i'm really nervous about coming down from this, should I be?

D: No. What we'll do, we'll decrease your rate of withdrawal [dosing discussion].

P: Is there anything else i should do, any vitamins?

D: No, I'm okay with the milk thistle.

P: Should my diet change?

D: No.

P: Just keep livin' as I am?

D: Yeah.

P: Okay.

D: You're gonna be fine.
Appendix F

Conversation Sixteen

P: I'm tired all the time.
Taking my medicine at night because it makes me really tired.
Y makes me jittery, so I take X and Y together.
D: Can't be the methadone, but we can't have you tired.
P: I was fine at 55, but at 65 I was on the border of tired.
At 85 I was fallen asleep in birthday cakes and in my soup bowl.
D: Well, the reason we increased it, to increase the blocking capacity;
you're still usin' perks.
It's usually higher than that, but we'll drop you down to 55.
P: I don't know, you're the doctor.
I need something.
When [her baby] screams, sounds like a busted speaker.
It is first here, then back here.
I need to find a family doctor and get referred to a neurologist.
D: Both hospitals have a general doctor.
P: This is like crazy, feels crazy.
D: Why do you want to stay off X?
Are you sleeping?
P: I sleep for two hours then I go into the kitchen.
Does anyone talk to you about this?
Everyone talks about it in the waiting rooms, the way you wander around on methadone.
Everyone goes into the kitchen.

They tell you this, ever hear these stories?

You gain so much weight cuz everyone's in the freakin' kitchen.

D: Well, what's weirdest to you, driving or going into the kitchen?

P: Both. It's weird being in the kitchen and not knowing why I'm in the kitchen. I could start a fire, or do somethin' stupid to myself, or wake up on the wrong side of the road when I'm driving.

D: Well, that's not the methadone.

P: What do you think it is?

D: Maybe it's your head.

P: Are we gonna figure this out now or at my next appointment? [Dosing and medication talk.]
Appendix G

Conversation Nineteen

P: Work's miserable, work's run out.

I was gonna talk to you about getting' back on X.

D: Okay. How you payin' for suboxone?

P: I don't know what I'm gonna do.

I tell you, work's been terrible.

Worked today for the first time since last week. [Talk about where patient is living, etc.]

D: You have a history of doing well that's proportional to the groups you go to.

P: Yeah. I just get myself into these moods and I can't shake it.

D: When you relapse, how much?

P: All depends on the money.

I don't have a set amount.

D: [Talk about money and prescriptions to treat depression, anxiety, and addiction. Doctor threatens to give patient's spot to another patient, if he doesn't comply.]

I'm not sayin' that to be an asshole.

I'm saying that because your spot is really valuable.

You're gonna need this stuff for the rest of your life, but if I don't see ya, I'm gonna give your spot to someone else.

P: [Doctor and patient talk about addiction.] I miss it [drugs] because anytime something goes wrong, you know how to fix it, at least in your eyes.

D: Because you know how to survive—how to get something to feel normal for four hours?

P: You don't realize it, but you are surviving.
I try everything. It's about the effort, up to the individual.

Then, other times, it doesn't matter what I do.

The urge comes, the craving, you get it in your head, then forget it. But you gotta keep yourself in check.

I mean I gotta keep myself in check. I try and stay busy.

D: You have two tattoos.

P: Yeah. Heaven and hell. I know people in both places.
Appendix H

Conversation Six

D: [After talk about patient wishing to raise methadone dose:] I guess the issue, the issue is the marijuana.

P: Yeah, well, that was the issue the entire time with [two other doctors].

I kept sayin' let me see the proof, show me the research.

And they couldn't come up with one bit of research that said that marijuana made you—

D: Well I'm not gonna talk about that.

I'm talking about that you don't really know what you're getting.

P: What do you mean?

D: It's not a pharmaceutical substance.

The person you go to, he buys it, or sells it, or whatever.

You hope you get what you wanna get, but um—

P: [Patient laughs] I've been going to the same guy for ten years.

I've never had an issue. Are you sayin that there's somethin' in it?

D: We have different cannabinoid receptors.

One that is the big one that everyone wants to hit, and the other one that does some strange stuff.

P: I don't know.

I have no doctor, and sleep is a huge issue.

I've been in care since I was fourteen.

I have serious anxiety issues.

You come here and you can't get any anxiety medication.

So, I'm between a rock and a hard place, you know what I'm sayin'?
I need sleep. It's getting to the point where [marijuana] is only lasting me three hours.

I'm waking up miserable.

So, I don't know what to do.

At this point, I'm about ready to stop comin' here because it's a constant battle.

D: Okay. [Silence.] How long you been coming here?

P: Over six months.

D: Is this your first go-around with methadone?

A lot of your symptoms are overlying.

You have some withdrawal from the methadone; then, you get chronic pain and anxiety — the methadone's not a cure-all.

P: I understand that, trust me, I understand that.

D: The marijuana doesn't help either.

I know you think so, but it doesn't.

P: What research are you going by, excuse me for asking.

D: There's research out there at a medical library.

You don't know what you're actually getting.

P: Want me to bring some in, then you can check it out.

D: No. I don't.

P: Okay. I don't know how else to resolve that issue.

D: What I'm saying is that I trust the makers of [prescription drugs]—

P: Right. I get that you're a doctor,

but I get to some point where I've told them [other doctors] repeatedly, if you give me something that helps the anxiety, I won't smoke the marijuana.

Of course, that's never happened.

D: [He chuckles.]
P: I don't know what to do.

I can't not sleep, I can't.

D: Okay, so we'll continue on [list of medications, doses, each of the patient's physical problems addressed here].

P: I get it.

There's gotta be something to do.

I mean, I'm not a doctor, so I don't know, but not sleeping makes everything so much worse.
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