intima a journal of narrative medicine

ACADEMIC | FALL 2014

The Rhetoric of Addiction

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Abstract

Introduction
This article investigates how a doctor and his patients conceptualize addiction, use language to express conceptualization, and respond to each other in the context of their conversational illness narrative.
Methods
The following is a case study at a methadone clinic in the Midwest. Participants were a random selection of twenty patients and their doctor. Conversations were audio-recorded and transcribed. Metaphors in their dialogue were analyzed using George Lakoff and Mark Johnson's Conceptual Metaphor Theory (CMT).
Results
Patients' predominant structural metaphor is *addiction is illness experience*, and the doctor's predominant structural metaphor is *addiction is disease*.
Discussion
Each conversation is an illness narrative within which the doctor and patient respond to each other's metaphors with utterances of attributive metaphors, according to CMT. Patients respond using metaphors of thought and emotion most often and, based on rhetorical patterns, the doctor responds more or less to patients.

Key Words: addiction, conceptual metaphors, illness narratives, communication processes, patient-doctor interview

Introduction

The following study aims to understand, from a rhetorical perspective, how a doctor and patient effectively respond to one another through the development of their conversation, understood as a "conversational illness narrative." This mutual narrative is socially and orally constituted, and as such it adds to extant literature on life writing and illness narratives.

Scott Vrecko (2010), Howard Kushner (2010), and Caroline Acker (2010) have argued that addictions are socially constructed and regulated by individuals' values, which reflect social norms of a time and place. Scholarship in health and communication has likewise argued that illness is socially constructed and that how we understand disease is dependent, at least in part, upon communication practices. See work from medical rhetoricians Judy Segal (2005, 2007) and Carol Berkenkotter (2009) and medical sociologist Arthur Kleinman (1988), who have examined perception within the patient-doctor interview. They have argued that the impression one has of the patient affects the patient's argument on his/her illness. Life writing scholars have argued that identity is formed by narrative in social context, see John Paul Eakin (2008) and Sidone Smith and Julia Watson (2010). 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) have demonstrated how illness narratives help patients relate to others and foster empathy.

My study adds to the above literature that the doctor and patient communicate from particular vantage points that arise from each one's embodied life experiences. Particular notions are reflected in a speaker's utterances, both initial expressions and responses to another. The patient and doctor respond to each other with degrees of empathy that determine the conversation's agreement. I borrow Conceptual Metaphor Theory[1] (CMT Lakoff and Johnson 1980), which holds that speakers' utterances arise from conceptual frames, to explain the relationship between conceptualization and utterances. Furthermore, CMT explains that conceptual frames follow one's embodied life experiences. 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.

My study addresses the following research questions: How does the doctor and patient conceptualize addiction by his/her conceptual metaphors? The second inquiry of this study seeks to answer how the doctor responds to the patient's sense of self, characterized by the patient's expression of his/her thoughts and/or feelings in a given conversation. Based upon patients' expressions of their thoughts and/or feelings and how the doctor

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1 This study investigates how conceptual metaphors arise and inform language among individuals dealing with addiction(s). I employ Conceptual Metaphor Theory (CMT) by which Lakoff and Johnson argue 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. Using their theory, I study the doctor's and patients' utterances as metaphorical and investigate their responses to each other in the context of a single conversation, which I understand as an illness narrative.

responds to these utterances, the doctor and patients progress from addiction and related problems, or they fail to do so.

My study demonstrates that the doctor most often conceptualizes addiction as disease, while patients most often conceptualize addiction as personal illness experiences. Consequently, the doctor's focus is diagnostic, and he speaks of acting on the body with methadone treatment. Patients' focuses are emotional, and they speak to voice their feelings and thoughts, which require the doctor's response in the way of follow up questions, affirming statements, and silent attention, which persuades patients to share responsibility for wellness. There exists a disconnect between doctors and patients that can begin to be addressed by understanding patients' problems in the context of a conversational illness narrative co-constructed by patients' and their doctor's rhetoric. Specifically, the manner of response each elicits from the other determines the effectiveness of their narrative.

Methods

Study Design

I designed a qualitative case study in a private, not-for-profit, regional methadone clinic (hereafter identified as the "Center"). During 2011-2012, after approval from Kent State University's Institutional Review Board, I documented communication between one doctor and 20 different patients during appointment sessions that lasted on average 10 minutes. To see how the conversational narrative unfolded in real time, rather than relying on the doctor's and/or the patients' impressions of their conversations, I audio-recorded conversations during doctor/patient sessions. After each session, I transcribed the conversation.

Setting and Subjects

The Center is one of only 10 regional methadone clinics offering methadone maintenance and detoxification treatment for opiate addiction. 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. 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.

Data Collection

My primary data consists of 20 audio-recorded patient-doctor interactions, averaging 30 lines of transcription per conversation for a total of 670 lines of transcription. Additionally, I attended addiction club meetings among medical providers and luncheons with the participating doctor and his colleagues, and the participating doctor and I discussed addiction after each weekly observation.

In my study, the doctor's and patients' utterances are understood as two levels of conceptual metaphors.[2] All utterances are in themselves *attributing* metaphors and support one of the two *structural* metaphors.[3] Attributing metaphors are both the markers and carriers of the two structural metaphors that dominate the rhetoric of addiction in this data set.

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[2] 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.

[3] 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

From initial observation, I defined the two most prominent conceptual categories that emerged from the data collected and tested these categories against 20 conversations between the participating doctor and 20 different patients. After initial reading of my data corpus, I defined 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 was 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.

Based on my definitions of the structural metaphors *disease* and *illness experience*, I investigated how pervasive the doctor's conceptual metaphor of disease is and, likewise, how often patients conceptualized addiction as an illness experience. To these ends, following CMT, I studied the doctor's and patients' attributing metaphors to determine how often each referred to *disease* and *illness*.

Data Analysis

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).[4] 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 illustrates four utterances, two from the doctor and two from a patient.

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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.

[4] "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.

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

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 my study of the doctor's and patients' responses to each other, I found patterns that account for the rhetorical position in the conversation.

Results

My study demonstrated that the doctor most often conceptualized addiction as disease, while patients most often conceptualized addiction as personal illness experiences. Consequently, the doctor's focus was diagnostic, and patients' focuses were emotional.

The doctor paired addiction with disease and patients paired addiction with illness most often, but both also paired addiction with the other concept. The doctor responded to the patient's sense of self, characterized by the patient's expression of his/her thoughts and/or feelings, when patients related their thoughts and/or feelings.

The conceptual metaphors *disease* and *illness* are represented in the summative tabulations[5] 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.

5 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.

Summative Table

	All Utterances		Physician Utterances			Patient Utterances		
	Number	% of All Units	Number	% Physician	% Physician of Total	Number	% Patient	% Patient of Total
Totals "Disease"	79		61		77	18		23
Body Acted On	28	35	24	30	86	4	5	14
Expected Bodily Response								
Response to Medication	22	28	17	22	77	5	6	23
Response to Drug Use	8	10	6	8	75	2	2	25
Response to No Drug Use	21	27	14	18	67	7	9	33
Totals "Illness"	206		39		19	167		81
Acting Body								
Pain Expression	18	9	0	0	0	18	9	100
Doing Harm/Good	25	12	1	0.5	4	24	99	96
Reflexive Thought	108	52	28	14	26	80	38	74
Emotional Responses	55	27	10	5	18	45	21	82

Table 2: Summative Analysis

Totals by Attributive Metaphors

The doctor and patients characterized addiction by their attributive metaphors, a process through which each one's utterances followed from one's conceptual scheme that arose from embodied, everyday experiences. 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

Illness Conceptual Metaphor and Rhetorical Patterns

The highest frequency for the structural metaphor *illness experience* occurred with the attributive metaphors emotion and thought. From the doctor's and patients' utterances of emotion and thought, they established a rhetorical position of agreement or resistance in their conversation.

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 compared the doctor's and patients' number of utterances for emotion and thought in each of these conversations.

Patients had more utterances of emotion, and the doctor responded based on rhetorical patterns.

Emotion metaphors					Thought metaphors				
Conversation	Patient Utterances		Physician Utterances		Conversation	Patient Utterances		Physician Utterances	
High to low patient utterances	Number	% Patient of Total	Number	% Physician of Total	Ordered by Emotion high-low	Number	% Patient of Total	Number	% Physician of Total
12	7	13	2	4	12	0	0	0	0
4	5	9	0	0	4	7	6	1	1
5	4	7	0	0	5	7	6	1	1
20	4	7	0	0	20	3	3	1	1
2	3	5	1	2	2	8	7	2	2
3	3	5	0	0	3	1	1	2	2
8	3	5	0	0	8	5	5	3	3
9	3	5	0	0	9	8	7	0	0
16	3	5	0	0	16	3	3	6	6
18	3	5	0	0	18	7	6	0	0
19	3	5	0	0	19	7	6	3	3
14	2	4	1	2	14	7	6	3	3
1	1	2	0	0	1	2	2	0	0
6	1	2	0	0	6	9	8	1	1
7	0	0	0	0	7	0	0	0	0
10	0	0	0	0	10	1	1	1	1
11	0	0	4	7	11	0	0	3	3
13	0	0	0	0	13	0	0	0	0
15	0	0	0	0	15	0	0	2	2
17	0	0	0	0	17	2	2	2	2

Table 3: Attributive Metaphors: Emotion & Thought

Based upon the frequency of utterances, the doctor's focus was diagnostic while patients' focuses were emotional. Because of their unique intentions, the doctor and patients have different thought utterances. The doctor's thoughts were on why the patient's physical and emotional states would improve with methadone. Patients' thought utterances expressed their emotions related to their personal illness experiences. As such, patients' thoughts were more varied than the doctor's.

Additionally, the doctor and patient structured their utterances differently. The doctor's utterances of thought were often rhetorical questions. Patients' statements of thought related to how they felt. The doctor's utterances of emotion were often used to persuade patients to the doctor's diagnostic focus and the usefulness of methadone. When patients' utterances were of *disease*, they continued to speak of thoughts and feelings.

Discussion

The results from my case study of the rhetoric of addiction leads to the following three-part claim:

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/her 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.

The findings in my study affirm my hypothesis that the doctor conceptualizes addiction as *disease*, and the patient conceptualizes addiction as his/her own *illness experience,* which complicates the process of negotiation necessary in order for the patient and doctor to reach agreement concerning treatment. 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.

Patients' and the doctor's specific utterances uniquely characterize addiction. The speakers' language reflects his/her understanding of addiction. Together, through their attributive metaphors and responses to each other's, the doctor and patient socially construct an illness narrative that includes characterizations of addiction as both *illness* and *disease*. 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 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 develop agreement.

Conclusion

The rhetoric of addiction is about the ways in which one fails or succeeds in eliciting response. 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.

Disability, addiction, mental health, and language scholars have studied how language affects individuals' social statuses 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 research complements illness narrativists Charon's and Frank's research and adds to their findings that empathy is not constant within conversational narrative. The doctor's and patient's empathy depends upon the rhetorical dimension of their interactions. 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. 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 conceptual metaphors in conversations. My research adds to addiction research on the social nature of addiction (Kushner, Vrecko) by affirming that the ways patients and their doctor conceptualize addiction leads to particular ways they conceive of treating it.

My study is limited in that treatments and recovery were not investigated, the sample size was small, and the duration of the study was short. However, 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. Successfully addressing the problem of addiction requires degrees of patience and attention to understand the whole-body effects drugs have on individual patients.

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 on doctors to elicit patients' emotions and thoughts and to use these responses to their rhetorical advantage in persuading the patient towards whole-body wellness. In order for communication between the doctor and patient to successfully lead towards whole-body wellness, each interlocutor must understand the impact of his/her words and seek to speak and so construct a conversational illness narrative in such a way that would allow the other to re-conceive the meaning of one's sense of an illness experience.

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