

Fatal attraction: A narrative of early opioid addiction

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journals.sagepub.com/home/nad**Willy Pedersen** 

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Abstract

Norway's first clinic to treat drug abuse was established in 1961. Most patients had been initiated into drug use through the healthcare system, i.e., in an iatrogenic manner. However, we know little about the drug users from this period. Here, we present an in-depth interview with a woman born into a wealthy family in the early 1920s who developed a heavy morphine addiction. In the course of the interview, she gradually reveals how her husband, who was a physician, as well as two other physicians, who were also erotically attracted to her, had key roles in this development. The narrative illustrates and elaborates how females from the upper strata of society with close links to male physicians may have been at particular risk of opioid misuse in the period before 1960. We now witness a new wave of iatrogenic drug abuse, particularly in the USA. We suggest that experiences from this period may again be relevant.

Keywords

drug history, iatrogenic drug use, narrative, opioid addiction

Down by the Oslo Fjord, there is a large and beautiful wooden house, probably from the early 20th century. It must be expensive and has its own substantial stretch of shoreline. On this particular day, wisps of frost were gliding over the surface, and G was sitting so the light fell across her face. She was almost 90

years old but still very beautiful. An entire wall of the sitting room was devoted to bound hardbacks, while oil paintings and graphic art adorned the other walls. She served me tea, crackers and Stilton. She smiled, "If it hadn't been so early, I might have offered you a nice glass of port."

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I had written a popular article in a Norwegian newspaper about the early misuse of opiates in the USA, where females from the upper strata of society were at particular risk. Friends and colleagues had contacted me. Their mothers or grandmothers had been in such a situation, they told. With G it was different. She had read the article herself and phoned me: "I can tell you about this", she said. She spoke a pleasant, upper-class sociolect, with the softly rhotic r's peculiar to someone of her social standing. She was born in the early 1920s, she said. She had first been exposed to narcotic drugs in her late teens, due to personal problems, she somewhat vaguely described. Later, she had developed a drug problem. She married a physician and he had supplied her habit, before he had to give up his right to prescribe opioids, she told me.

It was a bright January day when I visited and interviewed her. We sat down by a large window looking over the sea. "I love Mahler; let's first listen to *Kindertotenlieder*", she said. She once used to play Mahler herself, she said. Our conversation lasted for many hours. We took breaks and strolled down by the seashore. The most important parts of the interview are described below. Names and milieu have been changed so no one will be able to recognise G. G was still clear-headed, but some events had taken place more than 60 years before we talked. Reconstructing them was sometimes difficult.

Around the time I visited G, I read *Pentimento*, the memoirs of the American author Lillian Hellman (1973). As she writes, new memories are revealed, like when a painter paints, with old drafts still detectable in the final picture. The interview with G, in a similar vein, uncovered that there had been three men around her in her morphine abuse. All were physicians, and all had been attracted to her as a woman. As the sunlight waned, her description of these men changed. Thus, the interview may also be seen as an example of "narrative practice". Gradually, G developed a more complex personal narrative centring on her morphine abuse and with these three relationships at the centre. In this manner, she was also able to link "actors and events into

plots, [and] allocate moral responsibility" (Smith, 2005, p. 14). For G, this "practice" was painful, and in the course of our conversation, she started to cry several times. However, as you will see, she also mobilised aggression and one key character completely changed role and characteristics during the interview.

The narrative turn in social sciences, inspired by, for example, George Herbert Mead (1964) has often been seen as a contrast to the "subjectivist" tradition where life histories were seen more as individualist projects. A narrative perspective typically centres on *temporality*, where one event comes after another, and *causality*, where one event leads to the next. However, the radicalism of Mead's position also lay in his argument that there is always a plurality of possible pasts, constructed from the point of view of an ever-changing present. As we will see below, G struggled to link her life to often multi-faceted events. Some of these events were gradually described from a new angle. As described, for example, by Holstein and Gubrium (2000, pp. 103–123), narrative practice always lies at the heart of self-construction. The aim of this article was to try to identify the *hows* and *whats* of G's storytelling; i.e., how she is both actively constructive when she talks, at the same time as she is constrained by a variety of narrative resources. Such resources may be broadly construed, and might "include any and all experiences that can be accountably incorporated into personal stories" (Holstein & Gubrium, 2000, p. 104). However, for such experiences to be interpreted adequately we need to contextualise them. Let us begin with G's social milieu, her family context.

G's story

Wealthy background

- I: Can you tell me about your parents?
 G: My father had a great deal of energy. He grew up here in the city with wealthy parents. My mother was also a delightful person, but she was calmer.

- I: You started high school about 1935?
- G: Yes, and that is where I met my husband, Knut, who was supposed to study medicine. I liked playing [music] even then, and I knew many poems. I think Knut liked me because of that. I feel grateful that he is still here even after death. His spirit and his being are so close.
- I: You started at the conservatoire. Which instrument did you play?
- G: The cello was the right one for me. It is the sound.
- I: Were you fit and healthy at the time?
- G: Yes, I was. Then I had my problems. Indeed I did.

As described by Labov (1972), many narratives begin with a short summary, before the context of what has unfolded is introduced. G's family was wealthy, but poetry and music also played an important role in their milieu. In more recent terminology, they were well off in terms of economic as well as cultural capital (Bourdieu, 1979). She told me that her husband had been a physician, and she then offered the key to the narrative and the reason why we should speak: she had run into problems. Hence, as we will show, her background was typical of many opioid addicts of the late 19th and early 20th century. They were often females from the higher social echelons of society, and the risk increased if there was a physician in the immediate family. There are few descriptions of these users from Norway (but see Bergersen Lind, 1975; Evang, 1965). The material from the UK and the USA is richer (Berridge & Edwards, 1987; Courtwright, 2001; Driscoll, 2000). Moreover, in fictional literature there are many such narratives. Mary Tyrone in Eugene O'Neill's *Long Day's Journey into Night* was from a prosperous family, with a respectable façade masking years of suffering from morphine addiction. In the play, the son Edmund accuses his father of letting an incompetent physician treat her, reflecting the drama in

O'Neill's own family (Black, 1999). Mrs. Henry Lafayette Dubose in Harper Lee's classic *To Kill a Mockingbird* was perhaps the archetypical American morphine addict in the early 20th century: a wealthy, Christian woman from Alabama, with property and servants, hooked on the drug by her physician during a bout of illness.

In contrast, the drug addicts who entered the stage in the late 1960s, reflecting the emerging new control regime, were often male, had few resources and were typically from the lower social classes. Moreover, they were defined as criminals (Bewley-Taylor, 2012). The aestheticised, wealthy surroundings of G when she was approaching 90 years are key to understanding how her life had played out. She never had any dealings with the police or the courts; indeed, prosecuting someone of her standing would have been more arduous than criminalising the young, run-down addict in the post-1960s era. Moreover, her drug problem was iatrogenic (Musto, 1985), reflecting close interactions with physicians with questionable professional ethics, actually echoed in recent reports from the current opioid epidemic in the USA as well (Quiones, 2017; Temple, 2017).

At the beginning of the interview, G spoke calmly. She was proud of her background. She also drew on a repertoire of sensibility and spirituality. Poetry and music had always meant much to her and her family.

Original plot

- I: Can you tell me about the first time you used these medicines?
- G: Something painful happened in our family. I could not sleep; it was a terrible situation. I could of course pray to God. I believe in the strength of warm thoughts from good people who want to do well. However, it is hard, when you are young and sensible. I received something to calm me from our family physician, Christian.

- I: You had a family physician you called by his first name?
 G: He was my father's closest friend.
 I: He gave you medicines?
 G: Only now and then; it increased somewhat when I started at the conservatoire. However, it was during the birth of my first child that the medicines started to play a greater role. It was an awful pregnancy. I thought something was wrong, that the child would have a bad, bad life. I ended up using methadone, but that was later.

Reportedly, a physician close to the family was the source of supply in the first phases of her use of drugs – probably barbiturates or opioids – just before World War II. She described herself as sensitive, needing something to calm her down owing to death in her family. Then, a decade later, a difficult pregnancy and birth greatly affected her developing addiction. In the USA, women suffering from “female complaints” were at particular risk, and “uterine and ovarian complications cause more ladies to fall into the habit than all other diseases combined”, one observer stated (Courtwright, 2001, p. 48). For G, the problems were linked to anxiety and fantasies about possible problems for the child she was expecting. Her main substance then became morphine. In the first part of the interview, the family physician seemed to play the key role throughout all these years, at least until the early 1950s, when she was in her early thirties. Note also her description of her later introduction to methadone, probably in the late 1960s. At the time, this was not a routine option in Norway. Later in the interview, she described how her husband established contacts in Sweden, where a methadone programme had already been initiated (Gunne, 2018), thus circumventing the Norwegian health service. But why did she, by her own account, need these medicines?

- I: When did you take the medicines?
 G:

I was given something to calm me by my husband when I ran into trouble, in particular if my mother-in-law was there at Ustaoset [a holiday resort in the Norwegian mountains]. She was . . . nasty . . . [G starts weeping]

- I: You took medicines to calm yourself when she was around?
 G: I just had to . . . to survive these periods. I had to take something or other when Knut's love and care were just not enough [G fetches a photo album].
 I: Is that you and Knut?
 G: Yes, that is the two of us. He was a delightful fellow.
 I: When the medicines worked properly, how did you feel?
 G: They calmed me down. It was her [the mother-in-law's] attitude towards our children. Therefore, Knut and I found a medicine that was as peaceful as could be, just to escape the despair, that unrest when she came.
 I: Did you ever try to reduce your use?
 G: We [she and her husband] tried several times, both of us wanted that. You feel freer, cleaner. In addition, there was so much joy in my life, so much light and meaning. I had to tackle it, even if it was not easy.

Thus concretising her story, G argued that tensions in relation to her mother-in-law were the key to her developing addiction. Note that these experiences are dated later than in her first account, after her children were born, in the mid-1950s. Moreover, in this new story, her husband, who was also a physician, played a key role as her primary source of supply. In this revised story, he gave her medicines, in particular when they went to the mountain cabin that still belonged to the mother-in-law, who also used to be there. Much of this second part of the interview then revolved around G's complicated relationship with her mother-in-law.

Whereas Mead emphasised the “plurality of possible pasts” in all life histories, Paul Ricoeur (1984) – who may be situated in the same narrative tradition – suggested that events are also organised into meaningful narratives by way of “emplotment”. Thus, the plot is a mediator between fragmented elements of the past and the life history taken as a whole. Drawing on such a perspective, the husband now represents the caring and opposite pole to the evil mother-in-law. At the same time as we narrate our lives, we construct “a natural order” of time, Ricoeur argued. Thus, for a prolonged period of the interview, G dwelled on the destructive role of her mother-in-law. Emotionally, it was not easy for her to talk about it, but she obviously knew the story well. It was finely balanced with the story of her caring husband. However, as we shall soon hear, it seems as if she had fallen into serious problems with substances well before her mother-in-law arrived on the scene.

Complicating element, evaluation

- I: So Knut [her husband] decided what dose of medicine you should take?
 G: Yes, and I took as little as I could. Later, when I started on methadone, I was surprised how little impact it had on my personality. Knut also talked to the family physician, Christian.
 I: And your husband and Christian always agreed on how much you should take?
 G: Yes, they cooperated so wonderfully – so eye to eye [using English terms].
 I: Some think that physicians should not prescribe for their relatives . . . [Silence for a while].
 G: It was not my husband who gave me it.
 I: Wasn't it? [Surprised]
 G: Oh no, no, no. Just Christian.
 I: Oh? What did your husband think about Christian giving you medicines?
 G: He was disappointed that Christian had not talked to him about it first.

- I: I don't quite understand . . .
 G: My husband was disappointed that Christian had not found another way to help me.
 I: Did your husband tell Christian he did not like it?
 G: Yes.
 I: How did Christian react?
 G: He said: “This is my responsibility, Knut. I gave her it. I wanted to make her life so gentle and lovely, but I made the wrong choice.” That was the last time the three of us met.
 I: When you look back and think of Christian now, what do you think of him?
 G: He thought I was his darling little child. It was me he had to have.

In narrative theory, a complicating element is often introduced in the story, followed by an evaluation (Labov, 1972). This sequence contains such an element: Christian, the family physician, was first described as an excellent physician and a close friend of her father's, who had occasionally given her medicines to relax in her late teens. In the first story described above, it was much later, when she had married and had children that she ran into real substance problems, owing to her mother-in-law. In this new sequence, the family physician was initially still described as her husband's competent co-worker in her treatment during this period, while she was a young married mother. I pressured a little, encouraging her to reflect more on her husband's role in prescribing morphine, and the plot changed completely. The family physician had *not* helped her husband; rather, there was a conflict between them. Moreover, this implies that her problems started *before* she met her husband, and thus well before she met her mother-in-law as well. In the new narrative, her young husband fought heroically with the much older and experienced family physician. The mother-in-law lost significance and the family physician became the key causal agent in her

iatrogenic use. Her husband had no other choice than to help her address her already established problems.

I was surprised how easily the original plot, centring on the evil mother-in-law and the caring husband, was replaced with a new one, with the family physician in the key destructive role. However, central to the narrative turn in the social sciences has also been the study of the processes through which individuals construct explanations of their own behaviour (Maruna & Copes, 2005, p. 246). The habitual use of so-called neutralisation techniques may be an aspect of a certain “explanatory style”. Such a style points to the individual’s tendency to offer spontaneous and similar accounts for negative events, and these schematised interpretations are thought to be important for establishing continuity in one’s own behaviour over time (see also: Weiner, 1985). Much research suggests that processing bias may occur along the dimension of internality (“I am responsible for this event”) vs. externality (“It is someone else’s responsibility”). Explanatory styles skewed towards one of these styles (e.g., when people hold others responsible) are suggested to correlate with certain behavioural patterns, such as drug use (McGuire, 2000). Thus, we may hypothesise that the *structure* of G’s explanation of her problems may not have changed greatly, even if a new plot was offered.

The family physician was given a new role in this revised story, and from this new position, she revealed other aspects to him as well. He had been obsessed with her ever since she was a child. He had wanted to make her life “gentle and lovely”. Nonetheless, she still seemed to accept that his wish to help her had been his key motivation. However, note the final sentence: “It was me he had to have”. This hints at a different motive.

G’s morphine dependency became more acute in the mid-1950s. She had to leave her small children for prolonged periods and went to a number of treatment centres. Some were small and private institutions, with no proper healthcare professionals (see also Evang,

1965). There, she encountered other women with similar problems, and she described developing new friendships and receiving valuable support. However, she also became a patient at a place we shall call Pine Hill. This was a larger institution treating mental illnesses; she stayed there for quite some time at the end of the 1950s. The therapist in charge of her case was K, a well-known Head Physician at the institution who wrote a number of books.

Plot expanded and concretised

- I: What sort of help did you get at Pine Hill?
- G: K gave me some new medicines for us to try, and we talked a lot. I thought these medicines would make me apathetic, but they did not. We were outdoors a lot, and I often had my cello with me. K liked me to play to him.
- I: Can you remember what you talked about?
- G: Yes, I remember I told him I felt like I had been raped. I felt I had been abused.
- I: Who abused you?
- G: K himself. He reckoned he was such a good friend to me and we went for walks together. I read poetry to him and had my cello with me. In reality, he was just using me to the best of his ability.
- I: You said you felt raped; why did you use that expression?
- G: I am very gullible and naive. He really enjoyed it when we took a flask of coffee and sat in a glade in the forest. I used to read him something. Then there was that experience. It was wrong. He probably felt that I was so young and that it was interesting . . .
- I: Can you remember whether he touched you sexually?
- G: Yes, he did. However, fortunately I had my feet on the ground enough so that I

managed to stop it before any painful, ugly wounds grew inside me. [Again, G starts to weep.]

I: Was he older than you?

G: He could have been my father.

I: He wanted a sexual relationship?

G: Yes, he did and it was completely outside of my world. It is just a painful, ugly memory I wish I could be rid of.

Here we can again detect the sexual motive that also lay smouldering at the end of the previous excerpt, but it was now associated with K at Pine Hill and described much more explicitly. Initially, I thought that “rape” was a metaphor to describe her reaction to some part of the treatment. However, it was meant literally. K made sure to get her *à deux* and made a direct sexual move. This theme arose quickly when she spoke of K. There were many obstacles to her thematising the erotic undertones in her relationship with the family physician Christian, but no such impediments were present in relation to K. In this section of the interview, she spoke easily. True enough, she did start to cry, but this was a detailed story she knew well. She became aggressive when she spoke of K and her story flowed freely.

Coda

I: Let us return to Christian, the family physician. Did he and Head Physician K share any traits?

G: Yes, they did. Christian used to say: “This is between you and me, my darling. This is our secret.” After the fight with my husband, he wrote a long letter saying he regretted it.

I: Can you remember what the letter said?

G: Lots of annoying stuff. Far too personal for a letter from a physician . . .

I: Did he ever approach you more lovingly?

G: I was at his house. Thea, his wife, was out on an errand . . .

I: What happened?

G: “We’ve just got this leather sofa with space for two”, he said. I was supposed to cuddle up to him on the sofa. However, I got out quickly.

I: Can you remember how old you were?

G: In my twenties. It was me he wanted, his old girlfriend.

I: One last question: when you look back on your life, has it been shaped by the medicines?

G: Well, they did not destroy all the beauty.

I: Do you still play the cello?

G: Once in a while, but only if I am alone.

Her description of Head Physician K’s sexual advances also allowed a story that was richer in detail to emerge about Christian, the family physician. In this manner she offers a *coda*, an epilogue where the narrative is concluded (Labov, 1972). The plot centring on K’s unethical practices was expanded to include the family physician. Note how this new broader narrative developed gradually; nonetheless, it was nuanced and highly detailed. She described a letter from the family physician and offered to find it for me. It was tucked away somewhere in the house, she said, but I declined the offer.

There was something particularly unpleasant about the end of this interview: she had described at length what a good physician Christian was, what an excellent friend he had been to her father and how he had later helped her husband treat her. Had she *really* meant it at the beginning of the interview? I think so. Hearing him change character thus made an even starker impression; he emerged as a potential assailant whom she had to outwit.

G’s many stories lay layer on layer; gradually, new stories emerged. This was why an association with *Pentimento* sprang to mind: when a story needs changing, a new one pops up. Mead (1964, p. 111), in his theory of time and narrative, is also preoccupied with the concept of “emergence”. It is only possible to

experience time-related continuity in relation to breaks and discontinuity. Novel elements will allow for a difference – a new meaning that would otherwise not be possible to grasp. Thus, Mead opposes the idea that “time is the unfolding of what is enfolded; the making explicit of what was implicit from the beginning” (Jarvinen, 2004, p. 49). Rather, one may not grasp the causes of the novel before the novel has actually been manifested.

All of us are regularly in situations like that of G when I talked to her. We are – more or less – aware of “our multiplicity of pasts”, and we all try to develop meaningful narratives to understand them. Freud (1975a) described a way of listening for the analyst in the psychoanalytical process, where such barely audible voices may come to expression. Bakhtin (1986), in a similar manner, emphasised so-called intertextuality and heteroglossia, pointing to the many layers of texts. The interview with G may be informed by such a way of theorising: she came into contact with a number of experiences, so different possible narratives emerged during our conversation. Talking about some of them was painful. However, I was struck by her eagerness and willingness to talk about these issues. Perhaps she felt it would help to talk about it to a stranger, reflecting how previous research shows that forming a story about negative experiences may be beneficial (Pennebaker & Seagal, 1999).

From physician’s surgery, to deprivation on the streets

To prepare for the interview, I read the novel *Gift* by the Danish author Tove Ditlevsen. The title is ambiguous in Danish, meaning both “married” and “poison”. The main character in the novel is called Tove and *Gift* is acknowledged to be highly autobiographical (Andersen, 1997). It is likely that Ditlevsen started to use morphine after an abortion performed by the man who was the baby’s father, and who she would later marry. He was also a physician, and he injected her for years. The main character in

the book, Tove, describes her first encounter with pethidine (a synthetic opioid) in this manner:

You have good veins, he says. Then he pricks me and as the fluid in the syringe vanishes into my arm, untold bliss spreads throughout my body. The room expands into a shining hall and I feel completely relaxed, dead to the world and happy as never before. I roll onto my side and close my eyes. (Ditlevsen, 1979: 24).

Tove Ditlevsen and G both had a kind of naivety in their way of expressing themselves. Ditlevsen uses this style consciously as a literary device. However, when I listen to the recording of G again, I notice that she seems to be surprised by her own story, especially by the way the people around her change character. In Ditlevsen’s novel, the cosy, homely atmosphere is described in hushed tones, and gradually becomes unpleasant. Her morphine addiction takes hold during the ostensibly dotting ministrations of her physician and husband. He seemingly helps her while binding her to him. In Freud’s (1975b) essay *Das Unheimliche* he describes a similar phenomenon. He shows how something can be simultaneously familiar and well known but – in an underlying unpleasant way – alien. The narrative that G gradually developed had some of the same quality.

We know little about illegal drug use in Norway before 1960. The Directorate of Health tried to chart the population in the late 1950s and concluded that there were approximately 300 users of morphine and another 400 who used other drugs, especially barbiturates. With a population of 3.4 million (SSB, 1955), these figures were among the lowest in Europe. Three groups were affected: (i) physicians, nurses, pharmacists and other types of health staff; (ii) patients weaned onto drugs during painful illness, with sleep or nervous problems; and (iii) a small group that had learnt to use substances directly as recreational drugs (NFN, 1970). Whereas previous studies suggest that females from high social classes were at particular risk

(Courtwright, 2001), one of the few studies of the patients at the first Norwegian clinic for drug addicts suggest that patients from lower social classes were somewhat overrepresented (Teigen, 1978, p. 32). However, the official figures obviously are too low. Drug use was closely associated with physicians who hid behind their duty of confidentiality, and such use may have been more typical in higher social strata. The Norwegian Director General of Health at the time, Karl Evang, argued that physicians were in a difficult situation, being exposed to strong pressure to prescribe drugs (Evang, 1965, pp. 56–67).

We know more about the situation in the USA and the UK. Based on surveys of physicians, records from maintenance programmes, military medical examinations and opiate import statistics, Courtwright (2001, pp. 9–34) suggests that there may have been around 300,000 opiate addicts in the USA in the period from the turn of the century to the First World War. The majority were women. The prevalence was highest in the rural South, and the use was overwhelmingly iatrogenic. Self-addiction among physicians was also quite common, and at the height of the epidemic it was suggested that between 6% and 8% of physicians used opioids (Musto, 1985, p. 698). Heroin use gradually replaced this pattern of drug use in the middle of the 20th century; it was predominantly a male problem and tended to cluster in poor areas of cities. The shift is encapsulated by the term “junkie”. The new addicts eked out a living gathering copper, lead and zinc from city dumps and a junkie was originally a “junkman”.

Thus, in the course of a few decades, the metaphors of dependency shifted from physicians’ surgeries to the deprivation of the streets (Courtwright, 2001, pp. 85–110). A similar picture was revealed in the UK, but somewhat later. Here, the substances began to circulate through a large black market. Drug use and crime inevitably became associated. Users assumed a subcultural identity, and in the UK too, “the ugly American word ‘junkie’ began to be heard” (Berridge & Edwards, 1987, p. 236).

The first clinic for drug addicts in Norway was set up in 1961, and it was one of the first such institutions in Europe. The clinic was meant for patients who typically had an iatrogenic pattern of use. However, as described by Waal (1975, pp. 4–5), in the mid-to-late 1960s these patients were being supplemented by a new and completely different group. The new patients were younger and often involved in drug-related crime. They often had a subcultural identity and, in contrast to the old patient group, they “opposed the illness role”. Gradually, this new group would coin the new metaphors of drug use (Stang, 1976). G was probably one of the last who were able to tell the story of those who had become addicted before this transformation of the landscape.

G resembled many of the drug users portrayed in the USA and the UK before these transformations. She was a well-educated woman from a wealthy family, speaking in conservative language, with many references to intellectual and cultural life. Her drug problems were iatrogenic, and both the family physician and K at Pine Hill were first described as competent professionals. As she presented it in the initial narratives of her sickness history story, they wanted to help her.

In Davis Musto’s (1985) pioneering study, he distinguished between three types of iatrogenic addiction: (i) inadvertent addiction, where the addictive properties of the substance are not yet acknowledged by the physician; (ii) negligent addiction, which includes prescribing when it is not necessary, e.g., to keep the patient in a competitive health delivery system; and (iii) intentional addiction which includes treating terminally ill patients or using methods such as methadone maintenance. However, the self-addicted physician was in a particular risk zone for malpractice, Musto argued: “He always seemed more casual or at times even enthusiastic about providing drugs without restraint to patients” (1985, p. 700).

We do not know if any of these categories fit the physicians around G. However, the most salient characteristic, she maintained, was that all had

been erotically drawn towards her. Were these mere fantasies? Erotic transference–countertransference is a recurring theme in studies of relationships between patients and therapists (Newirth, 2016). Could it be that G only developed intense transference-like reactions, which she later mistook for “real” experiences? As far as the family physician is concerned, it seems unlikely. His complex role was revealed layer by layer. At the start, he was described as her father’s best friend, as a boon to her physician husband when they were both supposed to be tackling her drug abuse. However, he gradually emerges as an immature man who had been obsessed with her since she was a child. These narratives are not contradictory. Little by little, the story became more elaborate and specific.

However, the relationship with K at Pine Hill may have been more complex than she let on. G was a sensitive woman whose life had run into serious trouble well before she came to Pine Hill. She may have interpreted the relationship with K in a more erotic way than was justified. However, I am doubtful: this story as well was very specific. An array of details about their strolls in the forest was offered; not least K’s desperation when G decided her treatment there should be brought to a close. He agreed she should leave, but he could not see how the two of them “would ever loosen their powerful bonds”.

The male physician typically seems to be vulnerable to malign countertransference when he over-identifies with the patient; however, he may also respond to triggers from his own life such as marital discord, loss of important relationships and crises in his professional life (Simon, 1999). The ethical standards of the medical profession have obviously been improved since G’s experiences as a patient in the 1950s (Kim & Rutherford, 2015). Nevertheless, studies still report unethical practices ranging from meddling in patients’ sexual lives to inappropriate touching and rape (Jousset, Gaudin, Penneau, & Rouge-Maillart, 2008). However, we know little about whether the unethical prescription of addictive drugs plays a role in this larger picture.

G was almost 90 years when I interviewed her, but she retained a strikingly feminine allure. I also recognised the fragility of G’s aestheticised life foundation. She was surrounded by inherited paintings in an old and beautiful estate. But she had lived a life of clandestine syringes. What was her route to methadone? What had her marriage been like before her husband had to give up his right to prescribe? There must have been tension and conflict. Throughout the interview, she protected her husband. What did he think about losing his right to prescribe? They had four children; how had they found the situation? She never said, so we will never know. G embodied many stories. It seemed right to leave them in peace.

New drug policy, well-known challenges

The first sociological study of the new drug problem in Norway was published in 1975, with the title *The drugs conflict* (Bergersen Lind, 1975). The author shows that the new generation of addicts were treated in a way that was unthinkable compared with the previous generation. In recent years, we have witnessed yet another shift. In the wake of the decriminalisation of drug use in Portugal in 2001 (Hughes & Stevens, 2010; Laqueur, 2015), the global consensus on drug policy has fractured (Collins, 2017). We now see the contours of new harm-reduction-based policy regimes where, for example, opioid substitution has been introduced on a large scale, and where the thresholds for treatment are reduced (Kourounis et al., 2016). However, so-called doctor-shopping is clearly a problem (Simeone, 2017), and street-based use of substitution drugs is increasing (Bretteville-Jensen, Lillehagen, Gjersing, & Andreas, 2015), even if these substances seem to be situated at the bottom of the sociocultural hierarchy of drugs (Pedersen, Sandberg, & Copes, 2017).

A combination of all these factors may increase pressure on physicians, and open up the way for complex strategies by patients who seek

to feed their addiction through controlled drugs (Worley & Thomas, 2014). Noting the new opioid epidemic in the USA, many physicians now worry about iatrogenic addiction in a climate of increasing distrust (Buchman & Ho, 2014). Thus, we may perhaps learn something from the story of G. At the time when G still manoeuvred between physicians to obtain new prescriptions, the Norwegian Director General of Health Karl Evang reported that many physicians openly admitted prescribing medication that patients did not need, and that it was easy to make wrong decisions to keep their trust (Evang, 1965, pp. 56–62). The case of G may suggest even more subtle and complex dimensions to these relationships, where sexual exploitation may also have been a part of the picture.


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