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Solace of Substance

Agency, Surrender, and Consolation in Addiction and Polydrug Use

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Abstract

Although preceding its association with substance use, early uses of the term 'addiction' signified intense attachment or 'devotion' to an activity or pursuit, indicating compromised autonomy, a necessary 'culling' of conflicting obligations, such as family and other concerns, and a potentially dangerous surrender (Lemon 2018). Recent advances in biomedical and neuroscientific understandings of addiction, as a relapsing neurological disorder, have sharpened notions of substance use as being outside of conscious control. Yet framing addiction in terms of individual, neurobiological predispositions towards addictive behaviour, continues to impact how we view agency, responsibility, and autonomy, even as substances are ascribed their own powerful agencies.

Based on long-term ethnographic fieldwork with individuals and third sector services in south-east Scotland, this article attends to ambiguous notions of agency attributed to and by people who use substances, and to substances themselves. It asks how responsibility for recovery becomes divested onto individuals, and how a moral 'devotion' to one's recovery is mandated by medical and judicial institutions. The article further highlights how dyadic and intimate relationships with heroin are emplaced within wider webs of relations, and how heroin itself is suffused with agency and intentionality: becoming at once a force for destruction and source of life-giving surrender.

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Keywords

Addiction, Substance Use, Agency, Time, Memory.

Introduction

Erin had walked across the county, from her home to the courthouse, to be tried for shoplifting. It was a distance of some seven miles, on country paths hemmed on either side by the motorway and old coalfields.[1] When she emerged from the court—the charges dropped for lack of evidence—the mild heroin withdrawal she had begun the day with had deepened in intensity. Without the money to return by bus and fast sickening with withdrawal, she found the house of an old acquaintance, someone she'd broken with years before, and asked for heroin. The acquaintance had supplied it, along with four benzodiazepine tablets, which she swallowed all at once. Erin later told me that she had not felt herself slipping into overdose. She was aware only of instant, familiar relief, a spreading numbness, her head becoming heavy. Getting high with heroin and benzos was a form of letting go, a stepping out of time and place, which could soothe, console, and smother distress and exhaustion. Erin most often evoked feelings of warmth, emptiness, and forgetting, in the boundless ways she described polydrug intoxication.

When Erin became unresponsive, her acquaintance injected her with naloxone, a drug that temporarily reverses the effects of overdose. When she came around, she left the house, angry with him for wasting the heroin.

This article considers the agencies and temporalities that co-emerge between people and substances, and the dynamic of choice and choicelessness conditioned by poverty, social marginalisation, historical setting, and diffuse structural forces.[2] It draws on several years of ethnographic fieldwork, beginning in 2016, within recovery and harm reduction services in Fife and Midlothian, Scotland, and with individuals who use drugs. Exploring the intimate, affective, and at times hazardous relationships that interlocutors cultivated with substances, the article proposes consolation as an analytical lens with which to apprehend addiction. In the face of personal loss, grief, and structural harm, consolation speaks to the agential, relational act of seeking and giving solace, albeit one that carries fraught tension in the context of addictive substance use. To be consoled is, Maddrell (2019) writes, to find expression for loss, but what if the consoling object is held to be an architect of one's loss? What forms of expression are

[1] All names have been changed to pseudonyms and identifying characteristics removed to protect anonymity.
[2] 'Substances' and 'drugs' are used interchangeably in this article, and both terms are inclusive of alcohol.

possible when consolation takes one out of conscious experience, or when use of substances fragments memories of loss beyond recall? This article turns over such questions and anchors their exploration in the lives and stories of participants.

Perhaps surprisingly, substance use as a form of consolation remains under-explored in addiction scholarship, owing in part, I suggest, to the dominance of framing drug use as an 'escape' from difficult or distressing circumstances (see Burraway 2018; Jouhki and Oksanen 2021; Kalmár 2020; Watson and Parke 2011). Burraway (2018, 476), for example, frames 'blackout' intoxication among people experiencing homelessness as a form of escapism from the desperate despair that living under liberal capitalism entails. The 'addicted escape artist', as Burraway writes (2018, 479), becomes an absence without presence, severed from memory, time, and meaning. Many of my interlocutors did characterise intoxication in terms of 'escaping', but many also spoke of a solace found in sitting *with* painful memories; of soothing unruly emotions; and of accepting things as they were. Understanding addiction as consolation can, overall, add new depth to discussions of agency and choice in dependent drug use, and foreground the meaningful, pleasurable, fulfilling (and ordinary) aspects of taking drugs so often overlooked. Exploring the pursuit of solace can further challenge tropes of addiction as an inherent loss of agency, while grasping the complexity of agencies that are both asserted and surrendered (Sedgwick 1994; Lemon 2018).

Agencies in addiction

Across intermittent research projects, I heard many evocations of heroin addiction, and substance use more broadly, as an ensnarement, in which one's actions were endlessly constrained by a physical and emotional need for the drug. Interlocutors' perceptions of their substance use, and in turn senses of self, were pollinated by prevailing discourses around addiction in Scotland and the wider UK. Such discourses varyingly encompassed medicalised models; trauma-informed perspectives; harm reduction practices; and stigmatising notions of drug use as a moral failing. Personal narratives of addiction at times featured the counties' landscapes and histories, particularly the decline and collapse of the coal industry, or else the need to anaesthetise the realities of living in extreme poverty—discussions largely still absent in policy and practice contexts. Ebbing and flowing in interlocutors' accounts were the agencies of substances themselves, as they orchestrated action; forged, disrupted, and mediated social bonds; harmed and consoled.

Tensions continue to inhabit conceptions of agency and responsibility in contemporary studies of addiction, which have received only sporadic attention in recent academic discourse (Racine, Sattler and Escande 2017; Weinberg 2019; Gowan, Whetstone and Andic 2012; Uusitalo, Salmela and Nikkinen 2013). In both

academic and non-academic contexts, such as policy and healthcare, constructions of agency continue to be heavily influenced by biomedical perspectives. In spite of their encompassing a diverse corpus of evidence and positions, biomedical accounts are often distilled into an understanding of addiction as a chronic, neurological illness or 'disease', characterised by interchanging periods of recovery and relapse (Dennis and Scott 2007; Strang and Tober 2003; Singer 2008). In this working, substance use becomes compulsive—necessary for 'normal' functioning—and the free agency of the individual is compromised.

In healthcare and recovery contexts, much practice paradoxically rests upon affirming the agency and control of the individual, who is expected to take responsibility for their own recovery—even as the chronic nature of addiction is acknowledged (Garcia 2009; Gowan, Whetstone and Andic 2012).

Anthropologists and social scientists have long called attention to the socioeconomic, political, cultural, and historical factors that underlie experiences of addiction. Philippe Bourgois and Jeffrey Schonberg (2009, 181) caution against overemphasising individual agency where everyday survival is threatened by intersecting webs of structural forces. Michael D'Arcy (2023) alternatively attends to precarious forms of moral agency carved out by people undergoing inpatient care for dual diagnoses of mental health and substance use disorders, in which assertions of oneself as a moral agent are constrained, demeaned, and contested by systems of care. Angela Garcia (2009) similarly illustrates how intersecting structural, medical, and historical formations result in a struggle to 'maintain the everyday', for people who use heroin. Drawing on Freud's framework of melancholia, heroin addiction in her conceptualisation constitutes a work of mourning, wherein losses and wounds are actively, even endlessly, sustained. Heroin use is not a form of consolation, but rather an intensification of grief, oriented to keeping vigil over past losses and composed in historically formed struggles (2009, 74).

Outside of addiction, anthropological works have addressed contested forms of agency that arise in situations of extreme marginalisation, structural violence, and social abandonment, or else in situations of 'slow violence', in which harms are gradual, iterative, and cumulative (Biehl 2005; Desjarlais 1997; Berlant 2011; Nixon 2011; Segal 2023; Ahmaan 2023). Individual and collective agencies can often be incapacitated by structural forces, and yet can be provoked, reclaimed, and enacted in myriad ways: through, for example, collective activism and the deliberate manipulation of time (Ahmaan 2023); conscious maintenance of the ordinary in the everyday (Segal 2023); and camaraderie, reverie, and self-assertion (Biehl 2005).

This article, then, builds on works that excavate the precarious and intersubjective forms of agency forged in situations of vulnerability, poverty, and marginality. It traces interlocutors' attempts to craft senses of meaning and agency in, through, and outside of substance use, alongside the ways they harnessed time and memory to navigate everyday life. In slight contrast to Angela Garcia, the article further argues that addiction constitutes, in part, a work of both mourning *and* consolation, in which solace is found by dwelling in, accepting, and at times distancing painful memories. Just as my interlocutors fought to assert their agency and senses of self, many portrayed substance use as a giving over of oneself to the substance. The article does not, as such, seek to forward a straightforward account of agency in addiction: rather, it contends with a novel negotiation of both agency and its wilful surrender. Refuting medicalised constructions of addiction as a loss of willpower, interlocutors often negotiated ambiguous spaces in which control and compulsion, agency and ensnarement, were imbricated, and which blurred the lines between harm and solace.

Through the field

The experience of Erin's long walk to her shoplifting trial above was occasionally reflected in other interlocutors' accounts, many of whom similarly found themselves compelled to travel without the financial means to do so. Where car lifts could not be negotiated or where buses were unaffordable, most could describe isolated incidents of walking miles through rural back-paths to reach crucial appointments, or to source substances. More common were the short, daily walks through neighbouring streets and towns to reach friends and peers, or visit the multitude of services most were involved in. As a result, many hours of my fieldwork were spent traversing the landscapes of Fife and Midlothian on foot, and the scattering of towns, villages, hamlets, harbours, and pasture fields that composed them. At times, these journeys were marked by urgent need, such as the need to source money or substances; at others, they were lethargic meanderings intended only to kill time. Much of my time, however, was spent driving people to appointments, services such as the food bank, and others' houses. Several times people brought friends along unexpectedly, hoping I would ferry them to various locations. The car itself became an intimate space, full sometimes of lively chatter; sometimes awkward and stilted conversation; sometimes intensely emotional distress when people faced acute forms of crisis.

The ethnographic material in this article is drawn from two separate periods of fieldwork: an initial twelve months from 2016 to 2017, and a further three months in 2020. During time spent in local recovery and harm reduction services, including a third-sector needle exchange and community recovery group, I met dozens of

people who used drugs, with approximately twenty attending the services regularly. My primary methods were participant observation, semi-structured interviews, and casual conversations. Although written consent was obtained from all participants quoted, with the understanding that they could withdraw from the research at any time, consent was less a singular event than a continual process.

Throughout the research I was guided by interlocutors in the amount of time spent with them and the subject matters discussed, never purposefully raising topics of trauma or distress, and above all attempting to avoid risk of re-traumatisation. Stories and ongoing experiences of abuse, violence, trauma, and mental ill-health nonetheless permeated the research, as did experiences of hunger, cold, withdrawal, and other physical discomfort. As my involvement in individuals' lives grew, I was continually at a loss for how to approach such situations, other than short-term solutions of buying food, sourcing warm clothes, attempting to negotiate with energy companies, and offering what solace I could by listening to their distress. I kept an extensive list of relevant counselling and support services, and yet was unprepared for both the challenges of accessing them and how under-resourced local advocacy services were. My role as researcher often blurred with that of advocate, such that countless hours were spent on the phone and on hold with local and state services, or seeking advice from service staff I knew. I was repeatedly caught off-guard by the 'messiness' of fieldwork, and each day became mired in new and unexpected ethical quagmires (Billo and Hiemstra 2012, 312).

It is partly such ethical complexity, however, that results in the common exclusion of people actively using drugs from research (Souleymanov et al. 2016, 9). Severe stigma associated with drug use, and concerns around the legal implications of researching criminalised activities, can hinder both research on drug-related issues and meaningful engagement with people with lived/living experience (Transform Drug Policy Foundation 2023). The Transform Drug Policy Foundation (2023) guidance on researching these topics argues, however, that foregrounding the stories of people who are systematically excluded from public life and policy discourse, can displace stigmatising preconceptions. Championing the diverse perspectives of people who use drugs can advance a more progressive and compassionate discourse, in which care is prioritised over policies of criminalisation, and in which people can exercise autonomy over the narratives of their own experience (Transform Drug Policy Foundation 2023). Moreover, research that brings the social, historical, and structural conditions that perpetuate inequality to the forefront of policy discussions could lead to more emancipatory drug policies (Estes, DiCarlo and Yeh 2024). How to mobilise alternative forms of knowledge that account for the full complexity of lived experience, grounded in regional histories, however, remains an ever-present question.

Counties of coal

The largely rural counties of Fife and Midlothian are situated in the eastern lowlands of Scotland. Both contain clusters of highly deprived areas, characterised by, for example, low income, low educational achievement, high unemployment, poor health outcomes, and poor standards of housing. Fife in particular is home to several areas ranked among the most deprived in Scotland, some of which border the county's most affluent localities (Scottish Government 2020). Substance use is prolific throughout both counties, particularly in the more isolated rural villages, larger central towns, and, for Fife, in pockets along the coast.

Interspersed through the landscapes of Fife and Midlothian, and other areas across the Central Belt, are remnants of a heavily industrial history: disused factories and other industrial structures appear through towns and villages, and colliery winding gears stand as the most visible remnants of coalmining.

Figure 1: Mary Colliery winding gear, Lochore Meadows Country Park. Photo taken by the author, 2021.

The histories of coal and heroin are intimately intertwined. Until the end of the 20th century, when the Thatcher government of 1979 rapidly accelerated the

deindustrialisation that had marked the later stages of coalmining, community life in south-east Scotland was heavily structured around coal. The labour relations formed around mining had given rise to local and national cultural identities, at the core of which were strong notions of belonging, collectivism, and trade unionism—even as new and distinct generations of workers grappled with workforce reconstruction and deindustrialisation (Gibb 2021). Longstanding community heritage, collective memory, and intergenerational bonds were embedded within the local topographies, ties that were ruptured and reconfigured with the mass closure and privatisation of mines. It is well-evidenced that the loss of coal as a livelihood greatly exacerbated deprivation, poverty, and unemployment in those communities (Dawson 2002; Syrett and North 2008). A 2014 report by Sheffield University found that former mining neighbourhoods in Scotland, England and Wales were 'significantly more deprived than the GB average', experienced higher instances of ill health, and that the percentage of residents on welfare benefits was 'exceptionally high' (Foden, Fothergill and Gore 2014, 6, 27). It was in the dying stages of coalmining that heroin and other drugs found their market.

Only occasionally did the region's history, or family histories, surface naturally in conversations during fieldwork, although I made occasional attempts to introduce them. When they did sporadically arise, thinking on family genealogy and heritage evoked a strange sense of continuity and discontinuity: for instance, many in circumstances of deprivation and financial hardship themselves remembered relatives' stories of extreme poverty from previous generations. Yet, at the same time, narratives of generational deprivation were tied to specific forms of employment, mainly mining or shale oil, underscoring a material disparity between history and present day.

In the 1980s, initial UK and Scottish government approaches to the widespread emergence of heroin in socially deprived communities were characterised by aggressive criminal justice policies and a framing of the issue as one of transgression, disorder, and criminality (Robertson and Richardson 2007). Some centralised funding was nonetheless made available for the establishment of (largely non-medical) community treatment initiatives (Yates 2002). It was not until Scotland, and Edinburgh in particular, however, gained widespread international attention for injecting-related HIV outbreaks, that discourse began to meaningfully shift towards the public health implications of using and sharing injecting equipment, and state responses incorporated treatment and harm reduction efforts (Robertson and Richardson 2007). In recent years, similarly, overarching policy discourse in Scotland has revolved around Scotland's drug-related deaths, with rates per million remaining the highest in Europe and roughly three times higher than the UK as a whole (NRS 2023). Policy approaches—grounded in medicalised understandings of addiction as a chronic condition—have prioritised health-

focused interventions and measures aimed at reducing rates of fatal overdose. Such interventions, however, have failed to meaningfully divert individuals away from the justice system, with much substance use remaining heavily criminalised (Price, Parkes and Malloch 2021).

Medicalising addiction in policy and practice

Current policy and practice, based on medicalised models, contain inherent contradictions. Although addiction is widely considered a chronic, relapsing condition requiring long-term, partially effective treatment, many practices still focus on linear, abstinence-based recovery. This approach depends on the individual's capacity for rational self-control and willpower. Research participants, such as those involved with NHS Addiction Services or the criminal justice system, reported feeling compelled to pursue abstinence from non-prescribed drugs to continue receiving support, avoid sanctions, or prevent incarceration. Despite the Scottish government's 'recovery-oriented system of care' claiming to support non-abstinence-based recovery, discussions remain dominated by abstinence-based treatments and philosophies (see Scottish Government 2018, 2021).

Medical models support genetic and biological views of addiction by using neuroscience advancements and neuroimaging to show brain function changes from chronic substance use (Kakko et al. 2019; Dennis and Scott 2007). However, viewing addiction as a disease does little to counteract its perception as self-destructive and taken as holistic representation of the self (Keane 2002, 8). Netherland (2012, xii) explains that medicalising addiction does not separate drug use from moral issues but associates the disease model with a lack of agency, control, and rationality, justifying coercion. This medical discourse validates the addicted body as a site for medical practice and recovery interventions (Netherland 2012, xx). While medicalisation is complex and not solely coercive, framing social issues as medical problems can bring them into public discourse and help people understand their experiences (Netherland 2012, xx; Correia 2017).

This is not to argue that long-term abstinence is impossible but to highlight that prioritising it over addressing systemic conditions shaping addiction experiences can harm individuals. Many are caught in cycles of attempted recovery and relapse, significantly affecting their mental health (Garcia 2009; Roe et al. 2021). Harm reduction practices, which do not prioritise abstinence, also place responsibility on individuals. Fraser (2004) notes that harm reduction targets individual behaviour, urging safer, rational choices. This presumes a rational, 'self-governing' individual, making them 'centrally culpable for misfortune, illness, or other crises' (Fraser 2004, 200). Thus, contemporary understandings of addiction limit agency and choice while placing responsibility for recovery in the wilful devotion of the individual.

Responsible recovery

Such tension was frequently underscored in interlocutors' own accounts of addiction and recovery, which often emphasised personal responsibility, even as they echoed the rhetoric of addiction as a chronic illness. One interlocutor named Paul, a longstanding volunteer of the community recovery group I worked with, once said during an interview, 'You've got tae try, ken? If you dinnae want it, you wilnae get anywhere. I'm just taking it day by day, ken, trying to keep busy. Seems to be working anyway.'[3]

Paul's ten-year heroin addiction had spanned the same time period he had spent locked into a ceaseless cycle of incarceration and release for shoplifting. At the time of the interview, Paul had been abstinent for well over a year and was actively engaged in volunteer work with a community recovery group. During the interview, he described addiction in the following terms:

> I believe addiction is an illness. It must be. How else do you explain it? If I gave you a gun and told you tae shoot yourself, you widnae dae it, wid you? No, you widnae dae heroin either, but I do. Why? Whit is it that I've got that you dinnae? Whit's inside of me but no' you? I must hae been born wi' it, like.[4]

Paul reworks an understanding of addiction as something that goes to the core of the self, eliding structural influences like deprivation, inequality, and class, and instead positioning addiction as existing at a genetic and cellular level. Taken together, his statements testify to contradictions within biomedical approaches to addiction, or at least their popular application, by conceiving of addiction as outside of one's control and yet subject to individual determination.

Where interviews and conversations took place inside recovery and harm reduction services, descriptions of addiction could often be less ambiguous. Many service users and some service staff strongly emphasised the role of personal choice in continuing to take substances, overlooking notions of chronicity entirely. I interviewed the staff of a counselling and support service, including a trainee named Mark, who was himself in abstinence-based recovery. The interview, which took place in a small, near empty back-room of the service, largely dwelt on Mark's own experiences of addiction and what led him to stop using drugs. Mark became steadily more terse as the interview went on, appearing frustrated with my line of questioning. I had shifted focus from his recent, personal experiences of being in recovery to the general philosophies and practices of local recovery services. The conversation landed on the prescribing practices of NHS Addiction Services, with

[3] In the Fife dialect, 'tae' means 'to'; 'Ken' is used to signify 'you know?'; 'dinnae' means 'do not'; and 'wilnae' means 'will not.'
[4] In the Fife dialect, 'widnae' means 'would not'; 'dae' means 'do'; 'wid' means 'would'; 'whit' means 'what'; 'hae' means 'have'; 'wi'' means 'with.'

Mark outlining his views on the responsibility required to maintain a methadone prescription.

> It's too open to abuse at the moment, to using on top [of methadone]. You don't get tested. In four years I got tested twice to see if I was taking heroin. I think when a client comes to Addiction Services, there should be an understanding that they'll be topping up, until they get the methadone to an appropriate level, to stop withdrawals. But that next period, if they can't prove stability, their script should be withdrawn. Or they need to come somewhere like [the counselling service], to prove they're inclined to recovery. Using on top of a script leads to overdose. Deaths waiting to happen. Okay?

My response was noncommittal. Mark's tone had been somewhat blunt. He had continued without prompting. 'There has to come a time—where people are stuck and using on top—there has to come a time when they have to work for that prescription. Patients have to take responsibility. Or else it's a grey zone forever.' I asked Mark if he agreed with conceptualising addiction as an illness, in which incidences of relapse and continued substance use could be expected.

> No, not whatsoever. It's a choice. Every individual has the right to that choice . . . It's a right to take risks. It's their life after all. It was a choice for me, nobody forced me. I have to live with that. Yeah, I chose to take it. I never blamed anybody else for my addiction except myself. Okay?

The interview concluded shortly after this particular strand of conversation, but there was little ambiguity in Mark's rendering of addiction as both conscious choice and moral failing. Mark was one of many service staff who polarised heroin and methadone, substance use and recovery, although it was rarer for staff to disregard biomedical perspectives entirely. In striving for a conceptual separation between substance use and recovery, however, Mark implies a 'grey zone', in which both could tentatively co-exist.

Although our encounter was brief, and unable to facilitate much nuanced discussion, Mark's overarching perspective on responsibility in recovery is understandable. As Gowan, Whetstone and Andic (2012) highlight, much of the stigma faced by those with addictions stems from deeply entrenched portrayals of the 'addict' as a person incapable of rational thought—one 'enslaved' to the substance and chronically unable to take accountability for their actions. Throughout fieldwork, many adopted a 'counter-discourse' in which they asserted themselves as moral agents engaged in determining their own life courses (Gowan, Whetstone and Andic 2012, 1252). 'Moral agency', Michael D'Arcy contends, relates to a person's ability 'shape their life story' in ways that foreground the pursuit of meaning, social connection, and what it means to live a 'good' life (D'Arcy 2023, 6; Myers 2015). Interlocutors' narratives often foregrounded

individual and collective demands for respect, in which notions of rationality, accountability, and autonomy were intimately tied to the recognition of their personhood. Such narratives, however, strongly tended to favour abstinence-based recovery as a defining marker of moral selfhood, and commonly framed substance use as a failure to take responsibility for their lives. In this way, those in recovery tended to echo the dominant heuristics and practices of recovery-oriented institutions, in de-politicising and individualising addiction. Only occasionally was reference made to the structural conditions that contextualise experiences of addiction, and harms were more often attributed to the innate nature of the substances themselves. For those who actively used drugs, or else struggled to sustain short-lived periods of abstinence, the fusing of agency, empowerment, and rationality with discourses of abstinence-based recovery overwhelmingly led to senses of despair, hopelessness, and self-blame.

Substances of solace

In the latter months of 2017, I came to know a woman named Joanna, who was in her mid-thirties, and several of her friends particularly well. At the time, Joanna's life was characterised by continual crises and upheaval, in part as she struggled to make her meagre benefits last more than a week or two into the month. Often Joanna could not afford to shop for food or pay into her pre-payment utilities meter, meaning her flat was often freezing cold and without electricity. Being without money, she frequently found herself facing heroin withdrawal, reliant on inconsistent loans from friends, family, and acquaintances. Withdrawal and unintentional abstinence occasioned not only physical pain, but the return of painful and traumatic memories, the past resurging within the present to disrupt senses of temporal stability and worsen her mental health.

One day, we had travelled quite a distance to visit one of her friends, who happened to be out, and so found ourselves in a nearby carpark waiting for the next destination to present itself. Sitting in the passenger seat of my car, Joanna plucked a litre-bottle of cider from the footwell and, after drinking from it, placed it in her lap. She was engaged in phoning other people she knew, largely because she was bored and wanted company. In our periphery sat the lonely winding gear of a long-disused coalmine.

I asked her something about her time in prison for shoplifting convictions, but she was distracted in making calls, so when she answered it was not in response to any of my questions. 'Heroin saved my life. It's kept me alive, aye. After everything,' she murmured, her tone offhand. 'There's no way I'd have made it through all the shit that's happened to me.'

‘What do you mean?’ I asked. Joanna had never framed her heroin use in such a way before, and I had known her for two months at this point. Someone answered her call, however, and she became absorbed in arranging to visit them. When she finished on the phone, I asked her again to clarify, to her confusion. At first, she had forgotten she had said anything, before brushing off her comments as ‘talking nonsense.’ I did not push her.

We wound our way through back roads to the caller’s house, speaking only of things like weather and cars on the way. This was the only time during my fieldwork that anyone expressed such a sentiment, of heroin as life-saving, although occasionally people indicated senses of intimacy and attachment—even affection—when speaking of it. At times this was tempered with or followed by expressions of hatred, resentment, shame, or, alternatively, detachment and ambivalence. Often the agency of heroin, and other substances such as cocaine, benzodiazepines, and alcohol, became clear in these conversations, not only in their ability to provoke powerful emotions and responses, but in their structuring of experience, social relations, and the life-worlds and trajectories of people who use them. The portrayal of heroin, as mentioned, was usually resoundingly negative if conversations took place inside recovery services. Outside of more institutional settings and after they had known me longer, many expressed complex and layered relationships with substances. Joanna for one acknowledged that heroin and a multitude of other drugs had been sources of intimate consolation, comfort, and pleasure, particularly during times of loss, hardship, and grief. If she had once fleetingly thought that heroin had kept her alive, however, Joanna more often represented it as an oppressive force that had negatively affected much of her life.

Consolation as an analytical concept has received something of a resurgence in academic literature in recent years (Jedan, Maddrell and Venbrux 2019). In works on death and mourning, consolation has emerged as a signifier of solace, comfort, and resilience in the face of grief, intimately connected to ethics of care, empathy, and compassion (Jedan, Maddrell and Venbrux 2019; Pavesich 2015). It has often been associated with tempering the emotional burden of bereavement, framed as a temporary passage in the progression towards resolving grief (Jedan, Maddrell and Venbrux 2019). Anthropological works have alternatively explored consolation not as a transcendental means of coping with or assuaging loss, but of enduring it in the everyday. Lotte Segal (2016), for example, explores attempts by Palestinian women to endure under the ‘maddening’ forces of Israeli occupation, in which consolation forms an intersubjective and relational acceptance of the martyrdom of lost sons and husbands. Blumenberg (in Sels 2013, 6) relatedly gives consolation as a mode of ‘bear[ing] the unbearable’, one not oriented to altering circumstances but to accepting things as they are. In consolation, ‘suffering remains,’ and memories both console and torment (Blumenberg in Sels 2013, 7).

For Joanna and others, use of substances provided a temporary solace to the immensely difficult and structurally determined circumstances that precipitated everyday forms of crisis. The consolatory power of substances spoke to an acceptance of situations as they were, a comfort that permitted endurance, in direct contrast with neoliberal health discourses that insist upon moving forward and exerting rational control (Sels 2013, 6). Painful and difficult memories were simultaneously kept proximate and held at a distance, often in situated and solitary patterns of use. Even where personal suffering led to isolation and fraught relationships, as returned to below, seeking solace in substances opened up space for new modes of meaning and relatedness with the substances themselves. In contrast to understandings of consolation proffered by Gabriel Marcel ([1951] 1965), wherein consolation can subvert the isolation of suffering and reforge communality, substances provided an intimate, situated, and often solitary form of comfort.

Another day, not long after the one above, Joanna and I found ourselves in a different carpark, this time facing a derelict tenement block that was close to where she lived, having driven in looping circles from the coast. She complained of a stomach ache and cramp in her legs—the early symptoms of opioid withdrawal. As she was without money, with eleven days until her next fortnightly benefits instalment, there seemed small chance of sourcing heroin or other drugs. ‘Fucking bastards just couldn’t care less. They’re meant to be my pals.’ I remained quiet as Joanna expressed her sense of rage and betrayal towards those who would not help her. She had phoned almost everyone she knew, including friends, family, other people who used, and those who dealt—many belonged to more than one of these categories—and each negative response had intensified her agitation. Her words echoed the common sentiments of frustration, anger, and unmet expectations that became familiar over the course of the research. Often already fragile social relationships suffered further tension and discord due to a scarcity of resources, personal conflict, or at times, simply, disaffection and disinterest. Shortage of money to buy drugs or else disruptions to drug supply caused regular interpersonal crises, which had rippling effects on social circles.

‘I’ve fucking helped people out enough before, ken? I mean, what am I meant to do now? I feel so ill. I can’t do this. I just can’t do it anymore. It’s never-ending.’ She spoke through tears, sorrow and anger giving sharp edges to her words. ‘I’m sorry,’ I replied, unsure of what comfort I could give. When she was able to gather herself, she dialled the next number and we waited in quiet anticipation.

Throughout the research, heroin was usually spoken of in terms oscillating between fondness, antipathy, and hatred. Joanna’s friend Dods, who was homeless and occasionally stayed in her flat, for instance, often professed an

ambivalence for the drug and maintained that his use was purely pragmatic. ‘It’s like, aye, if I could get aff it, I’d get back to normal, get my life sorted out, but I ca’ dae anything without it.’ He continued, ‘I dae take it for anything but to get myself sorted. I cannae take methadone, I’ve been there and done all that.’[5] Another of her friends, Sofa, on the other hand, was neutral in tone when he said of injecting heroin, ‘It’s self-harm. It is. It’s ironic, it’s harm that takes away the pain.’

Indications were also given, however, of a meaningful intimacy with substances, and heroin in particular. Joanna’s articulations of her feelings could alternate between almost tender fondness for the relief and pleasure heroin afforded, and hatred, frustration, and sorrow over its perceived dominion over certain aspects of her life. Heroin as a ‘comfort blanket’ was a description repeated by several interlocutors, while one person describing the combined effects of heroin and benzodiazepines as like ‘taking a trip up to the clouds, wrapped up in a cloud, aye.’

There were also occasions when both intimacy and entrapment came together. On a day like the one at the outset of this article, in which Joanna was beginning to experience withdrawal and where the chances of sourcing heroin appeared unlikely, I ventured naively that perhaps the methadone she had taken that morning had not had time to take effect. Joanna replied with ‘Nut, that’s not . . . that’s not it, it’s the fucking methadone, it doesn’t hold me, I hate it. Heroin is the only thing. I need heroin.’

The specific term of being ‘held’ was commonly used to describe the emotional and physiological need for heroin, which many argued was less about pleasure than staving off withdrawal. Many of my interlocutors with a methadone prescription complained it was not enough to ‘hold’ them, implicitly constructing an unspoken, yet still linguistically constituted, intimate, and affectionate relationship with heroin. In many fieldwork conversations, similarly, the word ‘caught’ was often used to describe addiction’s perceived inescapability, connoting not only a sense of physical capture and entrapment, but also in a way captivation and fascination. Heroin itself was rhetorically constructed as something that exerted control over people’s lives, bodies, and subjectivities, and which was coiled around intimate aspects of their worlds. The holding power of heroin spoke to senses of ensnarement, of surrendering for a duration to one’s addiction and to the substances themselves. To be at once caught and held was suggestive of a violent consolation, in which love, affection, hatred, and resentment were as indivisible as pleasure and pain.

[5] In the Fife dialect, ‘aff’ means ‘off’; ‘ca’ and ‘cannae’ both signify ‘cannot.’

During one conversation about using various substances, Paul outlined aspects of both his relationship to substances and the experience of getting high:

> You're feeling doon, so you get out your nut, and it takes everything away. You enjoy it, you forget. Life's easy, nothing matters, life becomes a' about that, all consuming, like. It's almost like a cult, but the leader isnae a person, it's a drug. There isnae anything else, nothing else matters. Nothing else.[6]

Paul evokes a sense of heroin, and other substances, as anthropomorphic figures that not only play active roles in social life but come to subsume it entirely. Heroin strips away and replaces present time, acting as a consoling balm to the unbearable emotions, memories, and burdens the present carries. Likening heroin to a cult leader suggests a lack of choice and control over one's situation, a subjugation (and perhaps devotion) to a power beyond oneself, and the difficulties of breaking from such a relationship. Throughout the conversation, Paul imparted a complicated, shifting sense of agency, in which he described both actively pursuing drugs and being drawn along in their wake.

Methadone, Joanna often said, never fully satiated her and it seemed each time she was forced to go without heroin precipitated a negative shift in her emotional state. Heroin's absence wreaked severe emotional impact, and in the worst days of withdrawal I knew Joanna to oscillate between steady streams of tears and detached listlessness. There were days when she seemed perpetually in motion, unable to still for a moment, and others when she proclaimed that any movement caused her agony. In these times, heroin would be distraction first and foremost, and a route to lessening her physical and emotional anguish, though failing to procure it intensified these emotions tenfold.

It could be, too, that Joanna bore abstinence with calm. When I visited her many months after the end of fieldwork, she proudly told me that she had been sober for four days. I had rarely seen her so at ease, in spite of once more being completely out of money. More often, however, an inability to source drugs, particularly heroin, caused intense distress. 'It all just starts coming back, ken, it's just all the time, because you're just sitting there all day.' This was a sentiment Joanna often repeated. I had picked her up from her sister's house to collect her for an appointment with Addiction Services. Jess had appeared first, alone, and told me that Joanna was going to ask me if she could have a friend of hers transfer money to my account for Joanna to then take out. Jess implored me to refuse, and I hesitantly agreed. When Joanna did appear, and did ask, I told her I was sorry and she burst into tears. When we reached the street adjacent to the clinic, she calmed herself. Her intensely emotional state had become one of murmuring anxiety, as

[6] In the Fife dialect, 'doon' means 'down'; 'nut' means 'head'; 'a'' means 'all'; 'isnae' means 'is not' or 'isn't.'

she dreaded the appointments and never knew who she would be seeing that week. I had asked her, perhaps insensitively, if the pain of withdrawal had been what caused her to become upset, to which she had replied about memories of past trauma returning. ‘And does heroin stop it?’ I asked.

‘What like, thinking about stuff? You don’t think about it as much, or if you do, you can’t feel it anymore, so you don’t care,’ she replied. I asked her if she thought she could be happy if, rather than trying to stop using, she was able to use heroin on a daily basis. ‘If I had my bag a day, even just one, I’d be great, ken, that’s all I want. Then I could just live. Forget about all the shit. It’s the money.’

Heroin as an intimate, consoling, life-giving partner of sorts was often simultaneously cast against heroin as a force for destruction, and ultimately these renderings were emplaced in interpersonal and kin-based relations. It was in part through the dyadic and intimate relationships cultivated with material substances that other forms of relatedness were foreclosed or made possible, and which affirmed heroin as life-giving or life-endangering (Goodfellow 2014). As Aaron Goodfellow (2014) has remarked upon, heroin bonded people together even as it disrupted and overwhelmed relationships.

Equally, however, the strength of attachment to heroin was a source of conflict among kin. Joanna, for instance, once told me that Jess had locked her in her house for three days to prevent her from seeking heroin; allowing her to smoke cannabis and to leave only to collect her methadone. Someone named Leon that I came to know well through a needle exchange service had been living with his grandparents, though they asked him to leave after stealing money to purchase heroin. This resulted in Leon travelling to live with his father, who was in sporadic contact with the exchange. When I inquired after Leon, a staff member said, ‘His dad locked him up. Told me he’d bought him Subutex aff the street. I said “you could’ve killed him.”’ Heroin was ultimately a mediating force in kinship for many, and kin-based relations often appeared to refract heroin’s propensity for effecting joy, solace, sorrow, and harm. Acts intended as care by kin could be coercive and, moreover, life-endangering, which stands in sharp and unexpected contrast to heroin conceptualised as life-saving, life-affirming, and consolatory. As Goodfellow (2008, 289) notes, substances and the intersubjective relations that surround them can therefore subvert how life and death are conceptualised and encountered.

Harnessing time and memory in intoxication

Erin, like many others, both fastened to understandings of addiction as a chronic, relapsing condition, and asserted her own moral agency over her substance use, often struggling to reconcile tensions between the two. Spending time with her

outside of clinical and recovery settings, her use of substances oscillated between a deliberate pursuit of her preferences—such as injecting heroin in the morning and smoking it alongside crack at night—and more ad hoc, urgent, and indiscriminate seeking of substances when in crisis or financial difficulty. Periods of involuntary abstinence could occasion intense emotional distress, heightened by the physical pain of withdrawal. In sobriety, memories of traumatic sexual abuse in childhood intruded abruptly upon her, as did grief for several bereavements, some of whom were friends lost to overdose. In these moments, Erin, like Joanna, expressed a visceral hatred for heroin and the hold it had on her, and for those who would not help her with money or substances: expressions tempered by longing. On one occasion, Erin remarked, 'I don't have any choice, what can I do? It's my life.' And yet at other times she took great pains to assert her ability to practice control and self-care, even where these involved taking heroin.

The urgency of heroin-seeking itself came with a kind of claustrophobic temporality: time shortening and closing in, before hurtling forward once more. Other substances could dull the physical (and emotional) aching and lessen the urgency, such as methadone, benzodiazepines, alcohol, or any number of prescription tablets, like gabapentin, pregabalin, or amitriptyline. When heroin was sourced—its dirt-clod, powdery form liquified with water and heat and then injected—teetering temporalities dropped off and time melted into autotelic, drowsy bliss. Heroin, particularly when mixed with other substances such as benzodiazepines or alcohol, could bring about a stilling of time's passage, which could counter senses of time felt to be overly fast-paced, turbulent, disruptive, or otherwise overwhelming in stressful circumstances. Slowing or stilling time with drugs could also, alternatively, counter senses of time perceived as empty, endless, or stagnant.

During a recovery café held by a local community recovery group, I sat at a table with a man named Kyle, who was in his late twenties, and a quiet woman whose name I never learned. I had met Kyle several times, but this was the first time we had spoken for any length of time. Kyle had a warm manner and was curious about my research, volunteering his own experiences of addiction, recovery attempts, and intoxication. I asked the two of them about whether drugs altered how time was experienced, to which Kyle replied: 'I'd say so, sort of. Yeah. Hours can pass you by, that sort of thing?'

After some clarification of the question, I had asked if that was the goal of substance use.

'It's hitting pause, it is. They, they—you just want to block it all out. I don't know, what, I inject just so I can have a moment, out of it. Once that needle goes, in, that's it. It's like floating.'

‘Floating?’ I’d asked.

‘Floating.’

I pressed on: ‘But are you aware of what’s happening?’

Kyle took a moment to reflect. ‘Sometimes, just depends. People want the stuff, right, that’s going to hit them hardest. I ken people who’ll overdose, or that, and get the same stuff.’

I made a banal remark about how that seemed dangerous, and Kyle and the woman had laughed. ‘Aye, can be.’

Such descriptions were fairly common, and drew on a seemingly shared lexicon of ‘blocking out’, being ‘out of it’, and other phrases that implied senses of numbing and forgetting. Even Kyle’s use of ‘floating’ connotes a kind of detachment, if one of a drifting, dream-like semi-consciousness over total absence from the present. Many interlocutors, relatedly, described purposely bringing themselves to the cusp of overdose, in a dangerous and potentially fatal interplay of control and surrender. In intensively mixing a number of potent substances, interlocutors actively brought themselves to an unstable precipice (often, quite literally, the edge of consciousness), that once crossed could not easily be turned back from.

Throughout the research, interlocutors implied a deliberate harnessing or ‘working’ of time (Ahmann 2023), that could dull senses of the present as overly fraught and create new temporal flows. Harnessing time was a strategy with which to reforge the conditions of the present, while changing the character of difficult and painful memories in ways that allowed them to be borne, made sense of, or forgotten for a time. Erin, for example, once told me, ‘I don’t ever grieve for people, I just keep them in my head.’ When I asked her what she meant, she answered somewhat indirectly. ‘Smack lets me think. See, when I’m clean, I just go demented.’

On another occasion, almost repeating her own words to her, I asked her if heroin let her think about things that were difficult. Her words, when she replied, were staccato, and hesitant: ‘It’s just like that space sometimes. My aunt died of cancer. I think about her a lot. She was an addict. You’d think that would have stopped me, but I think seeing her . . . [. . .] When I’m in that bad zone I just take everything, and let it all, kind of, pour down on me. That’s a bit fucked, isn’t it? [. . .] It’s how I deal with it all anyway.’

The threshold of intoxication, in which complex forms of agency and surrender are imbricated, recalls what Burraway (2018) terms ‘blackout time’ among homeless residents of London. In a real sense, the experiences of blacking out from substances among people in south-east Scotland are precisely what Burraway

describes among those in London: namely the consumption of multifarious, ‘anaesthetic’ substances to the point at which memory formation is inhibited and linear time-sense lost. Driving the homeless residents of Itchy Park to pursue states of non-remembering are, at heart, their past and ongoing traumas, alongside the smothering, incapacitating effects of structural violence. The desperate need to ‘banish’ memory—and the feeling of memory and one’s own presence within the present being intolerable—is deeply resonant with the experiences of those in my fieldwork (Burraway 2018). For Joanna and Erin, for example, the multiple, recurrent traumas that spanned their life courses were evoked as a sense of deafening clamour that had to be drowned out.

Where my interpretation diverges from Burraway’s, however, is in the characterisation of meaning and agency. Burraway describes continual, intensive polysubstance use as both an ‘endless vacuum of meaninglessness’ and ‘embodied expressions of resistance’ to liberal capitalism (2018, 472, 470). My own participants expressed lack of meaning, purpose, and fulfilment that were felt to extend over long spans of time, but such expressions were inconsistent and in constant negotiation. Their desires to ‘banish’ traumatic and painful memories were juxtaposed against experiences of intoxication that aimed to keep the past present. Getting high enabled memories to be lived *with*, even held up and examined. Substance use could constitute ‘killing time’, but it could equally afford meaningful, joyful, and pleasurable experiences that were deliberately drawn out, even in the midst of acute personal crises. In this sense, their experiences are more reminiscent of the theoretical understanding proposed by Angela Garcia (2009) in her positioning of addiction as ‘mourning without end’. Garcia (2009) harnesses Freud’s theory of melancholia to posit heroin use as an intensification of grief, oriented to keeping vigil over past loss, rather than to total forgetting. Melancholia does not negate meaningfulness, rather, Garcia (2009, 110) argues that to be ‘passionately engaged with the past on its own terms [. . .] constitutes a way of being in the world.’

Senses of agency, too, were less intentional acts of resistance to structural violence and liberal capitalism, than they were everyday negotiations of irresolvable grief, loss, and trauma. It is an agency tailored to circumventing the imposition of structural institutions in everyday life, and a means of creatively experimenting with time, memory, forgetting, and pleasure. The ways in which interlocutors harnessed time and exerted agency, overall, both distanced and kept proximate troubling memories. Mourning and loss ran as an undercurrent to many situations of heroin use, but so did the need to seek solace from grief. Explicit focus on the consolatory power of substances, wherein heroin use not only finds expression in sustained mourning but in comfort and endurance, can, I argue, better illuminate the nuances of addictive experience.

Conclusion

Despite renewed theoretical attention to consolation, few works in the study of addiction have explored substance use as a form of solace, or as a means of engaging with the world 'as it is' (Sels 2013). More often addiction literature has centred on substance use as an 'escape' from daily life, such that escapism forms a persistent trope in narratives of addiction (Friedman, Des Jarlais and Sothern 1986; Preble and Casey 1969). Yet substance use is often intimately embedded within the everyday, giving rise to contested forms of agency, just as it at times entails a purposeful surrender. Interlocutors refuted accounts of addiction that portrayed them as incapable of taking responsibility for their lives, even while they found their choices severely constrained by structural conditions of deprivation, inequality, and marginalisation.

Much contemporary addiction discourse continues to reproduce an amalgam of biomedicine, neuroscience, and notions of 'conquest', which obscure the local, historical, and structural factors in drug use (Singer 2008, 7). The incorporation of the chronicity model into UK treatment approaches has spurred paradoxical expectations of addiction as unending and yet surmountable with personal will and devotion to recovery (Bourgois 2000; Garcia 2009). Throughout the research, however, people took on and reinterpreted individualised, biomedical notions of addiction, occasionally echoing popular conceptions of addiction and at other times discarding them. Those I came to know well expressed complex and conflicting feelings towards drugs, alternately asserting their own agency in use of substances and subsuming themselves in complex dynamics of surrender and self-destruction.

The relationships formed with heroin were, as such, ever-shifting, and characterised by warring desires for closeness and distance. Joanna's, for one, relationship with drugs was complex and so in some senses was their relationship with her—she would cast them aside in bids for abstinence and they in turn would slip her grasp in times of need. Always, however, they came together again. Substances could wreak their own havoc, but they could also be intimate sources of comfort and pleasure in the face of mental health crises, poverty, and isolation: a ballast in tempests of grief, loss, and sorrow.

Authorship statement

I am the sole author of this article.

Ethics statement

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