# How Youth With ADHD Narrate Their Relationship With Marijuana

by

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A thesis submitted to School of Child and Youth Care

in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

In Child and Youth Care

University of Victoria

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## Abstract

This qualitative study emerged from my observation that some youth diagnosed with ADHD gravitate towards the use of marijuana, and my resulting hypothesis that this is the substance used most often in self-medication for the symptoms of ADHD. Selected literature investigates ADHD, its causes, behaviour patterns, symptoms, diagnosis, and treatments, then connects ADHD with other psychiatric disorders and with substance abuse. Other research reports the relationship between marijuana and mental health and explores the medicinal use of marijuana. I present narrative stories resulting from my extended interviews with 5 participants aged 20 to 32, all of whom have been diagnosed as having ADHD, and who use marijuana daily. My interpretive process suggests that these young people believe marijuana helps them attain a sense of normalcy in their lives. My summary explores predominant themes that evolved during the study: culture, addiction, and normalcy.

How Youth With ADHD Narrate Their Relationship With Marijuana

This is to certify that the master's thesis of

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has met the thesis requirements of the University of Victoria

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Acknowledgements

I would like to take this opportunity to acknowledge and thank all those people who supported this project.

First, I would like to thank the five participants who willing shared their lived experiences of life with ADHD and their journeys of self-medication. It was their honesty and openness that has made this project possible.

Second I would like to thank my committee for their support and guidance throughout this process. Dr. Marie Hoskins, in her role as my supervisor, whose understanding of qualitative inquiry inspired a deeper level of understanding within this process, and who consistently seemed able to put aside all of her own work to respond to my time lines. As well as Dr. Daniel Scott and Dr. Gweneth Doane for their encouragement and insightful feedback. Their collective approach, as my editorial team, has been one of genuine support and interest in this topic.

I would also like to acknowledge my three colleages who assisted in locating and engaging participants for this inquiry. Lenox Neher, Jodi Higgs and Chris Weekes, who have all worked with adolescents for years, were instrumental in the initial contact with three of the participants. It was their introduction to this inquiry that lead to the enthusiastic and open response I received from the participants.

Pacific Community Resources Society, my employer, has been very support with administrative assistance and the printing and copying that is necessary in a projuect of this size. Their continuous support of the advancement of their employees is commendable.

I would also like to acknowledge the support and encouragement that I have received from the factulty and staff in the School of Child and Youth Care. As well I would like to thank Dr. Robert Martin for his unwavering belief in my ability to achieve my academic goals.

And finally I would like to thank my friends and family who have supported me throughout this project with their patience and personal support.

# Chapter One: Introduction

Between 1997 and 2002, I was a foster parent with a three-bed therapeutic residential resource for young men 15 to 18 years of age. These youth were in the care of the Minister of Children and Family Development in the Province of British Columbia. The focus of my residence was to assist these youth to become responsible, self-reliant young adults. Several of the youth in my residence were the inspiration for this inquiry.

Many of the young men with whom I have worked over the years have, at some point in their childhood, been diagnosed and labelled with Attention Deficit Hyperactivity Disorder (ADHD). By the time they entered my program they had developed numerous behaviours and coping strategies to deal with the symptoms of this disorder and with the reactions of the world around them (Garmzry, 1983; Wolin & Wolin, 1993). These young people, for a variety of reasons, were removed from their homes time and time again and have consequently had a disrupted and inconsistent upbringing. Some had as many as 20 to 25 home placements while they were in the care of the Ministry of Children and Family Development.

The loss of their own family systems, and the subsequent inconsistency in parenting, exacerbates problem behaviour as the child attempts to make sense of his or her world (Brendtro & Ness, 1983; Garmzry, 1983; Wolin & Wolin, 1993). Shuffling from one home to another, along with having to let go of relationships and create new ones, can lead to a sense of low self-worth, anger, and frustration. These are difficult emotions for anyone, and especially for those who are characterized by developmentally inappropriate degrees of inattention, over activity, and impulsivity. These youth often lash out or withdraw to avoid being hurt again (Fahlberg, 1991;

Wolin & Wolin 1993). Such coping strategies can backfire because they result in a tendency to push caregivers further and further away. This creates for the youth a situation which is their own worst fear, rejection, as yet another caregiver asks them to leave.

One place these youth can find some sense of welcome and acceptance is within their own peer group. Caught in the "no-man's-land" of adolescence, they are too old to be children and too young to be fully initiated into the adult world. By constructing their own norms, codes of conduct, and language, they create coping strategies for survival (Brendtro & Ness, 1983; Vorrath & Brendtro, 1985). One of these strategies is the use of drugs and alcohol.

Developmentally, adolescence is known as a time for identity construction and experimentation (Miller, 1989; Stassen Berger & Thompson, 1995). The power of the peer group is a prevailing force in a youth's life, and the peer-influenced use of illegal substances is becoming more common among young people. Many of them try, at least once, drinking alcohol, smoking cigarettes and marijuana, and experimenting with the more exciting adventures offered by other drugs, including ecstasy, cocaine, and psychedelic mushrooms. (I include statistics on the use of marijuana later in this thesis.) It would seem that, during this experimental stage, some youth find what they are looking for: some sense of peace or acceptance, of adventure or expression.

My observation of young people over many years indicates to me that those diagnosed with ADHD seem to gravitate towards the use of marijuana. Most of these youth use this substance daily; it seems to help them maintain some sense of calm and control within their lives. I have observed that these young people seem to use marijuana as a coping mechanism to diminish their feelings of anxiety, frustration, and hyperactive energy.

An investigation of the current literature revealed that very little attention has been given to understanding the relationship between ADHD and the use of marijuana. There were numerous studies on the correlation of ADHD and the development of addictions to nicotine, cocaine, and alcohol. Although some studies mentioned marijuana as a frequently used substance by individuals with ADHD, there were no studies on this specific relationship, and no reference to the effects of marijuana on this specific disorder. Further research uncovered that individuals with mental health disorders reported using marijuana to decrease feelings of anxiety and depression as well as improve sleep and a sense of self-esteem; however, ADHD is not considered a mental health disorder.

Because the youth in my residential care demonstrated that the use of marijuana has a clear impact on their mood and sense of control, it seemed imperative that I conduct an inquiry into this relationship. Although a quantitative inquiry would have given the reader a sense of the numbers, frequency, and amount of marijuana consumed as self-medication by these youth, it seemed more appropriate to focus this inquiry on an understanding of the lived experiences of these participants and their view of their use of this substance. The purpose of my research was to explore how youth with ADHD narrate their relationship with marijuana.

Locating the Author

As I attempt to locate my self within an epistemological framework, I find myself drawn constructivism. Gall, Borg, and Gall (1996) suggested that constructivist theory "is based on the assumption that social reality is constructed by the individuals who participate in it. These constructions take the form of interpretations, that is, the ascription of meanings to the social environment" (p. 18). Through understanding and the use of language, truth is socially

constructed. There are multiple truths and no absolute truth. I see the self as an entity under constant evolution and revision, as well as both multiple and relational. As Kvale (1998) pointed out, "Constructionism replaces the individual with the relationship as the locus of knowledge. The knowledge created by the inter-view is inter-relational" (p. 45).

As a counsellor and a researcher, I am curious to know how each individual constructs their reality and comes to believe that reality to be true for them. Within this discourse, I acknowledge my role as co-creator and yet offer only one possible interpretation of the story. Knowing is a subjective process. Language creates reality, rather than reflects it.

## Chapter Two: Literature Review

**The Men That Don't Fit In**
(Robert Bill Service, 1874-1958)
There's a race of men that don't fit in,
A race that can't stay still;
So they break the hearts of kith and kin,
And they roam the world at will.
They range the field and they rove the flood,
And they climb the mountain's crest;
Theirs is the course of the gypsy blood,
And they don't know how to rest.
If they just went straight they might go far;
They are strong and brave and true;
But they always tire of the things that are,
And they want the strange and new.
They say: "Could I find my proper groove,
What a deep mark I would make!"
So they chop and change, and each fresh move
is the only fresh mistake.
And each forgets, and he strips and runs,
With a brilliant, fitful pace,
It's the steady, quiet, plodding ones
Who win in the lifelong race.
And each forgets that his youth has fled,
Forgets that his prime is past;
Till he stands one day, with a hope that's dead,
In the glare of the truth at last.
He has failed, he has failed; He has missed his chance;
He has just done things by half.
Life's been a jolly good joke on him,
And now is the time to laugh.
Ha, ha! He is one of the Legion Lost;
He was never meant to win;
He is a rolling stone, and it's bred in the bone;
He's a man who won't fit in.

During the evolution of this research over the past two years, many people have inquired about the focus of my thesis. One gentleman with ADHD was excited to share his story of discovery about this disorder and how it helps explain who he is. He ran to the computer and

printed out the above poem by Robert Service. It was significant to him that his own experience had been described by Robert Service so many years ago. This gentleman told me that many of the men involved in the gold rush were believed to have had ADHD. "Those who had the energy, courage and the drive to experience something new." With pride, he shared his perception that individuals with ADHD are agents of change in our society.

In order to gain a comprehensive understanding of the relationship between marijuana use among youth and the ADHD condition, it is first necessary to understand the basic symptoms of ADHD and the resulting challenges faced by individuals who live with it.

What is Attention Deficit Hyperactivity Disorder?

ADHD is an invisible disability with no clear physical markers to indicate its presence. The primary characteristics of the disability—inattention, impulsivity, and over-activity—can be easily observed. However, these are characteristics that can also be exhibited by most children to some degree in certain circumstances. These typical behaviours become the symptoms leading to the diagnosis of ADHD when they are exhibited in a developmentally inappropriate manner or to an excessive degree.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM- IV), described "Attention-Deficit/Hyperactivity Disorder [as] *'a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development'* (American Psychiatric Association [APA], 1994, p. 78). According to Frazier and Merrell (1997), to warrant a diagnosis of ADHD some symptoms must have been present before age seven in at least two settings. There must also be

interference with developmentally appropriate social, academic or occupational functioning that is not better accounted for by another mental disorder" (p. 441).

ADHD affects a significant portion of the population: 5% to 6% of all school-aged children. Approximately half of these individuals—30% to 60 %—continue to experience this disorder into adulthood (Biederman, Faraone, Spencer, Wilens, Norman, Lapey, Mick, Lehman, & Doyle, 1993; Clure, Brady, Saladin, Johnson, Waid & Rittenbury, 1999; Shelly-Tremblay & Rosen, 1996). ADHD affects more males than females (Frazier & Merrell, 1997). Wilens, Beiderman, and Spencer (1996) suggested an even higher percentage with research showing that 6% to 9% of juveniles are showing the effects of ADHD, which had an early onset in childhood. There once was the belief that ADHD was a childhood disorder that youth grew out of as they matured. It is recognized now that many adults continue to experience the symptoms of this disorder. Gabor Mate, M.D., is one adult who discovered that he had ADHD later on in life. In his book *Scattered Minds* (1999), he described the exhilarating, yet painful, "shock" of self-recognition that many adults experience when they learn about Attention Deficit Disorder (ADD), a similar disorder without the hyperactive component.

> It gives coherence, for the first time, to humiliations and failures, to plans unfulfilled and promises unkept, to gusts of manic enthusiasm that consume themselves in their own mad dance, leaving emotional debris in their wake, to the seemingly limitless disorganization of activities, of brain, car, desk, room . . . ADD seemed to explain many of my behaviour patterns, thought processes, childish emotional reactions, my workaholism and other addictive tendencies, the sudden eruptions of bad temper and complete irrationality, the conflicts in my marriage and my Jekyll and Hyde ways of relating to my children . . . my

> propensity to bump into doorways, hit my head on shelves, drop objects and brush close to people before I notice they were there . . . Beyond everything, recognition revealed the reason for my life-long sense of somehow never approaching my potential in terms of self-expression and self-definition. . . (p. 4-5)

In this report Mate recognized how this disorder had affected him throughout his life. For children and youth who are living with these symptoms, the process is even more confusing, frustrating, and disconcerting (Alexander-Roberts, 1995; Phelan, 1996). They may not recognize that they are not "normal". They may only see and feel how the external world is responding to their behaviours. Associated features of ADHD identified in the literature include low frustration tolerance, temper eruptions, bossiness, stubbornness, excessive and frequent demands that requests be met, mood swings, demoralization, peer rejection, low self-esteem, academic problems, conflict with family members and authority figures, and insufficient self-application (Mate, 1999; Milin, Loh, Crow & Wilson, 1997; Walker, 1998). These individuals struggle, attempting to make sense of self and the world around them. Anger and frustration increase as they experience confusion and failure in these attempts. Shelley-Tremblay and Rosen (1996) discussed the correlation between hyperactivity and aggression. These authors estimated that as many as 90% of those in our prisons currently experience hyperactivity, and that over 60% could be living with ADHD.

What Causes ADHD?

At this point in time, the etiology of ADHD varies. There is agreement among some researchers that the characteristics of people with ADHD stem from neurobiological malfunctioning (Shelly-Tremblay & Rosen, 1996). Although environmental factors do influence

the course of ADHD over a lifetime, there is a growing amount of evidence that it is rooted in the processes of the brain, specifically the frontal cortex. "Frontal underactivity has face validity as a biological correlate to ADHD in light of the known function of this region (attention, impulse control, and social interaction regulation, among others) and as evidenced by the behaviour of patients with frontal lobe damage, which can mirror ADHD in many cases" (Shelly-Tremblay & Rosen,1996, p. 4). Where the researchers disagree is in the etiology of this brain malfunction. There are a variety of hypotheses that explore hereditary, environmental, and neurobiological factors.

Shelly-Tremblay and Rosen (1996) sited several theories that offer evidence of a genetic component for ADHD. One theory pointed to a rare thyroid dysfunction. Several other studies compared identical and fraternal twins and suggested that ADHD is "highly heritable" (p. 4). Finally, a recent study by Paterson, Sunohara, and Kennedy (1999) indicated a strong genetic link between ADHD and dopamine processing. These authors provided a critical analysis of genetic studies of the dopamine D4 receptor gene with novelty seeking, alcoholism, drug abuse, and ADHD.

A second theory on the cause of ADHD was proposed by Sydney Walker III, M.D. in his book, *The Hyperactivity Hoax: How to Stop Drugging Your Child and Find Real Medical Help* (1998). Dr. Walker suggested that ADHD is not a disorder but a cluster of symptoms caused by underlying medical conditions as a result of toxic environments, infections, and medications. He proposed that

> The poor outcome of children labelled hyperactive is not surprising. Why? Because their underlying medical conditions were never addressed—and because many medical

> conditions that can cause hyperactivity also cause social problems, academic difficulties, and even criminality . . . By adolescence, these stimulant-treated hyperactives were still failing in school and continued to be behaviour problems; many had developed anti-social behaviours, as well as experiencing social ostracism. (p.14)

This misdiagnosed medical approach suggests the use of stimulant drugs to keep the hyperactive individual under control as merely a "band-aid" solution. Ritalin, the most commonly prescribed stimulant for hyperactive children in North America (Horner & Scheibe, 1997; Mate, 1999; Walker, 1998), is not addressing the real problem. Indeed it may even be exacerbating the problems (Walker, 1998).

A third school of thought is based on an early childhood developmental approach. The brain of an infant is only partially formed when it is born. Within the first few years of life, the brain undergoes astonishingly rapid growth. Mate (1999) suggested that "Five-sixths of the branching of the nerve cells in the brain occurs after birth. . . . In large part, each infant's individual experiences in the early years determine which brain structures will develop and how well, and which nerve centers will be connected with which other nerve centers, and establish the networks controlling behaviour. . . . Attention deficit disorder results from the miswiring of brain circuits, in susceptible infants, during this crucial period of growth" (p. 64). This wiring of the brain circuits requires three things for healthy development: nutrition, a physically secure environment and an unbroken relationship with a maternal figure. Mate (1999) proposed that it is within the infant's relationship with the mother that the brain cells are supported to develop. He suggests that the infant does not experience the parent, but the parenting.

> In the early months, the most important communications between mother and infant are unconscious ones. Incapable of deciphering the meaning of words, the infant receives messages that are purely emotional. They are conveyed by the mother's gaze, her tone of voice and her body language, all of which reflect her unconscious internal emotional environment. Anything that threatens the mother's emotional security may disrupt the developing electrical wiring and chemical supplies of the infant brain's emotion-regulating and attention-allocating systems (p. 70).

According to Mate (1999), this emotional connection is called attunement, which is the foundation for attachment. Happy interaction between mother and child generate motivation and arousal of endorphins inducing a joyful, exhilarated state, which in turn triggers the release of dopamine. Endorphins and dopamine promote the development of new connections and nerve cells in the frontal cortex. Without the experience of exhilaration and joy through the process of attunement with the mother, this process is hampered. The result of the miswiring that can take place due to mother's emotional state, the family atmosphere, and the environment that influences an infant's world is the impairment of the development of the frontal cortex of the brain. As mentioned earlier, this is the part of the brain that is responsible for such attributes as attention, impulse control, visual-spatial orientation, and emotional self-regulation. A relative scarcity of dopamine receptors is thought to be one of the major physiological dimensions of ADHD (Mate, 1999, p. 84). As we enter into a discussion on the relationship of ADHD and substance abuse, it is interesting that Molina, Smith, and Pelham (1999) reported that "ADHD and drug abuse problems may have a common grounding in the dopaminergic neurotransmitter

system, which has been implicated not only in ADHD . . . but also in both alcohol and other substance dependence" (p. 355).

It can go without saying that parents and parenting affect the development of children. Within the framework of ADHD and substance abuse, this influence can have an even stronger effect. Studies show that children of parents with substance abuse disorders and alcoholism are at increased risk for aggression, antisocial behaviour, anxiety, and conduct disorder; they are also found to have elevated rates of ADHD (Molina et al., 1999; Wilens, et al., 1996). It also follows that these children are at an increased risk for their own relationship with drugs and alcohol (Paterson et al., 1999). As we human beings are complex, so is the relationship between ADHD and genetics, upbringing, the influence of the environmental systems (gender, culture, family, etc.), the relationships with other psychiatric disorders, and the development of substance dependency.

The relationship between ADHD and other psychiatric disorders

Comorbidity is acknowledged in almost all of the literature available on ADHD and more specifically in the examination of the relationship between ADHD and substance abuse (Frazier & Merrel, 1997; Kaminer, 1992; Milberger, Biederman, Faraone, Wilens & Chu, 1997; Milin et al., 1997; Molina et al., 1999; Wilens et al., 1996). Frazier and Merrell (1997) reported that "Disorders associated with ADHD include Oppositional Defiant Disorder, Conduct Disorder, Mood Disorders, Anxiety Disorders, Learning Disorders, Communication Disorders, and Tourette's Disorder" (p. 25). Due to the complexity of these disorders, it seems to be difficult to determine if there is a sequential relationship involved. One study suggested that it is the combination of ADHD and conduct disorder (CD) that makes individuals most prone to

substance use and abuse. Flory, Milich, Lynam, Leukefeld, and Claytin (2003) reported that "When researchers have statistically controlled for CD when examining the relationship between ADHD and substance use and abuse, the relationship often disappears . . . they found that the association between ADHD and substance use disorders was entirely accounted for by a comorbid diagnosis of CD" (p. 417). Some studies have shown, however, that the relationship between ADHD and substance abuse suggest a developmental perspective. They propose that ADHD leads to conduct disorder, which in turn leads to the use and abuse of drugs and alcohol (Wilens et al., 1996; Molina et al., 1999). Overall, it would appear that the life of a youth with ADHD is one of a possible myriad of disorders and dysfunctions.

Within the vast research available, a clear relationship has been established between ADHD and the development of psychoactive substance use, abuse, dependency, and addiction (Biederman et al.,1998; Clure et al., 1999; Flory et al., 2003; Levin, Evans & Kleber, 1999; Milberger et al., 1997; Milen, et al., 1997; Molina et al., 1999; Wilens et al., 1996). These studies and more have shown that a high percentage of adolescents and adults diagnosed with ADHD have developed a dependency with cigarettes and/or drugs and/or alcohol. Milberger et al. (1997) stated that children with ADHD are at high risk for the early adoption of cigarette smoking and drugs, and that, for the ADHD youth, there is a significantly shorter than normal interval between abuse and dependence. They predicted that this suggests the consequent risk of an early onset of addictions. Another study showed that ADHD itself includes a high rate of substance abuse without comorbidity, and that those with ADHD are more prone to drug abuse than alcohol abuse (Biederman, Wilens, Mick, Milberger, Spencer, & Faraone, 1995). It is important

to acknowledge, however, that many of the associated disorders mentioned above are also at high risk for the development of substance use disorders.

The ADHD/Substance Abuse Connection

What are the possible reasons for an individual with ADHD to at first experiment with, and then develop a dependency to, psychoactive substances? Walker (1998) suggested that it is society's fault for using prescription drugs to cover up the symptoms of ADHD during early childhood. He purported that "They're using drugs to medicate their symptoms, just like they used Ritalin when they were children. Drugs and alcohol bring them down when they're hyper, calm them when they're anxious, help them stay alert when they are fatigued, or help them sleep when they are bothered by insomnia, headaches, dizziness, and other symptoms. It's not a great solution, but it's the only one they've ever known" (p. 35). We as a society have given youth the message that drugs are the solution to their problems. Walker (1998) cited a survey showing that, of fifteen childhood Ritalin users, all of them later developed substance abuse problems (p. 35).

Mate (1999) saw all addictions as anaesthetics. He suggested that the use of psychoactive substances separates us from the distress in our consciousness.

> It is easy to understand the appeal addictive substances would have for the ADD brain. Nicotine, for one, makes people more alert and improves mental efficiency. It also elevates mood, by stimulating the release in the brain of the neurochemicals dopamine, important in feelings of reward and motivation, and endorphins, the brain's natural opioids, which induce feelings of pleasure. The endorphins, being related in chemical structure to morphine, also serve as an analgesic, soothing both physical and emotional pain" (p. 298).

Following from his theory about the development of the infant's brain in the first years of life, Mate posited that it is evident that the brains of people who are prone to addiction are biologically predisposed by some imbalance of brain chemicals. People with ADD seem to be short on dopamine; it may be that they are seeking balance in their lives by seeking balance in the brain chemicals.

The self-medication hypothesis finds support from several studies on addictive disorders. It is a phenomenon within our global village that we find acceptable pleasure and relief from stress with the recreational use of alcohol and drugs. For some, having a drink after a hard day is commonplace; for others, it is smoking a "joint" of marijuana. Sometimes it is at the bar or at a party that they get "high" and really "let loose" to shake off the pressures of the week. While these are accepted practices within many segments of our society, use becomes unacceptable, or labelled as a disorder, when the substance of choice adversely affects one's responsibilities to self, family, work, and community. This emphasis on the pleasure and pain release aspect of drug use provides a footing for one explanation of the self-medication among those with ADHD. Khantzian (1985) suggests that "individuals use drugs adaptively to cope with overwhelming (adolescent) anxiety in anticipation of adult roles, in the absence of adequate preparation, models, and prospects....[drugs] are used adaptively by addicts to compensate for defects in affect defence, particularly against feelings of 'rage, hurt, shame—and loneliness'" (p. 1260). Since ADHD is known to be associated with morbidity, disability, chronic failure, and demoralization, it is believed that some individuals with ADHD develop substance use disorders as a result of their unsuccessful attempts to manage their disorders and their complications

through behaviour change strategies (Biederman et al., 1995; Clure et al.,1999; Wilens et al., 1996).

Where does marijuana fit into the scope of drug abuse?

In comparison to addictive psychoactive drugs such as alcohol, cocaine, and heroin, marijuana is considered to be a "soft" drug (Johns, 2001; Taylor 1998). It is not physiologically addictive, but one can develop a dependence on this substance (Lundqvist, 1995; Taylor, 1998; Zimmer & Morgan, 1997). It is my belief, arrived at through experience and through observing youth in care for the past 20 years, that an individual does "create a relationship" with marijuana. This relationship or habit can be as difficult to break as any addictive substance like caffeine, cigarettes, alcohol, or cocaine. Studies have shown that one does build up a tolerance for this substance and, after prolonged exposure, the user requires more to sustain the same heightened experience or "high" (Johns, 2001). Withdrawal signs were also found; "...during the first week of abstinence the subjects became very irritable, uncooperative, resistant and at times hostile" (Johns, 2001, p. 119). Although marijuana still remains illegal in our North American society, it has become the most commonly used prohibited drug (Ogborne, Smart, Weber, & Birchmore-Timney, 1997; Johns, 2001; Grinspoon & Bakalar, 1997). It is important to acknowledge that the consumption of alcohol and cigarettes is also illegal for youth. The Report of The Senate Special Committee on Illegal Drugs (2002) stated that the epidemiological data available indicates that close to 30% of the population in Canada has used cannabis at least once. Approximately two million Canadians over the age of 18 have used cannabis during the previous 12 months of their inquiry. For youth in the 12 to17 age group, approximately one million have used cannabis in the previous 12 months. Use is the highest among those between the ages of 16 and 24. Canada

would appear to have one of the highest rates, globally, of cannabis use among youth (Nolin & Kenny, 2002). The United Nations Office for Drug Control and Crime Prevention have estimated that 141 million people around the world use marijuana. This represents about 2.5% of the world population (retrieved from http://members/lycos.nl/medicalinfo/statistics.html). Marijuana is easily accessible and attainable by young people today. There is a marked increase in the reported use of this substance among people aged 15 to 21 (McGee, Bills, Poulton & Moffitt, 2000). Many of the studies on ADHD and substance abuse have stated that marijuana is the drug of choice and most commonly used by individuals with ADHD (Biedrman et al., 1995; Hectman & Weiss, 1996; Mannuzza, Klein, Bessler, Malloy & LaPadula, 1993; Milberger et al., 1997).

I find it very curious that there is little research examining the experience of marijuana use for those with ADHD to the end of discovering how this substance affects their symptoms or brain functions. Amen and Waugh (1998) did a study using high resolution brain SPECT imaging of marijuana smokers with ADHD. SPECT imaging is a brain scan which measures neuronal behaviour, cerebral blood flow and, indirectly, brain metabolism. This study showed decreased perfusion in the prefrontal cortex of individuals with ADHD. "With hypoperfusion in the prefrontal cortex there may be a loss of inhibition normally exerted by this part of the brain, resulting in hyperactivity, impulsive and inattentive behaviour" (p. 213). These brain scans also demonstrated that frequent, long-term marijuana use has the potential to change the perfusion pattern of the brain. They found, however, that this change was in the temporal lobes, those areas associated with memory, learning, and motivational levels. Symptoms of chronic marijuana use are known to be apathy, poor attention span, lethargy, social withdrawal, and loss of interest in achievement (p. 213). Although these authors do not attempt to propose a behavioural

connection, it would appear that the use of marijuana could counter-balance the hyperactive and impulsive behaviour for an individual with ADHD. At the same time, the use of marijuana could compound the symptoms of poor attention. A conversation with Dr. Fine at the ADHD crisis clinic at Children's Hospital in Vancouver revealed that at times he finds it difficult to determine if the inattentiveness in his patients is due to ADHD or to chronic marijuana use.

Marijuana as a medicinal substance

Marijuana has a long history of medicinal use. The first written account was published in China in the 15th century BC (Taylor, 1998). During the early 19th century, extracts of marijuana were recommended by respected physicians for a wide range of medical conditions (Grinspoon & Bakalar, 1997). At that time, marijuana "... was considered to have analgesic, sedative, anti-inflammatory, antispasmodic, anti-asthmatic and anticonvulsant properties and promoted for the treatment of tetanus, cholera, pruritis, uterine dysfunction, labor and menstrual pains, gout, asthma, neuralgia, rheumatism, convulsions and depression" (Ogborne et al., 2000). Marijuana fell out of favour with the medical profession early in the 20th century and, until recently, has been used illegally as a recreational drug for the purpose of attaining the euphoric experience of "getting high".

Since the 1970s, marijuana has been regaining popularity as a medicinal substance. Zimmer and Morgan (1997) stated that "studies demonstrate marijuana's usefulness in reducing nausea and vomiting, stimulating appetite, promoting weight gain, and diminishing intra-ocular pressure from glaucoma. There is also evidence that smoked marijuana or tetrahydrocannabinol (THC), the active ingredient in marijuana, reduce muscle spasticity from spinal cord injuries and multiple sclerosis, and diminish tremors in multiple sclerosis patients" (p. 17). Ogborne et al.

(2000) reported that HIV-AIDS-related problems, chronic pain, migraines, narcotic addictions, as well as everyday aches, pains, stresses, and sleeping disorders, are also reported to diminish with the use of marijuana. Adding to this list, Gurley, Aranow, and Katz (1998) included relieving phantom limb pain, alleviating menstrual cramps, promoting uterine contraction in labour, treating of addiction and withdrawal symptoms, preventing seizures, and reducing anxiety and relief from the symptoms of bi-polar disorder (p. 138). In my research, the majority (approximately 80%) of the articles available were reports on the effects of marijuana use by those with HIV-AIDS-related problems. A conversation with AIDS Vancouver, the support organization for those living with HIV and AIDS, revealed that it has been legal in Canada to possess marijuana for medicinal purposes since July of 2001.

Exploring further the medicinal use of marijuana, I met with Hilary Black, the founder and coordinator of B.C. Compassion Club Society. The Compassion Club is a non-profit organization that offers medicinal marijuana as a treatment for numerous disorders and ailments. Hilary reported that, upon a doctor's referral, they supply marijuana to members suffering from HIV and AIDS, chronic pain (from accidents, botched surgery & degenerative diseases), cancer, hepatitis C, seizure disorders, neurological disorders (such as muscular dystrophy and muscle spasms), digestive disorders (such as Crohn's disease and irritable bowel syndrome), anxiety, depression, schizophrenia, anger management issues, and to those recovering from addictions to "hard" drugs. Hilary shared the pamphlet of information they had prepared for potential members to give to their Doctors. In that package I found this quote:

> There is overwhelming anecdotal evidence supporting cannabis as an effective herbal medicine for numerous symptoms associated with a wide variety of conditions. In

> addition, the nausea and discomfort caused by various prescription drugs can often be overcome by use of cannabis. The BCCCS believes that no one should be subjected to the black-market street dangers and process in order to procure the medicine they need. Therefore, we have created safe and supportive access to clean, high quality, affordable cannabis for those in medical need. (Taken from the BCCCS information package for Doctors, 2003)

An article in the Penticton Herald, dated November 2nd, 2001, reported that "there are more than 10 compassion clubs in Canada, in cities such as Vancouver, Calgary, Edmonton, Toronto, Ottawa, and Montreal." During our conversation, Hilary pointed out that in British Columbia there are also Compassion Clubs in Nelson, Victoria, and a new one emerging in Coombs. On the website http://www.rxmarijuana.com, a reader can find countless stories of people who have experienced relief from numerous maladies with the use of cannabis. It would appear that the pendulum is swinging back to where marijuana is once again being acknowledged for its medicinal purposes.

Gurley, Aranow, and Katz (1998) also addressed the adverse effects of cannabis use: increase in heart rate, infections (due to the contamination of marijuana with other organisms), motor vehicle accidents and injuries (due to impairment during driving), lung damage, and impaired fertility. Usage during pregnancy has been shown to correlate independently with impaired fetal growth and with decreased length of gestation. In one story on the marijuana web page above, a women wrote about her use of marijuana while pregnant. In his response, Dr. Grinspoon stated that there is no evidence to support that the use of marijuana is detrimental to

the developing fetus. It is clear that, with this type of contradiction in the studies available, the jury is still out on the risks and benefits of cannabis use.

Marijuana and mental health

In 1988, pharmacology research on cannabis was revolutionized by the identification of a cannabinoid receptor in the central nervous system (Taylor, 1988). The density of these receptors in the different sections of the brain correlates with the drug's effects. "Receptor density is high in centers concerned with cognition and memory" (Taylor, 1998, p. 221). As with other psychoactive drugs, the effects are highly variable and mitigated by previous exposure as well as by the personality and expectations of the user. Zablocki, Aidala, Hansell, and White (1991) suggested that "dissimilar individuals may experience the drug quite differently. They may use it for different purposes, and may feel widely varying positive or negative emotions" (p. 66). The acute effects, which are dose dependent, include euphoria, joviality, relaxation, and alterations of cognitive, sensory, and motor functions (Hadorn, 1997; Johns, 2000; Ogborne et al., 2000; Taylor, 1998). "Loss of short-term memory is a hall-mark feature. Time passes slowly for the intoxicated users, and sensory sensations, including those of touch, hearing, and taste are enhanced . . . and drowsiness usually follows the euphoric effects" (Taylor,1998, p. 221). Zablocki et al (1991) reported some claims that marijuana use "encourages contemplation and global self-evaluation. It increases their understanding of self and others, and makes them feel more philosophical and more insightful about their surroundings" (p. 67).

There are varying reports on the psychiatric effects of marijuana. Many individuals who participated in the Ogborne et al. (2000) study reported using marijuana for both depression and anxiety. Another study on substance abuse among the mentally ill revealed a wide variety of

reasons for the use of a preferred substance. Of the seventy-nine patients who participated in this study, 41.8% identified marijuana as their preferred substance for self-medication. Alcohol was the only substance scoring higher at 55.7% (Warner, Taylor, Wright, Sloat, Springett, Arnold & Weinberg, 1994). These subjects also offered their reasons for substance use. In order of significance, these reasons were: activity with friends (72.7%); relieve anxiety (61.8%); relieve boredom (58.2%); relieve depression (47.3%); improve sleep (45.5%); improve self-esteem (43.6%); feel more likable (38.two%); feel better physically (36.4%); relieve pain (34.5%); feel normal (32.7%); increase energy (30.9%); alleviate side effects (27.3%); stay awake (25.5%); and decrease hallucinations (10.9%) (Warner et al. 1944, p. 34).

Conversely, Johns (2001) reported that marijuana use "can lead to a range of short-lived symptoms such as depersonalization, derealisation, a feeling of loss of control, fear of dying, irrational panic, and paranoid ideas" (p. 116). Thomas (1996) reported that, of those respondents who admitted to using marijuana and who were asked about mental health consequences, 22% reported panic attacks or anxiety. Degenhardt, Hall and Lynskey (2001), and Johns (2001) concurred, suggesting that marijuana use can lead to a state of anxiety, but this appears to be a potential symptom among naïve or inexperienced users. " . . . studies of regular users . . . found that cannabis use reduced anxiety levels. . . . Furthermore, half of the . . . long-term cannabis users reported cannabis relieved unpleasant mood states such as anxiety or depression" (Degenhardt, et al., p. 220). Gurley, et al. (1998) stated these symptoms of panic or anxiety are felt to be related to a numbers of variables, including the initial increased heart rate induced by cannabis, the disposition of the user to cannabis, and the "setting" or environment in which it is used. Acute psychosis was also frequently cited as a consequence of marijuana use. A recent

study, however, tried to determine if marijuana psychosis was possible in the absence of underlying psychiatric disease. Gurley et al. (1998) discussed a study, which looked at 10,000 psychiatric hospital admissions, and he subsequently argued that there is little evidence that a psychotic disorder can be induced in an individual with no previous mental health issues.

A longitudinal study of marijuana and mental health from adolescence to early adulthood by McGee et al. (2000) suggested that the primary causal direction leads from mental disorder to marijuana use among adolescents and that this direction is reversed in early adulthood. "Mental disorder at age 15 led to a small but significantly elevated risk of cannabis use at age 18; by contrast, cannabis use at age 18 elevated the risk of mental disorder at age 21" (p. 8). Degenhardt et al. (2000) found a strong univariate relationship between the involvement with marijuana and the prevalence of affective and anxiety disorders, but this did not remain in multivariate analyses. In particular, it was after controlling for other drug use that these relationships disappeared. This does not rule out an indirect relationship between cannabis use and anxiety or depression. For example, " . . . cannabis users might be more likely to develop other drug use problems, and this drug use might in turn increase the risk of depression" (p. 225). Johns (2001) wrote that "many of [the adverse mental] effects are dose-related, but . . . may be aggravated by constitutional factors including youthfulness, personality attributes and vulnerability to serious mental illness" (p. 116). Marijuana use is related to proneness to psychosis, but there is no confirmation of causality ( Gray & Thomas, 1996; Taylor, 1998). The explanation offered for their study results was that "marijuana has a propensity to unmask underlying mental pathologies" (Taylor, 1998, p. 222). Sibbald (2001) stated that there is some suggestion in the literature that individuals with schizophrenia may experience an exacerbation of symptoms if exposed to marijuana. He

suggested that "patients with a history of psychosis should be advised against using marijuana" (p. 329).

Conversely, Mueser, Yarnold, Levinson, Singh, Bellack, Kee, Morrison, and Yadalam (1990) found that psychotic patients with a history of marijuana abuse have fewer hospitalizations and scored significantly lower on activation symptoms. Warner et al. (1994), in a similar study with psychotic patients, suggested that this is because marijuana has a useful calming effect. They stated that "subjects who preferred marijuana reported beneficial effects on depression, anxiety, insomnia, and physical discomfort, while recognizing that the drug did not help with paranoia and hallucinations" (p. 36). Although ADHD is not considered to be a severe mental health disorder, such as psychosis or schizophrenia, the reports of the effects of marijuana by these patients sheds light on the possible influences on the mind by this substance.

It has been suggested that heavy marijuana use can lead to "a-motivational syndrome", described as loss of energy and the drive to work (Gurley et al., 1998, Taylor, 1998). Taylor (1998) reported that "about 40% of the surveyed adolescents, without prompting of any kind, reported loss of energy, and a significant number said they lose interest in activities" (p. 225). Johns (2001) questioned the validity of this diagnosis, suggesting that the supporting evidence of a-motivational syndrome is from uncontrolled studies. " . . . it is probable that a-motivational syndrome represents nothing more than ongoing intoxication in frequent users of the drug" (Johns, 2001, p. 118).

My own observation of youth who have a chronic habit of marijuana use indicates that they do exhibit a lack of interest in planning their day, setting goals, attending school, and participating in their own life beyond the immediate moment. We refer to it as the "couch-

potato" syndrome. For an individual with ADHD, this lack of energy and motivation may indeed be a relief from the ongoing bombardment of thoughts, feelings, and energy they experience during daily life.

The Compassion Club offers different types of cannabis, depending on the experienced symptom. The effects of *cannabis sativa* are primarily on the mind and emotions; they tend to be uplifting, stimulating, and energizing. Some of the proclaimed benefits of this strain are that it reduces depression nausea and the awareness of pain; relieves headaches and migraines; energizes and stimulates; increases focus and creativity; stimulates appetite; and supports the immune system. Workers at the Compassion Club recommend that *cannabis sativa* is better for daytime use. The effects of *cannabis indica* are predominantly physical and can be characterized as relaxing, sedating, and pain reducing. The proclaimed benefits of this strain include claims that it relaxes muscles; reduces pain, inflammation, nausea, seizure frequency, anxiety, and stress; relieves spasms, headaches, and migraines; stimulates appetite; aids in sleep; and works as an anti-convulsant. *Cannabis indicas* is recommended for use later in the day or before bed. Members of the Club have come to understand the different strains of cannabis and their uses for different symptoms, and they regulate intake by required outcome.

In my search for literature on the effects of marijuana on the lives of those experiencing ADHD, I wrote to Dr. Lester Grinspoon, an expert in field of the medicinal use of marijuana. I asked him if he knew of any published works on this specific topic. Here is his response:

> It was more than a decade ago that I first had the experience of observing a high school student with ADHD treat this disorder much more successfully with cannabis than with his doctor-prescribed Ritalin. His mother (now deceased), a vice president of the

Massachusetts Institute of Technology, who had asked me to see him for evaluation, was also persuaded that he did much better while using cannabis than he ever did with Ritalin. Since that time I have seen a number of patients, both young people and adults, who have had the same experience. And I have heard from many others (see my Medical Marijuana Site – www.rxmarijuana.com) and still I have seen no reference to this possibility in the scientific or medical literature. I think that at this time we are now in the same situation as we were with Tourette's syndrome about a decade ago; a number of anecdotal reports but nothing in the medical literature. Now you can find citations in the literature to cannabis and Tourette's. The bottom line is that this use of cannabis is still in the clinical observation or anecdotal stage and it may be impossible to find the citations you seek.

Summary

My literature review reinforces that, although ADHD has been acknowledged in our society for many years, there is still much remaining to be understood. There are several possibilities as to the cause or origin of this disorder: genetics, environmental influences, and symptoms of other medical ailments. ADHD often coexists with numerous other psychiatric disorders, and the individual can experience a compound of effects, from disorientation to delinquency. However, regardless of the origin or cause, there is a clear association between ADHD and the development of psychoactive substance abuse. The reason for this relationship appears to be both physiological and psychological, which leads to a hypothesis regarding self-medication.

Marijuana is the one substance that many youth and adults with ADHD use most often. They develop a relationship or habit with this substance. Marijuana seems to help counterbalance

hyperactivity and impulsiveness with an induced sense of calm and introversion. Research on marijuana and mental illness has suggested that this drug can alleviate the experiences of anxiety, depression, and boredom as well as improve sleep and self-esteem. There has been very limited research into the specific relationship between marijuana and ADHD. I believe that this relationship is significant and warrants further study.

# Chapter Three: Methodology

## Introduction

How does one person or society determine the meaning of behaviour in another? How do we know the purpose of that behaviour, if indeed there is a purpose at all? If that behaviour seems risky or unfamiliar to us, do we judge it to be wrong? Or do we attempt to understand the circumstances that would transform our interpretation from it being risky behaviour to it being necessary or even advantageous? Is it possible to understand the lenses through which another perceives his or her world?

I was curious to understand how young people living with ADHD would narrate their experience of marijuana. During my years of working with young people, I have observed that the majority of those who have been diagnosed with ADHD have also developed a daily habit of smoking marijuana. I have witnessed the effects of the change in mood and behaviour before and after smoking a "joint". These youth appear to move from anxious, frustrated, and, at times, frantic to calm, thoughtful, and more receptive to addressing the situation at hand. Both the purpose and method of this study was to hear their stories and to offer an interpretation of their experiences of ADHD and of the ways in which they see marijuana affecting their lives.

My review of current literature on the relationship between ADHD and the use of marijuana revealed that there is a direct correlation between ADHD and psychoactive substance abuse. Many studies stated that marijuana is the most common illegal substance used by these individuals on a frequent basis. These same studies chose to focus on the broader scope of psychoactive substances (alcohol, nicotine, cocaine) rather than on marijuana alone. Further

research discovered that patients experiencing mental health issues testified to using marijuana to relieve a broad range of symptoms, including depression and anxiety. However, ADHD was not included in the scope of these mental health studies. My main source of information about the relationship between ADHD and the use of marijuana, specifically, has been from direct contact with people rather than from the research literature. I introduced my question to several ADHD internet listserves and discussion bulletin boards hosted by universities and hospitals in the United States; on these I received testimonials that there is indeed a strong correlation. Adults shared their stories that they have used marijuana to self medicate their own impulsivity, anxiety, and lack of focus. As a practitioner in the field of Child and Youth Care, I have heard young people describe marijuana as the "stuff that keeps me sane".

I chose a qualitative methodology as the best approach for this inquiry. Denzin and Lincoln (1998) described qualitative research as "multimethod in focus, involving an interpretive, naturalistic approach. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (p. 3). To this end, I interviewed a select number of people who have been diagnosed with ADHD and are using marijuana on a frequent basis. I was interested in their stories and in discovering both the circumstances surrounding their experience with ADHD and their perceptions of their use of marijuana. In my review of the literature, I was unable to locate a study where someone questioned either youth or adults with this disorder about their experience of marijuana. Indeed, in the more empirical studies, the authors determined the self-reports of the ADHD youth to be a limitation of their study. They felt that the youth may have been inaccurate in their description of the symptoms of ADHD, the comorbid symptoms of other disorders, or in

their true estimation of the effects of their use of the substance. I believe it is time to hear the voices of those who experience these conditions. In doing so, I hoped to gain a better understanding of their use of marijuana. Is using marijuana an adolescent statement of rebellion and delinquency, a form of self-medication, or something else yet to be discovered? The underlying intent of this inquiry is to enhance the understanding by the parents, caregivers, and practitioners working with individuals who both live with ADHD and use marijuana.

## Research Paradigm

I have chosen a qualitative methodology because it is based on achieving understanding of a phenomenon by hearing and analyzing the culture and experience of those persons directly involved in that phenomenon. As a seasoned child and youth care worker, I have come to adopt the belief that each individual is the expert in their own life. Each personal journey is unique. Kvale (1996) suggested that the purpose of qualitative research "is to understand themes of the lived daily world from the subjects' own perspective" (p. 27). This is also the mission in child and youth care. The first step in assisting someone in the process of change is to engage them in a respectful process of exploration and understanding their "life world". Initially, the counsellor engages in "research" to help the client determine the course of the helping process. Quantitative methodology derives truth through measurement in terms of frequency, quantity, intensity, or amount of observed behaviour by an objective, detached researcher. Conversely, the qualitative paradigm implies an emphasis on processes and meanings, an emphasis which "stresses the socially constructed nature of reality, the intimate relationships between the researcher and what is studied, and the situational constraints that shape inquiry" (Denzin & Lincoln, 1998, p. 8).

Based on my exploration of the qualitative paradigm, it would appear that this method of research is as complex and varied as the people it proposes to study. Creswell (1997) likened it to "an intricate fabric composed of minute threads, many colours, different textures, and various blends of material" (p. 13). He noted that "This fabric is not explained easily or simply" (p. 13). Kvale (1996) discussed the philosophical lines of thought that are central to qualitative research. Although he presented four philosophies, each highlighting different aspects of knowledge relevant to qualitative interviewing, there are two that resonate with the intention of this research: postmodern thought and hermeneutics. There are characteristics within each of these philosophies that contribute to my approach for this inquiry. The postmodern approach focuses on interrelationships and on the social construction of reality in an interview with an emphasis on the narratives constructed within the interview. Hermeneutics focuses on the interpretation of text or conversation, with an emphasis on the interpreter's foreknowledge of the subject matter. It was my intention to focus on the personal view or "life world" of the individual, to maintain an openness to his/her experiences and descriptions, and to attempt to discover the meanings in those descriptions.

The use of narratives was significant in this inquiry. Qualitative research speaks to how we make meaning of our experience through discourse (Cortazzi, 1993; Creswell, 1998; Herda, 1999; Lieblich, Tuval-Mashiach and Zilber 1998; Riessman, 1993). Lieblich et al. (1998) reminded us, that "People are storytellers by nature. Stories provide coherence and continuity to one's experience and have a central role in our communication with others" (p. 7). It is within our stories that we define ourselves. Reissman (1993) suggested the following:

> How individuals recount their histories—what they emphasize and omit, their stance as protagonists or victims, the relationship the story establishes between teller and audience—all shape what individuals can claim of their own lives. Personal stories are not merely a way of telling someone (or oneself) about one's life; they are the means by which identities may be fashioned (p. 2).

Through the interaction of discourse and interpretation emerges a mutual understanding of the individual and their perception of their world. Knowledge is achieved by people talking about their meanings; it is laced with personal biases and values; and, as it evolves, it is inextricably tied to the context in which it is studied (Creswell 1998; Herda, 1999). Language is not only helpful in defining the social world for individuals; it is also essential for creating that world. Herda (1999) suggested that "Language does more than enable us to comprehend or represent this world and our understanding of it. Language plays a generative role in enabling us to create and acknowledge meaning as we engage in discourse and fulfill social obligations, which have, in turn, been created through language" (p. 24). It was through the narratives within my own interviews that themes of the combined experiences of ADHD and marijuana emerged.

The interpretive process is ongoing throughout qualitative research. First, there is interpretation occurring during the interviews. As suggested in the above paragraph, meaning is fluid and contextual (Liebich et al., 1998; Riessman, 1993). An adequate understanding of the interview process relies upon recognizing how interviewers reformulate questions and how respondents frame answers in terms of their reciprocal understanding as meanings emerge during the course of the narrative. Kvale (1998) reminded us that, "Starting with an often vague and intuitive understanding of the text as a whole, its different parts are interpreted, and out of these

interpretations the parts are again related to the totality, and so on" (p. 48). After each interview was completed and the story transcribed into "text", I had a single, frozen photograph of that dynamically changing personality. A second level of interpretation then took place as I located themes within the participants' descriptions; this offered a greater insight into and understanding of their reality. It is important that this narrative text be recognized and interpreted as a static product; as such, it only reflects a moment in time within each participant's "inner", existing identity, which is in fact constantly in flux. Each story is affected by such things as the context in which it is narrated, the aim of the interview, the mood of the narrator, and the relationship formed between teller and listener (Leiblich et al., 1998). The moment that we begin to study a phenomena, we change it.

It is in the interpretive process that the role of the interviewer is recognized. As Rubin and Rubin (1995) suggested, "In qualitative interviewing, the researcher is not neutral, distant, or emotionally uninvolved. . . . The interview is affected by the researcher's personality, moods, interests, experiences and biases" (p. 12). I brought to this interchange the experiences of a skilled interviewer, including the ability to build rapport and to focus on process as well as on content. As a collaborator in narrative inquiry, I carried my own beliefs, values, and assumptions to the exchange. I brought with me the preconception that the use of marijuana may be medicinal in that it offers a sense of calm in a life that may be experiencing turmoil. I also brought a personal knowledge of what it is like to develop a relationship with marijuana, along with my subsequent interpretations of both the positive and negative attributes of this substance within my own life. Ultimately, I brought my perceptions from my own "life world", and these perceptions undoubtedly influenced my approach as well as my interpretations. For example, my

25 years of working with "troubled" youth have undoubtedly influenced my ability to empathize, and perhaps validate, these stories of chaos, abuse, and struggle. If we create meaning through discourse, then the listener plays an equal role with the narrator.

Lieblich, et al. (1998) defined narrative research as any study that uses or analyses narrative materials. Mine is a descriptive study, the goal of which was to expand on our understanding of the experience of marijuana on the life world of a young person who live with ADHD.

The intent of this research and of the interviews was not for it to be therapeutic for the participants. It is important to acknowledge, however, that this process of collaboration, construction, and interpretation offered the participant an in-depth journey into self. This journey can result in an increase in self-awareness. It is my belief, arrived at from years of counselling in child and youth care, that self-awareness is one of the foundations for the process of change. Therefore, the participants may very well have experienced therapeutic value from this process. Lieblich et al. (1998) concurred with this: "In applied work, clinical psychology uses the narrative in the context of therapy. Restoration, or development of the life story through psycho-therapy, is considered the core of the healing process" (p. 5).

## Method

I interviewed five individuals who live with ADHD. From this I hoped to gain an understanding of how they narrate their relationship with marijuana. I went into these interviews with a very loose framework of questions. I began by asking each participant when he/she was first introduced to the term ADHD. We then talked briefly about their symptomatic behaviour and how their world responded to it. I then moved the conversation forward to a discussion of

when they were first introduced to marijuana. The conversation flowed as they shared their experiences and perceptions.

The term "interpretation" is well suited to describe the process in which the researcher transcends factual data and cautious analysis to probe for possible explanations of the information that has been gathered. Wolcott (1994) uses the metaphor of a teeter-totter "or seesaw, balanced at the midpoint but responsive to whichever end is more heavily weighted. Description is the fulcrum, the pivotal base on which all else hinges, but it is the researcher who decides how the description is to be played out—whether to bear down more heavily on the side of analysis or interpretation or, risking the dull equilibrium of static state, to try for 'perfect balance' between them" (p. 36). As the researcher in this inquiry, I believe in the balance between the two. Analysis offers important information for the reader; interpretation offers insight as to the possible meaning of that information.

Research Relationship

I approached the research interviews the same way that I approach the process of inquiry in my practice as a youth counsellor. Although the goals of these two constructs are quite different, the process is very similar. Hoskins (2001) reminded us that "the primary purpose of counselling conversations is to assist clients in the process of change, . . . [and, conversely,] the primary purpose of research conversations is to generate knowledge" (p. 121). It is imperative in both, however, that the inquirer be aware of her own beliefs, values, ethics, assumptions, theories, and worldviews throughout the process of inquiry. I worked on "being present" for the participants. I approached each interview with a curious attitude and focused on what they were trying to communicate. During my years of experience working with troubled teens I often had

to work with their emotional pain and anguish. This level of familiarity with the experience of trauma by youth living with ADHD allowed me to listen without judgment or negative reactions to their stories. I was able to be genuine, authentic, and respectful in my approach to each participant.

As a result of my own experience with marijuana, and of years of observation and discussion with ADHD youth who have utilized this substance to control their moods, I came to this inquiry with certain assumptions. Aware of my assumptions, I attempted to remain neutral and curious without influencing the discourse in any particular direction. I believe, however, that my open, relaxed, accepting attitude toward their tumultuous childhoods and their use of marijuana influenced the mutually open, relaxed attitudes with which they shared their experience. I did not have an agenda to influence change in these young people's lives. I believe, however, that each one of them experienced a sense of affirmation, and perhaps even pride, in the ability to speak openly about that which is normally kept secret. It seemed to be important for them to believe that their stories might influence some change towards understanding and acceptance of their behaviors and of their use of marijuana.

Participants

The participants were young adults, 20 to 32 years old, who had been diagnosed during childhood as having ADHD and who have since developed a chronic relationship with marijuana. (By chronic, I mean that they have smoked the substance daily for at least the past two years.) There were four male participants and one female. Although ADHD is more common among males, I felt that it would be valuable to hear the female perspective as well. I chose this age group because they are still close to being youth and have a relatively clear memory of what

their life was like during their adolescent years. I hoped that the added years of maturity would have prepared them to articulate their experiences in a reflective way. These young people also had the legal right and responsibility to sign their own consent forms. Initially, the age group was planned to be 19 to 29; however, when I met the participant who was 32 years of age, I felt that his story was an important one to add to this inquiry. His maturity seemed to enhance his ability to articulate the choices that he had made, his experience of ADHD, and his use of marijuana.

The recruitment of participants was, for the most part, done by word of mouth. I relied on my many connections in the field of youth care to assist me in locating the participants. I contacted several colleagues and discussed what I was doing and the type of participant I was seeking. If they had someone in mind that fit the criteria, then I requested that they make the initial contact with this young person and introduce the project. Because marijuana is an illegal substance, I felt it was important for the initial contact to be made by someone with whom the young person had already established a relationship of trust. If the young person expressed interest in participating, I was given their phone number. I then contacted the individual to set up a time and place for the interview.

I was acquainted with two of the participants. One, a past resident in my home, was the initial inspiration for this inquiry. The other was a student in the training program I co-facilitated during my Master's level practicum. Both of these young men fit the criteria for this research. I had met the female participant in the past when she was residing in a colleague's group home, but this young woman had no recollection of our meetings. The remaining two participants were unknown to me.

## Context

The interviews took place in a neutral and comfortable location. Once I had made initial phone contact with the participants, each was asked to choose the location that was most comfortable. Four of the interviews took place in the participant's home. The fifth took place at my home at the participant's request.

The participants were interviewed in the presence of an audiotape recorder. The interviews took approximately one to two hours; the length varied depending on the depth of the story and on the ability of the participants to remain attentive and focused on the process. Finally, after participants were each given a copy of their narrative description, there was a follow up meeting during which I requested feedback and final input from the participants.

## The Process

The audio taped interviews were transcribed into written text, word for word, replicating the conversations as accurately as possible. I then reviewed and analysed the transcripts looking for thematic statements that were particularly revealing about the experiences being described. Although I recognized some commonalities within these interviews, when the time came to write the stories from these rich texts I struggled with how to present these lived experiences. I empathised with other researchers who stood at the doorstep of interpretation, wondering how to transform the transcript into a descriptive narrative. How could I possibly tell their story?

It was after much reflection that I realized that the alternative to attempting to tell their stories was to instead tell my own. Because of my reluctance to speak for them, I decided to share their stories from my own perspective, to present my own experience of these five young people. How they proffered themselves to me began with our first encounter, then changed or

developed throughout the process. This approach dissolved my fear of making judgments about who they were. I would instead offer my interpretation of their descriptions of their "lived world". As I began to write, I realized I was reconstructing the conversations through my own eyes in order to make sense for myself as the researcher and for my readers. Throughout this process of inquiry, increasing with each interview, was the sense that I was being entrusted as a messenger who would present these stories to a larger audience. The participants were trusting me to treat their stories and their life choices with respect and compassion.

Once the narratives were complete, I compared similar clustered topics and often-used terms across the five interviews in order to identify any common themes. When I gave each participant a copy of the transcript and the narrative, I invited each to review the text for the purposes of giving feedback and adding further insight into the experience. The resulting feedback from each participant is included at the end of each narrative along with any final statement they wished to add.

Ethical Considerations

Conducting an inquiry that examines in detail the lives and activities of others inevitably raises concerns pertaining to ethics and integrity. Participation in this project was voluntary. The participants received a complete explanation of the purpose and process of the research. They were asked to sign an "Agreement to Participate" consent form at the onset of the first interview (Appendix B). I ensured them that they had complete freedom to leave at any point during the interviews. I guaranteed confidentiality. I invited each to speak about only what felt comfortable. Marijuana is an illegal substance, so disclosure of their involvement may have been seen as incriminating. For the interpretive writing of the text, they were given the choice to have their

name changed to protect confidentiality. All five participants were comfortable having their real names used. However, I later decided that, due to some of the incriminating nature of their histories, I would change their names to ensure their safety and confidentiality .

After the text of the narratives was written, I gave the summaries and interpretations of the text to individual participants for their input and approval.

Because this interview process would possibly become a journey into self-awareness for the participants, I believed it to be imperative, for the respect and consideration of these participants, that I offer and commit to a process of support if necessary. They were informed that if the interview process created or uncovered unresolved issues, either during or after the interviews, support services would be made available to them. None of the participants in fact requested this follow up support.

Interviews

I would characterize the interviews as a flexible strategy of discovery, the object of which was to facilitate a guided conversation. The process of the discourse was not predetermined; it developed as the conversations progressed. As Garfat (1998) reminded us, "A narrative approach views the interviews as a 'a discourse between speakers' . . . that is constructed jointly by both participants . . . with such an approach the meaning of the questions and answers are contextually grounded because of the joint construction of meaning that occurs when the participants engage in interactive discourse" (p. 48). I asked open-ended research questions, listened to the participant's responses, and shaped the questions as we conducted our exploration of each topic.

Within this journey of discovery there were general themes to be followed, but each answer inspired a question that was not predetermined. Each interview began with a statement of

my own curiosity about the participant's knowledge and experience of ADHD along with a look at when marijuana came into their lives. The focuses of the conversation were to discover the participant's experience of ADHD, their understanding and experience of the influence of marijuana, and what they believed to be both the advantages and disadvantages of this substance in their lives. The questions diverged during the process of the interview to reflect an increased understanding of their experience. Both the participant and the interviewer directed the flow of conversation. My role as interviewer was to maintain the focus to ensure that the conversation flowed around the intended content. The answers to some of these questions were very personal, revealing inner thoughts and beliefs about the participants' views of themselves, their "life worlds", ADHD, and the notion of self-medication. Through the use of their own narratives, they had the opportunity to recognize the construction of social reality as well as their personal belief system. It was within these discourses that the richness of their experience with ADHD and marijuana was revealed. Because this was a collaborative dialogue, I, as the interviewer, interacted with active listening skills, statements of empathy, understanding, clarification, as well as summarizing and suggesting interpretations of the discourse.

The Use of Discourse

Aside from what was said in the telling of these lived experiences, the manner in which participants chose to share their stories seemed significant. Following the storyline of a person with ADHD was at times challenging, as there was often no linear progression from one thought to the next. Indeed, a first response might be abandoned before it was finished as their discourse raced to keep up with their thoughts. When I listened to the tapes afterward and transcribed the text, I was occasionally surprised when a participant would return to answer a question that had

appeared to be abandoned in the discourse some time before. What I had assumed to be lost within all the activity in their brain had instead been temporarily set aside for retrieval later. I was impressed with the skill required to sort out what I had prejudged to be a constantly disorganized clutter of brain activity. I had assumed that, because I could not always make sense of what they were saying, they were not making sense. Tom, one of the participants, had commented that people assume that, because he talks fast, he must be an idiot. I realized the depth of this wisdom when I listened to his storytelling a second time. He really did have control of his discourse.

### The Use of Story

I was very curious about how the participants would use language, story, and metaphor to construct and make meaning in their "life world". I believe that, in a narrative constructivist paradigm, we create our reality with language and through our stories. Morgan (2000) suggested that "The stories we have about our lives are created through linking certain events together in a particular sequence across a time period, and finding a way of explaining or making sense of them" (p. 5). We have become a culture that subscribes to the belief that our words and thoughts create who we are. There are positive self-affirmations posted on the fridges and bathroom mirrors of North America as each of us tries to create a more positive image of ourselves. I was curious to see what reality the participants would create for the listener when given the freedom to tell their story in a comfortable and non threatening environment.

### Validity

The validity of qualitative research is determined by whether an interview study investigates what it intended to investigate. A post-modern perspective believes there are

multiple ways of knowing and multiple truths. As Kvale (1998) pointed out, " . . . validity refers to the truth and correctness of a statement. A valid argument is sound, well grounded, justifiable, strong and convincing. A valid inference is correctly derived from it premises" (p. 236). Validity in this study would therefore depend on my ability to interpret and relate the truths of the participants as they expressed their narratives and shared their constructed realities. I admit that there were times throughout the process of interviewing, transcribing, creating the narratives, and analysing and interpreting data that I wondered whether these participants were "pulling the wool over their own eyes". From my Caucasian, middle class, middle aged perspective, there were a few times when I wondered if the stories I was hearing were a stretch or exaggeration of the truth. I found it necessary to suspend my doubt, or my belief in truth or falsity, in order to hear what they were trying to communicate. Churchill (2000) spoke to the notion of distortion:

> An interesting feature of the psychology of narrative is that the act of description is a drama in its own right. When we ask patients or research subjects to describe their experiences, they do so with many of the same operative defenses and self-deceptions that were inherent in the experiences they described. Thus if empirically based phenomenological research is going to aim to achieve fidelity with respect to an original experience using narrative data and narrative methods of analysis, then out of concern for the validity of narration one must consider the possibility of "distortion" in the reflexive movement from the lived to the known (p. 44).

As a narrative researcher, I do not wish to investigate the mechanisms of experience, but rather the meaning of experience as lived by the participants. As Churchill (2000) suggested, "The question of the validity of verbal reports thus centers upon where those reports are

supposed to lead the researcher" (p. 45). The verbal explanations shared within the interviews are in themselves human behaviour and add another dimension to the investigative process. The "snapshot" or still life of the ever-evolving truth of these five dynamic lives, what they chose to share in that moment in time, was in itself a reflection of who they are, or better yet, who they chose to portray in that moment.

As a counsellor, I use "open" questions to invite the client to respond in whatever way they choose. The client and I share the assumption that they do have choice in what they reveal about themselves and as such we, both the client and I, attribute meaning to the choices they make. Carr (1986) proposed that "Narratives will reveal themselves to be not distortions of, denials of, or escapes from reality, but extensions and configurations of its primary features" (p. 16).

A drug and alcohol counsellor suggested to me that these participants were all simply justifying their actions so that they did not have to address their addictions or take control of their lives. I found it interesting that this counsellor also judges certain individuals in our society, those who are medicating themselves daily with prescription anti-depressants, as controlling their moods in a more appropriate manner. He acknowledged that he situates himself within our cultural guidelines, both legal and medical, of what constitutes appropriate substance use. Each reader will interpret the truth of these narratives from their own perspective. The issue of validity is not one of truth, but one of true reflection. According to the five participants, I have accurately captured what they wanted to say and have written a "true reflection" upon that.

Reliability

Reliability and the ability to generalize are not as clear-cut in qualitative research as they are in empirical methodology. Do the five individuals that I interviewed speak for all those who live with ADHD and self-medicate with marijuana? Perhaps those stories would be similar. Perhaps theirs would be a different understanding of the experience of coping with this disorder, or the experience of this substance. Is this research format reliable for future participants to share their experiences and report their own truths surrounding this phenomenon? I would venture to say that this is dependent first on the researcher and second on the participants chosen. Because of my years of living and working with "troubled" teens, many of whom were living with ADHD, as well as my own understanding of the marijuana culture, I was able to create a safe environment for open dialogue. I was able to validate their experience in both realms, living with ADHD and marijuana use. I personally believe that these five individuals do speak for others in similar situations; the consistency in their stories reflects this possibility. The role of the researcher is very important in the potential for reliability.

I think it is important, when addressing the issue of reliability, to acknowledge the number of self-reports I encountered during my research. As I shared my topic with various people in my personal and professional worlds, almost everyone I spoke to knew someone who was self medicating their hyperactive energy with marijuana. I came to expect a response such as, "I know someone who fits that description. I know a guy who I am sure is ADHD and he has been smoking pot daily for years." It seems that indeed these five participants reflect a large population of individuals who find solace in the use of this substance.

# Chapter Four: The Narratives

## Christine

The first interview was with Christine, a young woman of 20 years of age. I had met Christine several years prior to this, when she was living in the group home run by one of my colleagues. I knew a bit about Christine's background; I recalled that she was an adopted child, and that at the age of 15 she was very scattered and hyper in her energy. My initial contact with Christine for this study was made with the assumption that Christine remembered who I was, but, as you will see half way through the interview, Christine admits that she had no recollection of ever having met me before.

During our first phone call, it was agreed that I would go to Christine's home for the interview. She gave me excellent directions to her main floor suite of a home in a subdivision in Surrey. When I arrived she greeted me with a warm smile. Christine presented herself as a slender, attractive, and well-dressed young woman who kept her home very clean. I was introduced to her cat and the litter of kittens, then we settled in with our coffees and the tape recorder. Christine seemed very relaxed and open to the conversation. Once again, I assumed this ease was due to our previous connections and the relationships we both had with my colleague and her past caregiver. She took the time to look over the consent form; I explained the two-page document to her when she admitted that she did not wish to read it in detail. Throughout the interview, she was clear and articulate in her answers and demonstrated awareness of both self and others.

The first question in this interview process focused on ADHD and her understanding of it. Christine shared that she had been eight or nine years of age when she became familiar with

the term ADHD. She reported that "they did all the psycho-evaluation type deal" on her and had determined that she was ADHD. She then went on to suggest that perhaps they had been misguided in their diagnosis, as she had also been abused at the age of eight. She felt that "maybe back then they didn't realize that the symptoms of a stressed, abused child are the same as a child with ADHD." She did not appear to be denying the possibility of her ADHD, but she wanted it on record that there was more to her situation than just being hyperactive and having an attention deficit.

From this diagnosis, Christine had been put on Ritalin and then eventually on Dexedrine for a period of approximately four years. When asked how that had been for her, she acknowledged that the medication had helped at the beginning for a short period of time, but then it had "made me quite depressed". She reported that, from age 12 until when she ran away from home at age 14, she had been very suicidal. She then corrected herself and acknowledged that "it was not really suicidal . . . it was more self mutilation." She stated that she had been very depressed living with her parents. She qualified her statement by stating that her parents were wonderful people who had done a wonderful job of raising her, but she could just not live there anymore. "I don't know if that had to do with adolescence or adolescence being mixed with the Ritalin and Dexedrine and my life, but I had to go." This move to the streets of Vancouver had been the end of Christine's use of prescription medication. She admitted that she had sold her prescription drugs on the streets.

When I asked Christine when she first came across marijuana, she reported that when she had run away to Granville Street she had been first introduced to hard drugs, and that marijuana had not come until later. "The first drug I ever did was PCP . . . then evolved to many other

ones." I shared with her how some of the research suggested that young people who are living with ADHD and have been on Ritalin go on to use other stimulants as they get older. She agreed with this notion and stated that although she had moved away from her use of cocaine and other heavy drugs, she still had an addiction to cigarettes and believed that she could not live without them.

The conversation then moved towards her use of marijuana. Christine admitted that she had not really liked "pot" her first time. "Everything kind of spun." But then she moved quickly on to acknowledge that now it is a "chronic thing . . . I don't get totally, you know, baked off of it...it is something that is in my system all the time now." Without any prompting from me, she reported, "Me and my boyfriend have both noticed that I can't eat unless I smoke . . . so I definitely have noticed that there is a dependency on it. They say that a lot of people go on about how it is not addictive, but it is addictive. That much I have noticed."

At this point the interview developed a momentum of its own and Christine moved us into the next topic: school. "As for the stress, I can concentrate in school better." She laughed as she reported, "The one day that I did not go to school stoned was the one day that they kicked me out for being stoned." It seemed that the school had not known how to interpret her hyper energy and inability to focus. Christine reported that she has had a very hard time in school. She now had a grade nine education and, later in the interview, she acknowledged her goal to complete her grade 12. "You can't get a decent job without your grade 12."

Just as quickly, the conversation changed direction again and Christine was talking about the boyfriend who turned her onto smoking crack cocaine. "I just got really involved with a guy who loved and smoked it daily. We spent hundreds of dollars on it . . . sold his clothes for it . . .

but he ended up falling into the Hastings situation [Do you want to include a brief "aside" to explain "Hastings situation"?]where he ended up using needles as well. I had left him just before that." When I asked her if she had ever used needles, she was adamant. "No Never!" And when I was curious about how she managed to get off the coke habit, her response was, "He beat me. He beat me three times, and I went to a safe house and that's where I went into detox and ended up in a semi-independent living home. I got into detox and started school again. And then it just became just like a party base on the weekend sort of thing, where I lived my life for it. And then I started smoking a lot more pot and the coke just kind of disappeared." I sought clarification on that statement, asking her if she thought that the pot had helped her to get off the coke. Her response was, "Oh definitely." She clarified that it had helped "with the withdrawal you go through". She went on to add that "I was basically an alcoholic as well until I met my boyfriend. I drank every day and he gave me the ultimatum . . . the bottle or be happy with me." This implied that Christine had chosen the relationship rather than the alcohol, and I acknowledged the choices that she had been making at that time. Christine shared that her boyfriend was also ADHD and that the two of them used marijuana on a daily basis together. At the age of 15, her boyfriend had become a father, and Christine believes that this had helped changed his life around. "You end up with a lot of responsibilities."

The discussion shifted again as I asked her to focus on the present and what her current marijuana consumption was like. Christine shared that she smoked pot daily because "I can't eat. If I don't smoke I get very ill . . . and I feel like shit." She reported that she smoked four to five times a day. When I asked her if there was a time of the day when she felt like she needed it, her response was, "If I am really bitchy." She went on to expand upon this self-characterization. "I

am a very stressed person. I don't handle stress very well. There are some days when my boyfriend will just yell at me and say, 'God, will you just go and smoke [marijuana] so I don't have to listen to you anymore', so definitely it releases the stress, and I cannot handle the stress." Christine added, "It doesn't get me stoned to the point where I can't function." She went on to tell a story about another friend of hers who got really paranoid when she smoked marijuana and believed that everyone wanted to harm her. When I asked if she herself had ever experienced paranoia with the consumption of marijuana, she said no.

I went on to ask her if marijuana was the only drug that she was currently using, and she acknowledged that she smoked cigarettes and occasionally had a drink. She noted that what did not make any sense to her was why alcohol is legal and marijuana is not. "Because you know the majority of fights, killings, everything that happens, usually happens when you're drunk . . . yeah you don't hear about somebody starting a big brawl because they smoked a joint." She laughed then as she added, "They would rather sit down and eat something."

This was her opening to discussing the cautions of using marijuana. She stated that, with alcohol, young women are at risk because "guys use alcohol to get you drunk and take advantage of you . . . The only caution with smoking a joint in a group like that, is make sure that it's your own and that you rolled it yourself. Then you will always know what is in it." She went on to tell a story about sitting at a friend's house one night with "these guys who got us high". She said she had felt cautious about the situation and had stopped inhaling. Her friend had not been so astute and had ended up in the bedroom getting raped. She reiterated, "Always make sure you roll it yourself."

This story somehow ignited her memory and she began another one about when she had first run away. The girl she had run away with had been eleven years old. The girl had ended up being attacked by some "guys" with weapons, so she and the girl had run to Broadway Station and alerted the sky train cops. She reflected on how frightened she and the girl had felt at the time. When I commented on how young 11 years old is, she attempted reassurance by saying that she believed that her companion had gone back to her mom after four years on the street. I tried to imagine the "education" of a 15 year old girl who had already spent four years on the streets of Vancouver. When I commented on the lessons and resilience it must have taken to have survived such obstacles, Christine talked about how the celebration at her sixteenth birthday had been so extreme that she was surprised that she was still alive. She stated that the recovery had been so severe that she had had to rethink her priorities. The commitment to a healthier life had only lasted a couple of days, however, and then she had gone back to her use of drugs and alcohol. When I acknowledged that she had survived, she responded, "Yup . . . definitely. I figure if I hadn't of got out when I did three years ago, I don't know that I would. You know, there are 15 women being dug up right now [referring to the 15 women whose bodies were found buried at a local pig farm] and I could have been one of them."

The conversation veered off for a while as Christine talked about the several moves that she and her boy friend have made in the past few years. I then redirected the conversation back to her experience of marijuana by summarizing her statement about how it helps her to eat and to deal with stress. Concentration was the response. Then, "It was for the school factor. Like I said, I find that if I smoke one, you know, then I am going with the mind-set to do something. I can sit there longer and do it. Whereas if I don't, well, I am a very fidgety person you know, and I am

fidgety, and I won't be able to concentrate." She then restated the goal of getting her grade 12. She also talked about some volunteer work that she was doing and that she hoped to continue with that. It was clear that she was proud of that work, and I acknowledged her growth since I knew her when she was 15. She responded to this by saying, "Have I met you before?", and I tried to help her remember the numerous times I had seen her in her past group home. I acknowledged that she had always been on the move when I had seen her. She agreed by stating that she still had a lot of that energy; however, now that she was co-parenting with her boyfriend, she was more tired, as caring for the child took a lot of her own energy.

Christine reflected back on her time at the group home. "I don't remember too much living at [that group home]. A lot of the good things I do remember, but usually when those happened I was sober. So I have apologized to her. Two years ago after being with [my boyfriend], I realized everything I had done and I had to phone her, [and others] and my mom to say I am sorry." She associated this insight with her current experience of being a parent herself. "I couldn't imagine [my step son] running away on me. What heartbreak it would put me through." She then went on to talk about some of the disrespectful ways she had treated past caregivers and gave a short history of her time in the care of the Ministry of Children and Family Development.

Once again reflecting on her changes and resilience, I asked her why, with all the "cleaning up" she has done from the substances in her life, marijuana was the last thing she was holding on to. Her response was, "Because it does not fuck you up. It doesn't take you out of reality, like alcohol or coke or acid or any of that stuff. Boy! It is something that is just normal, like a cigarette, it still takes the stress [away]." I asked for more clarity about what reality was to

her, and she tried to explain. "When I flip out, I'm a nut. I don't think about what I am saying, and you know I can say a lot of things that I don't mean. But if I have a joint, I usually don't get to the point where I'm mixed up." When I asked her how often she smoked pot, she reported that she smoked when her step-son was in school or in bed.

The conversation moved on to a discussion of how easy marijuana is to obtain, and then on to how it affects her depression. She reported that she had not been depressed since being with her boyfriend. She talked about her cycles of depression in the past, and she associated those depressions with her use of hard drugs and alcohol. She stated that it had been three years since she had felt depressed. I asked her what she thought had changed for her in that time. "I see reality now. I am not out in my little slut clothes trying to impress men to get drunk and get free drugs. It was a hard life to leave. I had regular guys who would come and visit me and I would get $500 and they would take me out for supper. This is gone. I ended up on welfare and raising a child. But I am in reality now and it is a lot better. I have never been respected by a male. I have always been beat up by my boy friends and [my current boyfriend] has never raised a hand to me. I was kind of scared at first and I asked [my past foster mom] what I am supposed to do. And she said, 'Well don't you think that you deserve it? You know, finally it has come to you. Take it.' And I did."

She went on to talk about her past abuse and how it had put a major block in the way of communication with her parents. She stated that her boyfriend had encouraged her to reconnect with her mother, and, because of that, she and her mother had been rebuilding their relationship. There continued to be awkward moments in the conversations between them, but at least they were starting. When I acknowledged the lessons she was learning from being a parent herself,

her response was, "I have a lot of apologizing to do." She acknowledged that she had been learning what family means through her boyfriend and his mom.

She told another story about doing hard drugs, smoking heroin, and waking up naked next to some guy, having no memory of the night before; following that, she had decided not to try heroine again. I got the sense that this was one of her more vulnerable moments of the interview, and we reframed the experience into a lesson about her limits. The conversation then came back to her use of marijuana. I asked her if she had ever tried to quit smoking "pot". She shook her head. I asked if she had ever gone without marijuana, and she nodded her head. "Yeah . . . and I get sick. I go through withdrawal, you know, even if I have cigarettes it does not help. I can't eat." And with a giggle she acknowledged that she sometimes got very bitchy. She said she believed that she could not go more than a day without smoking a joint. When those days come, she explained, she just goes to bed and tries to sleep all day.

We talked a bit about the medicinal use of marijuana, and she told another story about an older friend of hers (in his 40s) who lives with epilepsy. "If he doesn't smoke pot then he will have a seizure, even with the Dilantin and Tegratol [seizure medications], if he doesn't have that joint, he will seize." This story seemed to confirm for her that marijuana is a medicinal substance, and that she was in good company with sufferers who require support form this substance. This conversation led to her stating her opinion that the government should decriminalize the use of marijuana. She supported this opinion with a story about her parents. She stated her belief that many professional people are using this substance behind the scenes, and supported this with a story about a professional person that she knows. She talked about how nice it would be if people could go about their normal behaviour without the fear based on the

fact that the use of this substance is a criminal offence. With another story, she described how the fear of being caught had a negative influence on one single mom's life. She concluded this series of short stories with one more about her mother-in-law, who suffered from a severe back injury and seemed to get a more comfortable relief from marijuana than from the prescribed morphine. I could not help but notice Christine's use of stories to confirm her own beliefs. She had an example from someone else's life to back up her beliefs about her marijuana use, and often used these stories as her answer to my questions.

I asked her if she felt that she had found a balance in her own life. Her response was, "Liquor was my favourite. That was my sanity. I never had enough self-esteem to actually like life so I liked the bottle." I asked her if she believed that marijuana affected her self-esteem at all, and her response was, "No. I feel good about who I am now."

As we were concluding the interview, I inquired if there was any other statement she wanted to make. She felt it was important to repeat that she was not going to say that marijuana was not an addictive drug, because for her using it has become "chronic". She spoke again about how she needed it in order to stay healthy and believed that without it she could not hold down food, and she needed food to be healthy.

I told her I was curious if there had ever been a time when her experience had not been good, when marijuana had gotten in her way. "No." Had there ever been a time when she had felt that she had gotten too stoned on it? "No." I thanked Christine for her time and we turned off the tape recorder.

As I walked away from this exchange, I felt affected by her story and by her own use of story to support her beliefs. I was impressed with her resilience to survive life on the street and

her journey toward the life that she had now created. She appeared to be quite self aware, articulate, and willing to take responsibility for who she had been, as well as who she had become. At the age of twenty, she had already experienced more of life's challenges than many much older than this.

Christine: Second Meeting.

A year and half passed before I spoke with Christine again. After I sent her the above narrative, we had played phone tag for several months. When we finally talked on the phone, we decided that, because it had been so difficult to arrange even a phone conversation, we would discuss her feedback over the phone rather than trying to meet.

She started her feedback by correcting my terminology. She stated that my use of the word "dope" was not correct. In her vocabularly, dope is not marijuana; it is the word used for heroin. She said that a couple of her friends had read the story, and they had all felt strongly that I should correct this.

I said I was curious what it was like for her to read her own story. She likened it to a flashback, but, "I still agree with everything I said back then." She was glad that she had made the point that marijuana is an addiction, and said she still felt strongly that it is addictive. I asked if she was still using it, and her response was, "Of course." She reported that her circumstances had changed considerably. She had left her boyfriend, moved into the city, was living on her own and looking for work. "It is better, but harder, to be independent . . . and I'm happy." When given the opportunity to make a final statement, she declined, stating that the paper had been well written and had captured her perspective. I checked in to see what name she wanted me to use for her in the story. She confidently stated she was comfortable with the use of her own

name. I was once again aware of how far this young woman had progressed from the very high risk 15 year old that I had originally met.

Tom

I first met Tom during my Master's practicum. He was a student in a 13 week intensive course that offered training in the skills and knowledge to work with street entrenched youth. Upon first meeting him, I had been taken by his energy, his enthusiasm, the speed with which he spoke, and with how quickly he moved from topic to topic as he tried to communicate his thoughts and feelings. He had been open about his current use of Ritalin to control his ADHD, and about his use of marijuana. Although at age 32 he was older than the initial age criteria for this research project, and his diagnosis of ADHD had not been determined until his adult years, I knew immediately that I would have to expand these boundaries to include his story. I could not help but notice that, although he struggled with his verbal communication, or, more accurately, I struggled to keep track of his discourse, his written assignments had been clear, articulate, and brilliant. I was curious to know how he managed the balance between his internal dialogue and his external presentation.

When I approached Tom to be a participant in this inquiry, he did not hesitate to volunteer. He opted to come to my home for the interview. We met, with the tape recorder, on my deck. It was obvious that Tom took pride in his appearance. I would guess that one of the ways that he had learned to deal with his excessive energy was to work out, as he appeared to be in very good physical shape. Broad shouldered, deep-chested, and narrow waisted, he looked like he would be at home in the weight room at the gym. Tom's mom is Japanese, and he consequently had the good looks of someone with mixed heritage.

As the interview began, I asked Tom how old he had been when he had first heard the term ADHD. He calculated that it had been approximately seven years prior, when he was 26 years old. I then asked how his hyper energy had been dealt with during his childhood, and he stated, "All the time I was regulated through beatings, drowning and burnings." He went on to explain that his mom had been essentially a "concubine" from Japan. She had married and had come to Canada knowing very little English. His father had been an alcoholic who had seldom been present. When Tom was seven years old, his mother had divorced his father and had begun to set up a life for herself. She had owned what Tom referred to as a "biker bar" and had worked all night. Tom assumed that both of his parents had had addiction issues of their own, and that this had influenced both his own addiction issues as well as his upbringing. He recalled that he had been, for the most part, raised by his grandparents, who had had very little control over his behaviour.

Tom recalled that, as a child, he had not liked to take baths, and that his mother had dealt with his resistance by holding him under the water. "I can remember as early as six or so being pushed under the water, and then you know, seven and eight she is still giving me baths, you know, and I should be bathing myself, right. I am getting stronger and I was relatively a bigger kid when I was younger. And she would turn me around so that my head would be near the tap. I remember one time in particular, um, just trying to, the tub was overflowing, and she slipped and fell and bashed herself, right, and ah, so all I can remember is that the palms of my hands being wrinkled really bad so I think I was being dunked for quite some time, right. Like I never enjoyed swimming [he laughs] when I was a kid, right. Why she turned me around was cause when I'd break the surface I would smash my head on the tap so I wouldn't be able to . . ." [His

sentence faded off.] He then reflected, "I think that it had a little to do with my addiction, just the whole feeling of drowning." He went on to recall losing his two front teeth as a result of the abuse, but quickly dismissed that by saying that they had been baby teeth and so it hadn't really been that big of a deal.

Tom then ventured to offer some understanding of his parents' situation. He projected that, as well as believing they had had their own addiction issues, he wondered if they perhaps suffered from ADHD themselves. Through his own recovery process, Tom had recognized that he had been self-medicating most of his life. He suggested that his father might have been self-medicating as well. With empathy, he acknowledged that it must have been hard for his parents to put up with him. "It had to be pretty aggravating being around someone who was always bouncing around and getting into shit all the time." When I asked if his excessive energy had ever been dealt with medically when he was young, he stated that his doctor may have hinted at it, but his mom, coming from the Japanese culture, had not wanted to hear that there might be a mental disorder in her son and had chosen to ignore it. Instead, she had told him to run outside and burn off energy on a regular basis.

At the age of 26, after years of self-medication with various drugs, Tom had gone to see a doctor after his sister suggested that he might have ADHD. "The first guy I saw, well you know I was like sitting and twitching, and he suggested that it [the twitching] could be because I was using [drugs] . . . but as soon as I hit Ritalin I stopped using [drugs], I had this thing to give me full focus." He went on to discuss his experience of school. "Before Ritalin, school was not an option for me. I mean I just hated it. I hated all the people, I hated being brought up and put on a pedestal and brought crashing down, you know what I mean, because you have the focus, you

have the intelligence sometimes, and other times you fade in and out. I would get complemented and then told you're not trying hard enough . . . and guys would almost give up on me, some of the teachers, right, 'cause I would have flashes of brilliance right, and then I would become this basket case idiot where I could not pay attention."

Tom then told me that when he had worked in a self paced school program he had managed to successfully complete a 90 hour course in 70 hours, obtaining three As. However, he had been required to take one of his courses in a classroom setting and had ended up in a major power struggle with the teacher, who had treated Tom like a child. He had eventually been kicked out of the class. This absence had affected his grade, but he had still managed to get a mark of "C" for the course and complete his grade 12. He chalked the whole thing up to a learning experience and finished by stating that he had been very proud of himself for not hurting the teacher. "Like I mean, at that point, it was one of the first times that I did not take someone's head off, that I really wanted to. But I had my priorities in order, I needed to finish school, right. So I just kind of put it behind me, and I did have dreams about bumping into him on the street and just kind of chucking him around a bit [he laughs] but I just . . . yeah."

Because I had first met Tom in a classroom setting where he was a student learning how to work with youth, this new image of him as someone who was comfortable with physically harming others was very curious. He had my attention now. Just when I was wondering how to steer the conversation to his relationship with marijuana, he took us right there. "And [after I got my grade 12] I went to Douglas [College] and I was taking Ritalin and really only smoking pot three or four times a week. A joint here and a joint there, to sleep." Taking this window of opportunity, I asked him to talk about his drug use, and he reported that he had been a pot

smoker before he was 12 years old. He had not really liked his first joint. His sister had given it to him so that he would fit in. "'Cause . . . I wasn't really fitting in, 'cause here I was this blurting out freak, right, not doing well in school, but I was athletic and was accepted in school because of athletics, so people tolerated a lot of my . . ." [His sentence faded off.] "I was like a class clown that some people were afraid of, right." He continued by stating that his first joint had been unsettling as "pot moves in frames". I was unable to get a clear understanding of what this meant. "But later on, my next experience with weed about three or four months later was much better. Relaxing, calmer, just not as potent I think."

Although Tom's story jumped from topic to topic, he explained that school had become a waste of his time and before long he had stopped caring and had eventually been dismissed. He described himself and his friends as having been "bad". When I asked for clarification, he stated, "By being hoods, right. Dumping people in dumpsters, dragging people around, not being violent, just joking around. Like what was funny to us was really traumatic, looking back, to them. It was horrible, right. [laughs] We took guy's lunches, right. We got away with so much, 'cause everyone was scared of us. Like we were really mean."

After getting kicked out of school the first time, he had worked with his dad on the tugboats for a period of time and had also spent a lot of time on Granville Street. "'Cause I remember I spent about a month living on Granville Street when I was 14, just selling hash. I mean, my buddy fronted me a quarter ounce of hash for $40, alright? I would dime it, a quarter ounce is seven grams, right, I dime it into 14. I would stand in front of Macdonald's on Granville Street and it would be gone in five minutes. Boom, I had $140. I just profited $100 and I am 14 years old . . . so I would work for five minutes everyday on the street and maybe an hour there

and back in traffic, right, and lay on the beach and we ended up staying at this guy's place . . . " Tom continued with his story to describe himself as a boy in his teens, unsuccessful at home and at school, discovering ways to use his intelligence and his physical size to work to his advantage. This new career opportunity had been the beginning of a transition period in his life where he had moved in and out of his mom's house and school and eventually out on his own. He acknowledged that once he had had a taste of life on the street, living with his mom had not given him the stimulation nor the resources to support his [marijuana] habit.

This period of transition had lasted for a couple of years. He had tried a few times to get back into school, but his reputation had not allowed his acceptance into regular school. He had ended up attending an alternative school, which he described as "Hood Central". "We were getting high in the morning. We're getting high at break. We're getting high at lunch. We're getting high after school. We are just getting high all the time. You know what I mean? I actually did pretty good there, but the thing was it took me a whole year to do what I could have done in six months."

I asked Tom what he thought the marijuana had been doing for him at that time. His first response was that it had offered him social acceptance. He had smoked it just to fit in. But he also went on to describe that he had been the only one of his peer group that had been "moving" the drugs. "That was the point that I was supplying everyone's habit too, right. I mean for free, really." So although he presented that he had been a follower trying to fit in, it sounded more like he had been the supplier and had actually taken care of his peer group, keeping everyone happy.

Tom then went on to talk about how his sister had introduced him to cocaine when he was approximately 18. She had been hanging out with a group of "bikers", and one evening they

had gotten him high on crack cocaine. Directing the conversation back to his use of marijuana, he stated that now "it calms me down". He started to share a story about playing sports with his "hood" against an organized team. "Like I mean . . . we would pass around joints and all get super creative, and fucking fearless. It gave me creativity in sports, not in academics. But later on in life as I got out of shape, it started to affect my motivation. Now it comes to the point where I won't smoke it in the morning. Like I have to smoke it in the evening just to calm down. It's more of a calming effect rather than a creative effect." And, keeping with this theme of moderation, he stated, "But now it is just in the evening, for video games, just because now I am in a relationship which is something I thought that I would never have. 'Cause I just couldn't. I was so flighty and I had issues with bolting. I was always in a hurry, I have always been this way. I'm in this big hurry to get somewhere and then I just stand around for five minutes and just go again, [and I am left wondering] why the hell did I want to get here so bad?"

He went on to talk about what it meant for him to be in a relationship. He drew out the role that marijuana played. " . . . and just to sit [and listen to his girlfriend] I will smoke a joint. While I am medicated I am hearing almost everything that everyone says, because with Ritalin you have to take it in the day time other wise you have sleep deprivation problems, so in the evenings I will smoke and I am hearing every word." He saw this ability to focus on a conversation as the thing that was saving his relationship, because his girlfriend felt heard. "But at least I would not freak out or become aggravated or want to run away. I just sit and it will calm me and I can hear [what she is saying], and she thinks that I am hanging on every word when, in fact, it's not every word, but I am hearing everything that she is saying." Tom went on to explain that his girlfriend suffered from a head injury and, because of that, she repeated herself

often. He explained that it had been a struggle for him in their interactions. "I am more accepting of it now, but I need the weed to just relax and be present."

Tom had many stories to tell, too many to include in this inquiry. He proceeded with several stories about having done illegal business with a local bike gang. He used to backpack cocaine across the border into Canada. He had been clean of cocaine for over four years, but had then had a relapse when his girlfriend's previous boyfriend had begun to create havoc in their lives. He also mentioned his consumption of alcohol and how it had been far more severe than it was currently. Finally, he talked about how his life had changed when he had entered into a treatment program for addictions and was able to get away from his cocaine use. I could not help but notice that, during his discourse about cocaine and alcohol, he did not include marijuana in the same category. He did not include it as an addiction. He did not see it as a substance that he had to overcome.

Then the story changed again. In the treatment program it had been suggested to him that he may have mild schizophrenia or bi-polar disorder. They had told him that the specialist would not be able to determine a diagnosis unless he had first been truly clean of all substances, including Ritalin, for six months. It began to make sense to me why Tom spoke so fast, jumped so quickly from topic to topic, got side-tracked onto a new story, and then seemingly miraculously would come back to the question I had asked him sometime before. He was not on any type of substance during this interview. He went on to say that he had even quit using sugar in his coffee because he got "clarity from the caffeine" without the crash from the sugar. He explained, "I am talking pretty fast, but I can talk a mile a minute, like, way faster than this. I process at a really fast rate. I don't think that I'm smart 'cause I'm hyper and I am impatient, but

if I can get a hold of this [hyperactivity] . . . I mean I don't want to treat my ADHD anymore with Ritalin. And I want to smoke weed, which I consider natural, and I want to go to a naturopath, aromatherapy, all that sort of thing. You know, relax." He went on to talk about the importance of breathing and being able to calm down; he demonstrated by taking a deep breath.

I asked Tom if he had ever used needles to do his drugs. Similar to the first participant, Tom was very clear with his "No." He had seen drug injection as adding yet another problem to those he already had, and he had chosen not to take that path. He had been content to just smoke the crack cocaine that he had used, but then added that marijuana had helped to control his urge to smoke crack. "I would rush out and buy a rock, or whatever, when I was younger, right, when in fact if I would just smoke pot I wouldn't need the crack in the first place, because it [the pot] would have zapped my motivation. I would have had enough mild paranoia or psychosis from the pot, to not want to go and snort coke, right?"

Tom admitted that he had struggled with the NA (Narcotics Anonymous) approach because they had insisted that one must be totally clean, without using any drugs whatsoever. "All I am doing with things like that is setting myself up for a fall." He appreciated the 12 Step Program and what it has done for so many people, but he did not agree with total abstinence. "One step at a time" seemed to be his motto. He admitted to believing in the Harm Reduction Model. This model suggests that, rather than practising complete abstinence, a person can reduce the harmful consequences of drug use by giving up the more severe substance, like cocaine, while still gaining support from softer, less harmful substances, like marijuana.

During this discussion of addiction, I asked him if he thought that he was addicted to marijuana. "No, it's habitual use. People do it out of habit. I mean they might confuse it with

addiction, but it's just everyday use. If something helps you and accentuates your personality, and accentuates the things in your life, why not do it, right? It helps you to forget. I don't get aggravated about bullshit when I smoke it." He went on to repeat his desire to see a naturopath to seek help in controlling his ADHD naturally. He clearly stated that he saw Ritalin as a "hard drug" and he wanted to rid himself of this as well. I got the sense that his main goal was to be calm, and that all the substances he had tried over the years, from alcohol and cocaine to Ritalin, had not met his needs. "I just need stress relief, but I haven't actually approached an aroma therapist or a naturopath yet, right? So I want to do all those things. I want to nail down my ADHD. Find out if I am bi-polar or schizo, nail all that shit down. Then maybe I won't need pot, so I can just enjoy it. I just want to enjoy it, rather than needing it."

He then went on to clarify. "In my way of thinking, clean time does not include pot. Pot is acceptable, ok? But I could not include those 14 months [off coke] 'cause I was taking Ritalin . . . where I didn't use coke and I didn't drink, I'm not counting those days. I am clean now from the day I quit Ritalin. Not from the day I kicked coke."

I asked him why he didn't put pot in the same category as the other drugs. He answered by first explaining how Ritalin affected him and that it had not been a pleasant experience for him. He had not felt that he had any control over the effect of the drug. He had felt very "spaced-out" and uncomfortable. "It would not give me strength or stimulation, just focus." And then he explained, "With pot, pot is better than Ritalin . . . initially pot gives me focus, but after awhile you just drift off . . . What I have learned too is not to smoke the whole joint. Just take a toke or two and sit back for 15 minutes. See how I feel and then, you know, when I need another toke I can take another toke. And I am fine and I know when I can function at a level, right?" We

discussed this approach of moderation, taking only what he needed to make it through his day, as a sign of his maturity. He then reflected back to the days when he would get "wrecked" with his friends. He stated that if he currently got together with his buddies, he could easily revert back to that pattern of behaviour, so now he mostly smoked in isolation in order to maintain control over his intake and his actions.

I asked him if he could describe a time when he felt that he needed to have a joint. His first response was, "When violence issues surface for me," but then he corrected himself, stating that "It's not violence, it's more like anger and frustration." He acknowledged that before he took Ritalin it had been violence, "anger, violence, and freak out." This lead him into a story about how he used to be a "grunt" for the bike gang who had sent him to collect debts for them. "I would get into violent confrontations. I would fight a lot . . . I would never back down. But a lot of people backed down from me, right? So now with the anger it is more anger and frustration with myself, [and I wonder] why am I getting angry and aggravated with this bullshit? So I take a toke, just to stop thinking about it. Just to forget, even for a moment." He went onto describe the extent to which he had always been a risk taker. He explained that he had cheated death on several occasions. He concluded, "So yeah, pot has been nothing but a bonus in my life."

Our conversation shifted again, with Tom talking more generally about how he was doing in his current life. He expressed that he was feeling good about himself. He said he had completed the training program to work with street entrenched youth and that this would enable him to take a new career direction. He said he wanted to take more drug and alcohol training programs so that he could pursue this field of work. He revealed that he felt good about his relationship and about letting go of the hard drugs, including Ritalin. "I don't want to have

anything in my life that I am ashamed of. And pot, and I'm not being delusional, but it is not anything to be ashamed of." He explained, however, that "there are people who reflect upon it negatively so I put it on the back burner. I am not going to be walking down the street with a joint in my hand."

This comment introduced the notion of the secrecy about marijuana because of its illegality. Tom was very clear that he did not want this substance legalized because he believed that if the government started to control it the expense of purchasing it would go up and the quality of the substance would go down. It was clear from the way he spoke that he was very familiar with marijuana culture, from growing, to selling, to needing it in his daily life, and that he did not want to see any of those aspects compromised by government intervention.

I summarized the highlights of what he saw as the positive influences of this substance in his life. As I started the list—stress reduction, focus, control over violence—he corrected me, stating that it used to be violence and now it is anger and frustration. I suggested the word "anxiety" and he quickly agreed. "Serious anxiety, man it runs in my family." He went on to describe again how marijuana has had a positive influence in his relationship with his girlfriend, allowing him to step back and relax, and "not get caught up in the bullshit." This lead to a story about having a lapse in his coke use. His girlfriend had asked him not to smoke pot while they were visiting the family for Christmas. He talked about what a disaster that had been, following as it had upon three weeks of not using pot. He had become so frustrated and anxious and people had begun to get on his nerves. Then, with more passion than was typical, he stated, " . . . and then there, right there, I am telling you right now. Everyone thinks that pot use leads to cocaine. Bullshit, OK? Cigarettes leads to cocaine use, not alcohol, not pot. Cigarettes, that's what leads

to cocaine, for me anyway. I can only speak for me. And pot is gold. I will always have it around . . . I could never have coke around. So many things trigger me, right, and it does not mean that I am going to use. It means that I have to fight, and become angry and frustrated and stressed and the pot helps to relieve the need to smoke coke."

The conversation shifted again. He began to speak about his desire for a career in helping others with their addiction problems. This lead to more discussion about his own experience with treatment programs, and how much he has learned from them. He ended this thought with the statement, "I totally believe in helping other people."

Leading us back to the discussion of his experience with marijuana, I told him about the previous participant and her statements about needing marijuana in order to eat. He said he felt that pot gives one the "munchies". He described his own tendency to eat candy and sugar when he smoked marijuana, and his suffering from the high and the crash in energy that comes with sugar consumption; the post-sugar crash caused him to get aggravated.

I said I was curious whether he saw any other negative aspects about marijuana. His response was, "Just the motivational aspect, but that is where my own personal structure comes in. Not smoking it first thing in the morning so that I am not brain dead." He explained that, once he started smoking, he had a tendency to want to keep it going throughout the day. If he smoked in the morning then he might later find himself in a position, either at work or school, where he could not get away for the needed toke. He had found it far better to wait until he has most of the day's responsibilities completed, when he would then use marijuana to relax. He once again brought up the issue of the way in which marijuana supported his primary relationship. "It's a two way street, right. She does things for me and I want to be able to do things for her, right?

Irregardless of whether or not I like them. I have to. I am an adult, and I have to do things I don't enjoy right? So I smoke a joint, and what she says is that much more interesting."

Continuing with my questioning, I asked if marijuana had an effect on his sleeping. His response was a definite affirmative response. "But not right before [bed]. I can't smoke it and pass out 'cause I will wake up loaded. Maybe around six or eight o'clock, as long as I have two hours and the real high is over with. Then I fall asleep. But if I am too exhausted physically, I am making a mistake smoking it. It taxes my body. Like I have to be clear of mind and know that I have accomplished something that day. I also have to have a good feeling going into it too." He went on to acknowledge that marijuana is a depressant and suggested that one should not use it to combat depression, as pot can make the depression worse. He recognized the responsibility of partaking in this substance when he stated, "There are a lot of things that I need to recognize when I go into it. It is a drug and I smoke little of it now. I have cut back so much on it. When you smoke chronically it is completely different and now I just maintain small amounts to keep me calm."

When I asked if there was anything else he would like to say, he chose to speak about ADHD rather than marijuana. "I would like to say with ADHD in general, people take it for granted. The people who don't have it, right? They think that they are listening and they are not. Walk a day in my shoes! That's why I feel self-aware. Anyone who has ADHD, I say thumbs up to them. Treat it the way you want. Ideally, don't treat it with medication, but self-medicate with the naturopathic way. I am serious. I listen, I genuinely hear. Spend some time on Ritalin and then wean yourself off of it. Just to get your mind around it." I asked him what he meant by "people are not listening", and he suggested that people believe he is an idiot because he talks

fast. They believe that he is not listening. "I can hear a slow talker, I can hear a fast talker. Just 'cause I talk fast does not mean that I can't hear anybody. I process things fast enough that I don't have to be thinking about the next thing I am going to say, so I can truly listen."

I responded to this by telling Tom that there had been times when he had been talking so fast and jumping from topic to topic that I had been unable to keep up or make the leaps or connections to his different topics. He acknowledged my challenges and said that this rapid talk was because he had been several days clean.

We finished the interview at this point and thanked each other for the experience. As Tom pulled out of the driveway, I was left with the image of a man who had been both the victim and the offender of abuse and violence throughout his early years. Now he was trying to find some sense of calm and normalcy in his life. It would appear that discovering the label of ADHD at the late age of 26 had been a turning point for him. It had given him a possible explanation for his past behaviours. It had also given him an avenue on which to pursue an understanding of what had been happening in his life and how he could change it. The treatment program that he had attended for his addictions had seemed to offer him a wealth of information about the effects of the drugs he had been using. It had also seemed to give him a sense of self-worth. He appeared to be empowered with this new perspective and was taking control of his life.

Tom's intelligence was obvious. He appeared self-aware and seemed to have a sense of responsibility for all the things he had done in his life, both the good and the bad. I felt strongly that the struggles were not over for this man who had been desperately seeking a sense of calm and comfort. I felt inspired that he seemed to have the intelligence, the willpower, and the

inspiration to find the right solutions in his life, or at least the understanding that leads to self-acceptance.

Tom: Second Meeting.

Approximately one year passed before I saw Tom again. I had sent him a copy of his transcript along with the above narrative, and we had agreed to meet again at my home to discuss any feedback. In one of his phone messages prior to our meeting, he had stated that he had had a hard time reading what I wrote. It was almost as though he did not believe that he had sounded like that in the interview. He wanted to hear the tape recording to verify two things: first, that he had really said those things, and secondly that he had really talked so fast and with such a lack of continuity and clarity.

As we began our second interview, I noticed that Tom was a little calmer. He seemed more focused and more able to complete his thoughts. On this visit, Tom asked if, rather than sitting and chatting, he could wash his car while we talked. So I pulled up a lawn chair and he kept busy with the bucket and garden hose while we spoke. He reported to be smoking marijuana again, and that it had been working for him.

When I asked him about the narrative, he admitted that he felt a little guilty about some of the things he had said about his mom. He felt that he had been too harsh and that now she was being very supportive. It seemed important to him that I understood that he really appreciated what his mother was doing for him now. He had decided that he had divulged that much information in the first interview because he had just gotten out of a treatment program, had been completely clean, and had really needed to let it all out. He started a statement with, "If I were

normal," and then added, " . . . most of the time I have felt like less than a person. I can't hold down a job. Many people do not get who I am."

I asked him about the past year since we had seen each other. His response was, "Being clean was the worst time ever. In the last year I would get so aggravated and anxious that I really needed the pot." He reported that he had had some pretty stressful times working for drug dealers. "I have had so much exposure to cocaine and I am proud of myself for not taking any. My tendency to lean toward coke is very strong and pot keeps me away from it. It is the ultimate in harm reduction." He reported that he was back to smoking marijuana four to five times a day. He was still with the same girlfriend and still trying to find work in a counselling field. He gave me the impression that his continued association with the drug world was strictly a financial decision. Due to his experiences, one of the few places that he could get work was with drug dealers. I could not help but comment on how he did have work in the field, just at the opposite end, supplying people with cocaine rather then helping them to find the strength to refuse it.

I asked him again for a final statement about marijuana. "It is a cure all," he said. "Doctors should be able to dispense it for all those people who could benefit from it."

Tom: Follow up.

Approximately one month later I called Tom again. I had forgotten to ask him what name he would like me to use in my report. He had stated earlier that, because he wanted to get into the field of helping others with their drug and alcohol issues, his name should be changed. I wanted to give him the option of choosing his own pseudonym. He stated that now he wanted his real name used. He was not ashamed of himself or his story.

During that phone call, I could not help but notice that once again he was speaking very quickly, changing topics mid-sentence, trying to communicate at the speed with which his thoughts were moving. I knew before he told me that he was clean again. He explained that he was once again trying to get help for his addictions and was required to be clean from all substances, including marijuana, in order to get into this special 12 Step Program. As I hung up the phone, I had a sense of this man's frantic need to find the solution that was right for him. He seemed caught between two belief systems. On the one side was the cultural belief that drugs are bad. Indeed, his use of cocaine has been a debilitating factor in his life because of his need to free himself from the constraints of his addiction. On the other side was the need to slow down and find some sense of normalcy, hold down a job, help others, and create a home for himself and his girlfriend. The problem for him was that, because of his severe level of ADHD, to be clean from all substances placed him far away from calm and normal. The two substances he had acknowledged as having given him some peace from his hyper and, at times, frantic existence, Ritalin and marijuana, are considered to be in the same category as all other harmful drugs. I was left wondering whether he would find the solution he was looking for. Even more so, I wondered how long it would be before he returned to the substance that offered him the greatest sense of peace, marijuana. I wondered how he would resolve the dissonance between these two beliefs systems and give himself permission to find the solution that works for him. He had stated that all drug rehabilitation programs insist that he be free from all substances. I wondered if the people who place these expectations on recovering drug addicts had any sense of what it is like for those who live with ADHD, or the potential torment of a drug-free existence.

Bill

Bill was the first of the participants referred to me by a colleague. When I reached out to find participants, this colleague had been quick to say that he had the perfect person in mind. Then he had called back to say that Bill was more than happy to participate in this inquiry.

When I called Bill, I immediately noticed his enthusiasm and eagerness to please. As we were setting up the appointment and deciding where to meet, he offered to rollerblade over to my house, a distance of approximately 20 km. In spite of his enthusiasm to do this, we agreed that I would come to his apartment.

I was curious about this interview because I had never met Bill. I had previously known the first two participants and had had some sense of who they were and what to expect. As I approached Bill's apartment, I felt like a true researcher entering into unknown territory. I "buzzed" Bill's apartment number and he called down asking me to wait in the lobby. I was met by a tall, slender, 23 year old man with sandy brown hair and a big smile. He shook my hand with a hardy handshake and escorted me to his home. He lived in an upper floor of an apartment building in Langley with his girlfriend and his cat. The surroundings were very nice and it was obvious that he took pride in his home. He explained to me that due to some mishap in the bathroom he had almost burnt down their apartment. As a result, the bathroom was waiting for repairs and the bedroom ensuite was the only bathroom available.

We began the interview. I asked him when he had first heard the term ADHD. He reframed the question for me, saying, "You mean when did I know that I was hyper?" Then, answering his own question, he stated, "When I had more energy than everyone else in my house . . . I have been hyper all my life, just a ball of energy. The doctor said that I would grow out of

it. I have little attention to anything I do in school. Like when I was in school you would pretty much find me at the computer. It was the only thing that I was good at." I commented on the fact that some of the youth I have known with ADHD have been able to spend hours in front of video games. This ignited Bill's enthusiasm. He announced that video games are the answer to the problem. He knows a hyperactive kid who played video games for five months and became a "normal child".

I asked Bill if the hyperactivity had become a problem in his life and he introduced marijuana into the conversation. "No, I was always high, so it just mellowed me out. When I get hyper I smoke one [joint] and mellow out. I just focus on two things, not everything around me. It's better that way." He reported that he had been younger than age 10 when he had first smoked marijuana at his mom's first wedding. Then he recalled another time when he had been 13 years old and at home from the hospital recovering from an eye operation and had been offered marijuana as "a source of pain relief". He was pleased to announce that after three operations he now had 20/20 vision. He again acknowledged the use of video games and smoking weed, this time for helping to strengthen his lazy eye.

Bill then discussed his opinion about harder drugs like cocaine and heroin. He made a clear distinction between the more dangerous and deadly hard drugs and the more "natural" drugs of marijuana and mushrooms. He reported to have done a lot of drugs between the ages of 13 to 20 years. When I asked him how much he currently smoked, he said that he used to smoke ounces, but now it took him up to two weeks to consume an ounce. This worked out to approximately four to five joints per day. He smoked three joints during the day, because his job

as a pipe setter "is too boring," and then a couple of joints in the evening. He loved his new job because he was working outside with "a good group of guys," most of whom smoke weed.

I tried to narrow down his consumption, and how consistent it had been. He quietly stated, "Oh yeah, it saved my life. Weed saved my life." He then went on to explain that for approximately three to four years he had had a serious cocaine habit. Then one day a friend had confronted him and stated, "I don't want you doing coke anymore man, you can't come around my kid if you are. Here's an ounce, go and smoke your brain." Bill had done as he was told and stated that he had never smoked coke again. As this story unfolded, he spoke with some shame and remorse about the four years that he had spent on cocaine, and then he once again repeated, "Smoking weed is the best thing that ever happened to me."

I asked him if there had ever been a time when he had felt that he needed to smoke weed. His response was two-fold. "When I am really stressed and when I am going to get really drunk." Bill explained that he also used pot to control his hangovers. If he planned on drinking a lot then he would smoke weed before, during, and after to prevent himself from getting really sick. We talked a little about the other participant who had stated that she needed the weed to be able to eat. Bill agreed with this, but only to say that he had such a slender body that his reason for smoking the weed was to eat more in order to gain weight. He went on to explain that his hyper-active body just kept burning everything off. On this more medical topic, he told a brief story about a friend who had severe arthritis and could not move his hands. Bill had introduced this man to marijuana. "It took away the pain. He was able to move them. You know? And after awhile he was able to do normal things with his hands, like working on cars." This lead him to discuss how difficult it is for someone to get permission to use marijuana legally as a medicinal

substance. Bill felt strongly that the government is wasting money on "busting" people rather than on helping them.

Earlier Bill had made a statement about being depressed, so I asked him to clarify that period of time. "I wanted to hurt myself so bad, every time I did 'high' drugs I would get so stressed out and think about so much . . . " The cocaine seemed to have caused these feelings of anxiety and depression. Without prompting, he went on to say that when he used weed he would just sit back, relax, and focus on positive and easy going things. When I drew the connection between weed and controlling his depression, he stated, "Yeah, it brought me back to reality, my reality . . . I encourage people to smoke weed, 'cause I go out and do things when I am high. I can rollerblade from here to Abbotsford in an hour and 35 minutes when I am high. I can't do that when I am straight [without the influence of drugs]." Bill shared his philosophy that drugs are all in your head, that he believed it is a subconscious process, that individual bring to the experience their own preconceived notion of how that drug will be. "People think that weed makes you stupid. Weed does not make you stupid; it's the individual [doing the weed] that makes them stupid. In school, if they had allowed me to smoke weed in every class I would have aced it. I would have flown right through high school . . . some kids need it, some kids don't."

Earlier in the interview Bill had stated that he needed weed when feeling stressed. When I asked him to clarify what stress he had been referring to in his life, he responded, "Someone coming after me. Someone threatening my life or my loved ones . . . I smoke it everyday the same way that somebody smokes cigarettes." The conversation once again moved toward the feelings of anxiety and frustration. Bill disclosed, "I am scared of a lot of things when I am straight. I'm like terrified. I can't do this. I can't do that. When I smoke weed I get a little more

encouraged to get out there. It is like a person in a play, their drama or their rush, or their drug is to act in a different role. That is what I am doing. I am using weed as the costume. Me as the actor." He made reference to the movie "The Mask", which is about a character having a different personality when he puts on this mystical mask. "I am into that face changing stuff . . . I act me when I am stoned. I act scared when I am straight."

I asked him which of these two personalities is the "real Bill". He described himself as being more down-to-earth when under the influence of marijuana, and living in paranoia when "straight". When questioned about the paranoia, he explained that he had grown up in the world of "gangsters and guns" and he has always looked over his shoulder for such characters. But currently, under the influence of marijuana, he lived a more peaceful life and had gained a reputation in Langley of "being the local nice guy". He then went on to talk about how he had also changed in his relationships and that he and his current girlfriend had been together faithfully for two years. He saw this as quite an accomplishment for himself, and acknowledged the positive changes that he had made.

Bill then spoke about his belief in Chinese philosophies, in Nostradamus, and about his experiences of watching a science fiction series on TV called "First Wave". He saw using tools like these, as well as movies and video games, as mind-expanding and educational. The use of marijuana helped him to focus and learn. "My hyperness has calmed down because I smoke weed . . . it has mellowed me out to the point of listening. You can't raise a family being hyper and being destructive. You've got to calm down. Weed calms you down, and that is a proven fact, everybody says it. Everybody says that weed calms you down."

Throughout the interview, Bill frequently returned to the notion that a person's experience with drugs is "in your head". He believed it begins with the person, who they are and how they approach the world. At this point in the interview, he acknowledged that there are people out there that smoke and lose their motivation. But Bill stated that he used the marijuana as a source of motivation. "I clean my house, I work on my computer, I do homework, I draw, I go rollerblading, I enjoy my woman's company." He drew a comparison with a friend who smoked as much, if not more than, Bill. In Bill's opinion, the friend was a couch potato. "Him, he smokes weed, he annoys his woman, he disgraces her, he puts her into small depressions, he treats her wrong." This statement reflected Bill's ethics about how one should treat another person, the value that he placed on relationships, and also seemed to prove his point that being stoned was just a reflection of who he was inside. He also mentioned in this conversation the notion of moderation and how much his consumption had changed over the years. "If you can smoke only one and get stoned, then why smoke three and get too stoned and become stupid?"

I asked him if marijuana has had an influence on his sleep. "It depends on what kind of a mood I am in. If I am in a really hyper mood and I want to stay up until two or three in the morning, it is not responsible. You can't stay up until that time and wake up a six a.m. and go to work. Smoke a bunch of dubes (marijuana cigarettes) and pass out. You fall asleep . . . you wake up and are ready for work."

Similar to what had happened during the other interviews, the conversation jumped back and forth between topics as Bill thought of stories and people that supported his point of view. At this point, he went on to discuss his rollerblading and his goal to rollerblade around Australia. He said he saw himself as being in training for that trip and reported that his rollerblading sessions

took between five to eight hours. He stated that he used marijuana on these trips to kill the pain and relieve the stress. He then moved the conversation onto the topic of health and began a deluge of various pieces of information about a healthy life style. When I asked him where he got all his wisdom from, he stated that he had a mentor, an older friend whom he respected as someone with wisdom and integrity. This lead him into discussing his mother, for whom he seemed to have little respect. She has had, and may still have, an addiction to cocaine. Bill stated that he had a restraining order against her entering his home. He described her as vindictive. He also reported that as a young teenager he had had to call the authorities to have his younger sister removed from their mother's care. His younger sister is handicapped, which he referred to as "retarded". He himself had been in and out of group homes throughout his adolescence. We discussed the brain damage that a fetus can sustain if its mother had been under the influence of drugs and/or alcohol while pregnant, and he assumed that this could be the cause of his sister's handicap. Bill's dad had died from a heart attack and subsequent car accident when Bill was 12 years old.

I acknowledged that the past two participants had experienced physical abuse as children, as part of their supervising adults' attempts to control their hyperactive behaviour. "Yeah, my mom beat me when I was a child. That's why I know that I am hyper, then the pain, suffering, everything. That's how I know that I am built for energy. 'Cause all my life I have been abused, 'cause most kids who are abused have ADHD. Their parents do not know what it is, or don't have the knowledge of it, so they control with violence and abusing their child." He then compared this to how a dog should be treated and stated his distaste of people who beat their dogs.

I made an attempt at a summary at this time. I noted that so far we had covered his ideas that marijuana gave him focus, calm, and sometimes helped with his sleep. He corrected me, stating that it helped with his sleep most of the time. I asked about depression; he did not see this as a significant reason for the use of marijuana.

He went on to say that it gave him confidence. "It brings me back to the ground man, it puts my feet back on the ground . . . it's like magic . . . Dennis Leary said that you smoke weed and you become a carpenter . . . it gives you the ability to use your imagination." He repeated once again that how marijuana affects a person depends on the individual who is using the drug. "It depends on who, what, when, where and why." And then, referring again to focusing, how the weed helps him to focus, he stated something that seemed significant to him. "Focusing, it gives you the ability to feel. You are there."

I asked him if there were any negative side effects from using marijuana. His first response was that there were too many "stoners". "There are too many lazies. There are too many sit back couch potatoes giving people like me a bad name. That's what I hate about it. Everyone wants to get high and get stuck inside and do nothing. Why not get high and go to the beach. Go get exercise."

I asked him if he had ever been on medication for his hyperactivity. "Yeah, but I don't remember the name of it. It wasn't Ritalin. It wasn't anything like that. It was a depression thing. It was a sleeping thing. Yeah, I was given medication at one point but I did not take a lot of it. All my friends have weed. I have taken weed for years. That's my drug of choice, it always has been. I don't take Aspirin, Tylenol, or anything like that when I get a headache. I smoke a joint and the pain is gone in an hour." Bill then took us on a short walk through history before the

invention of Aspirin and Tylenol. He declared that weed has been a natural pain-killer for years and that he believed everyone had used it "way back then". I shared a story that I had seen on a documentary about the use of marijuana. The documentary had stated that, in the American Civil War, General Grant had given his troops marijuana to smoke before going into battle to help them overcome their fears and build confidence. This story seemed to give Bill more fuel for his belief that it is a useful substance. "If people could just look at it as a positive thing rather than a negative thing, it would be fine."

I introduced the notion of marijuana as a gateway drug to cocaine and heroin. He made a distinction about the language being used. He stated that we have made a mistake calling marijuana "dope", that dope is the term used for cocaine and heroin. "Marijuana is weed or pot, ganja, smoke, reefers, twisties, whatever." He seemed to feel that, because the label "dope" has been shared between these substances, people make the assumption that if you smoke marijuana you are on your way to stronger drugs. He then shared his appreciation that I was doing this thesis and that maybe the positive side of marijuana could be shared. "Weed has such a bad rap. People like us, me smoking it, you don't get that positive thing, you get that questionable [response]. And that just sucks. Cause there are so many people who use it to their benefit."

Similar to what the other participants had done, Bill shared short stories throughout his interview about other people or other statistics that support his beliefs about the positive aspects of smoking marijuana. He shared his belief that it improves driving skills. Then he moved the conversation back to the use of computers and how much they help people with ADHD.

As we were finishing up, I asked him if there were any other statements that he would like to make. He chose to talk about his use of marijuana making his workday go so much

smoother. “You get a whole bunch done and look back on your day with [appreciation].” His final comments were about how unfortunate it is that those who use this substance have to do so secretively.

Among the participants, Bill was the most confident in his declaration that marijuana has been a positive influence in his life. He believed that it even saved his life. I could feel the strength of his conviction, and the pleasure, or pride, that he took in being able to speak out on a topic he feels so strongly about.

Bill: Second Meeting.

It was almost a year and a half before Bill and I met again. He still lived in the same apartment. He still lived with the same woman as before, but their relationship had changed to a roommate arrangement and they remained close friends. He was no longer a pipe fitter. He had become self-employed with several opportunities on the go. He was a general labourer, hiring out to construction sites that needed his help. He was also involved with the sales and promotion of an upcoming local band. This seemed to be the job that he enjoyed the most. He explained that, now that he had his own business, he could “write stuff off” for income tax. I had to smile when he said he was writing off his new rollerblades as a means of transportation to the job sites.

Bill approached this second meeting with a business-like manner. He had explained to me on the phone that he had not been able to read the whole narrative. He had struggled to find the time and focus required to read the story in one sitting. He had asked whether, when we met, we could go over it together. This had been a good reminder to me that the documentation I had sent to these participants may have been a little daunting. I had appreciated Bill for being straightforward with his needs and making suggestions about what would work best for him.

We met outside Bill's apartment and walked to a local coffee shop. He read over the document and made slight corrections along the way. He made a few word changes to better capture his meaning at the time. What I noticed most as he went through the narrative was which sentences caught his attention. As he read, he made comments about what he thought was significant. He thoroughly agreed with himself when he re-read that the government is wasting money on busting people rather than helping them. He had read somewhere that the entire process of busting one marijuana grow operation costs the taxpayers $54,000.00. He felt that this was a significant waste, "when you consider how many grow operations are busted in B.C."

He also felt inclined to restate the sentence, "Some kids need it, some kids don't." He spoke again about how we are all different so marijuana is not beneficial to everyone. He also stated that each individual should be able to choose for themselves whether or not to use the drug.

When he got to the part about rollerblading in Australia, he announced that had changed his goal; instead he was going to rollerblade from Hope to Princeton, over a rather large mountain range. He explained that some friends of his had moved to a large farm outside of Princeton and it was his goal to spend more time there, once he got over his fear. I was curious about this and asked for more detail. He stated clearly that he was afraid when in Princeton. "You're in the middle of nowhere. There is no nothing." I suggested to him that there are trees, rivers, meadows and nature, but he did not see this as a contradiction. He went on to say that he would like to get an all-terrain vehicle up there. I was left wondering if this vehicle represented civilization, or if it gave him the means to get away from whatever he was afraid of. I thought it

meaningful that he was afraid of being alone in the great outdoors, that he felt there was too much space and too little control.

His final comments about his report were when he read the statement that he had little respect for his mother. Like a wise sage, he declared that one needed to give respect in order to receive it. I assumed that he meant that his mother must show him respect before he would respect her. He clarified, however, that he had turned that around and decided to show her respect first. He would be sending her a peace bond for her birthday the following week. He seemed pleased with himself that he was making the first step, as though he saw himself as making a very mature move. After he read to the end of the story, he reiterated that he felt pride in being involved in this inquiry.

This second meeting seemed more formal than the first. He was more focused and subdued in his energy and in his need to tell numerous stories. He approached our task with a sense of purpose. It was as though seeing his story in print had lead to a sense of importance. I asked him for any final statements and he declined, declaring that the narrative had captured everything he wanted to stay.

Jim

Jim was actually the initial inspiration for this inquiry. He was the first youth in my home to demonstrate an apparent need for marijuana to keep himself calm. I had not seen Jim for several years since he left my home and was not too sure that I would be able to locate him for an interview. Our last encounter had ended negatively, involving some money issues, and thus he had assumed that he had terminated our relationship. I felt that there was a good chance that he was incarcerated and I would not be able to find him. However, one day he called and I was able

to arrange a visit. He had moved to Victoria, so I took the ferry to the island to meet with him in his home, a small, sparsely furnished, basement suite. Jim's pet rabbit had the run of the house, was very tame, and seemed comfortable in Jim's arms.

Jim had been a resident in my home for almost two years, from ages 15 to 17 years. At the time of the interview he was 20 years of age. Now that he was on his own, he was struggling with how to survive. His hyperactivity was so severe that he was in search of any way to find comfort in his life. He was so frantic to gain control of his energy that he had recently turned to the mental health profession to receive medication for his disorder and alter his current reality. Unfortunately, due to his long history of drug abuse, the medical profession had not been comfortable with prescribing even Ritalin without first doing numerous tests and interviews. This process had been too slow for Jim's liking, and he had been very frustrated with the lack of support. At the time of the interview he was on methadone as a recovery method from his heroin addiction. Just as when he had lived in my home, he had been in search of marijuana prior to the interview to help him remain calm and focused enough to talk to me.

Jim was quite different from the other participants in this inquiry, in that I knew him well. I had worked closely with him for the two years that he lived in my home. Therefore, I came into this interview knowing about his childhood as well as his struggles with ADHD and his history with drug use. Jim had been raised by a mother who was working on the streets of Surrey to maintain her own drug addictions. He had also received intermittent government care services.

Jim is a tall, 6' 2", slender, good looking young man with light brown hair. He has striking blue eyes and carries himself with determination and pride. Before I start to describe who I think he is, we should hear his story in his own words.

As we began the interview, I asked Jim to talk about his childhood, and about when he had first heard the term ADHD. He said that he had been 10 years old when this term first came into his life. “I grew up in a regular lifestyle with my mother. Always had different men around, no father figure, and you know, moved a lot, went to different schools, never got any friends. Never had, you know, any base. I always got what I wanted. My family was good. Maybe they were bad, I don’t know. Like my mother always smoked marijuana, and I was a smart kid and I knew what marijuana was. But I didn’t consider marijuana a bad thing. And I still don’t ’cause I use it now. At the age of ten I started finding needles and stuff and discovered that my mother was lying. She first claimed they weren’t hers and then she said that she was a diabetic and the guy shooting up with her was a diabetic as well. And I was stupid for a while and I believed them. In about grade six is when I started to figure it out. And she would let me stay up as long as I wanted, till six in the morning. She would rent me movies and video games just to keep me out of her face. She was always in her room. One day she took off and I went into her room and found all these wallets and a gun, and a bunch of rigs (intravenous needles) and all these ID and credit cards . . . I was terrified . . . but I didn’t know that she was doing cocaine. I didn’t know what cocaine or heroin was. I just knew that it was wrong.”

“A trick of hers, a sugar daddy, ended up turning me into social services ’cause she neglected me and she left me with a date of hers actually and he was a physically abusive man.” He went on to tell a story about being on the run with his mom and hiding out from the man who had sired his younger sister. He reported that the man had been “armed” and had come to find his daughter and take her from their mom. At that time, Jim had been given a choice to go with this

man and get away from a life on the street and drugs. At the young age of 10 he had chosen to stay with his mom. "'Cause I love her and she gave birth to me."

I then asked him to talk a bit about his hyperactivity. "Yeah, I have always been very, very fast, and very aggressive. No one liked me. I got teased in school when I was younger." He went on to tell how he believed that he had turned his life around from that short and fat little boy to the tall and good looking young man he was now, who "gets all the girls".

Jim had been 10 years old when he had come into the care of the government. He recalled his first foster home and the strict rules he had had to endure compared to the complete freedom he had had living with his mom. It was "in the system" that he had been first introduced to the term ADHD. He claimed that he had labelled himself as ADHD even before he heard the term. After the first foster home, he had gone to another and then to a third. It was in this third home that he had been sent to a doctor and had been diagnosed with ADHD. I asked him how it had affected him to learn this name for his condition. "It did not bother me at first. ADHD, so what? I was a kid and it didn't matter. Kids are supposed to have energy. Now, I think about it because it really affects my life . . . ADHD sometimes blocks [my wisdom and ability to learn] so I can't do that much . . . and like I try but I can't think properly sometimes . . . it's starting to affect me more in relationships than anything else."

I reminded Jim that when he had lived in my home he had been amazing in his ability to manipulate people to get what he wanted. He had been articulate and charismatic and could talk both adults and peers into anything. When he could not get what he wanted, he had thrown temper tantrums that had been very frightening, and these tantrums had eventually gotten him what he wanted. I reminded him of one incident that had occurred in my home during a time

when Jim had felt that our relationship was close enough that if he was honest he would get what he wanted. He had approached me and explained that if I loaned him $200.00 until he got his first pay cheque from his new job, he could buy an ounce of pot and proceed to sell it and make a profit. Although I had appreciated his honesty, I had had no intention of supporting this scheme. He had raged at me for several hours. He had kept coming back and trying again, somehow believing that if he explained his need enough, or got angry enough, I would change my mind and produce the money he required. This had gone on for almost four hours and had eventually resulted in his causing physical damage throughout the house. When I finished recalling the incident, Jim said, "Yes, I still do that. I don't try to do it. I don't purposefully go out to do it, but I manipulate. That's 'cause I have that need, and I need to make that go away. It's hell for me man. I struggle everyday. I can't stand to be at home. I can't sit and watch TV, and be happy. But I go out and buy a joint and I smoke it and I feel great. Now I can actually sit down and relax. I can sit and read a book or go out and hang out."

Jim explained that he had been given Ritalin when he was about 11, and he had taken it for approximately two years. He stated that he had not really liked it because of the side effects of nausea and the lack of sleep. "But then my cocaine mother, at the age of 10, I am sorry to say that I started doing crack cocaine at the age of 10, 'cause my mother introduced it to me. I didn't know what it was, but it got me fucked up and I liked it." At this point I recalled another story from when Jim had lived in my home, a story that he had told about being left alone in a small trailer by his mother. She had told him she would be back in a couple of hours and had been gone for a week. She had left a stash of cocaine with him, and that had been his introduction to

the drug. His story had been confirmed by the reports that he had been brought into care malnourished and with a severe case of impetigo.

I was curious to know if he thought that cocaine and Ritalin had the same effect on his ADHD. I shared the statistics about how so many people living with ADHD have developed a dependency on cocaine. His response was, "I didn't smoke weed but I smoked a fuck of a lot of coke and I did a lot of crime. I did a lot of stuff bad . . . a lot of bad stuff. I look at my life now and I am 20 years old. This is a 10 year span and I have hurt so many people that I should never have hurt, and it hurts me now. It really does."

I said I was curious about the motivation behind his hurtful behaviours. "I was in search of money for weed or cocaine. You know cocaine, it has certain additional personalities of its own and eventually my life was given over to crack. It has been a big part of my life, up until recently." When I attempted some empathy for his struggle he went on, "And it is awful, man. I hate myself. I push myself. ADHD doesn't help either cause I feel like a fucking idiot. So does heroin. I had a heroin addiction up until just recently."

Marijuana had entered his life when he was 12 years old. He recalled how stoned he had gotten the first time and that it had become a constant for him. "Now I can smoke a joint and I feel nothing, like a cigarette, right. It takes that anguish of the ADHD away. It helps me grasp a little bit, at least a little bit. I'm not saying that it totally cures me, but it gives me enough that I can talk."

I asked Jim to talk about how marijuana had become a constant in his life. He proceeded to talk about the pattern that had developed. He would be in a group home or foster home for a period of time. Then he would run away, find his mother somewhere on the street, and stay with

her for a few months until he was caught and sent back to another home. This pattern had continued from when he was 12 to the age of 15, when he had moved into my home. Each time he had been caught, it had been by the police for criminal activity. It had therefore become a pattern of running from the group home, finding his mom and entering into her street life, doing crime to survive and support his and his mother's drug habits, getting caught, doing jail time, getting released into another group home, and beginning the cycle again. "I kept on running away and I kept on cracking out, and cracking out, and cracking out. And I went back to my mom. I always thought that I had to be her protector, her saviour, and I love her and I would take care of her. And at the same time I was a child, I wasn't a real man, and I was trying to be a little man, trying to be a gangster in a little society like the movie, Boys in the Hood."

At this point, Jim continued with a sequence of short stories about his escapades on the street, his crimes, his first stint in juvenile jail, and his experiences of being beaten by the police several times. All of this had occurred before he was 15 years of age. I found it interesting that with each group home story he would talk about the other youth in the home. He had looked for kindred spirits in these homes. He then talked about the "bad" behaviour that he had learned from them. He also spoke about the difficulty he had had with the rules and attitudes of the group home staff. "It taught me something. It made me hard. I started hanging out on the street more and more. Whalley is a tough town, very tough, you learn a lot of shit there you are not supposed to learn. Like I have been to so many crack shacks. I have seen people get scalped. I have seen people get rolled up in rugs. I have seen people die. Shit that you have not seen, shit that no one should see. Shit, piss, vomit, flies, kids fucking dead in the cradle man. It's gross." Jim went on

to explain that, although it sounded like he was off topic here, he thought it important to mention because he had been using Ritalin in the group homes and coke on the streets.

"Crack cocaine. You put it in a crack pipe. You light it up and inhale it for as long as you can. When you blow it out you get a ringing in your ears and this feeling in your head that you never, never thought that you could possibly imagine. It is so good. It tastes so good. And it is so good. You want another one and another one and you are willing to do anything. You're willing to suck dick. You're willing to fuck someone up the ass. You're willing to take it up the ass and do whatever you have to do to get another rock. I have done some bad things man, some very bad things, including some pretty dirty things I am really sad about and I need some help from. I am sorry that I did them to whoever I offended. But I didn't have a choice. I was sick. I have a disease." He also offered an equally descriptive account of his experience with heroin. "When you first inhale heroin, it's like a warm embrace. It feels so good." From his body language as he described this, I got the sense of a small child curling up in a mother's arms, filled with a sense of safety, security, and even love.

After such a vivid description of his use of cocaine and heroin, I was hoping he could offer the same amount of detail about his experience of marijuana. "With pot, I can have a life. Initially, it was free and I could have a normal life. I would be normal. I would go to school. I would get a job. I would be normal. But it is not free for me anymore and so I have to struggle and I have to go out and sell drugs and stuff just to support my habit. You can't afford to smoke the way I do. Hopefully I can go back on Ritalin now, maybe that will work." Jim went on to explain that he was currently under the care of a doctor. The doctor had referred him to a psychiatrist to be assessed once again and to get a prescription, any prescription, to help him find

some sanity in his life. I was reminded of a piece of literature that had suggested that many young people who start out on Ritalin are given the message that the answer to their problems can be found in medication. Jim seemed desperate to be labelled with some mental health disorder just so that he could be given free medication, medication for which he would not have to steal, lie, and cheat. As he was already using methadone for his heroin addiction and, due to his long history of drug abuse, the pharmacy had been directed to dispense his medication on a daily basis, and to have Jim take it right there at the pharmacy. This had now become part of his daily routine. Jim said that they had set up this routine, with his permission, because he could not be trusted to not sell his methadone on the street for the money to buy marijuana. I thought it was interesting that Jim himself did not think he could be trusted.

I then pursued the notion of marijuana bringing normalcy into his life. "Yeah I would be able to do anything normal. Be a normal person. Just normal and not be obscene, not being in the world alone." He reported that the only time he had been without marijuana had been when he had been in jail. "And it sucked. It was hell. I was always anxious, nervous. I had a weird childhood, right."

I was curious how he had made the connection back to his childhood. "Well you know that I am very fucked up. I have a really, really bad case of ADHD. For the record, I hope that someone realizes that. Going without drugs sucked. I could not do it. I would do anything to get weed. Still. You know if I could save myself the pain of going out and being a goof and hurting people emotionally, and doing things that even I think are wrong . . . I'll go out and rob someone if I have to make myself to feel normal. But I am not like that though. I would love the world to

live in harmony. But at the same time I will go out and do something or hurt someone to get what I need."

Still trying to pursue the notion of what marijuana offered him, I asked him what it was like for him when he thought he needed a joint. "Everything! Sweat, anxiety, my feet move. I have this energy that makes every muscle feel so tight. And you want to just kill yourself. You want to destroy everything, you want to hurt people, you want to hurt animals. You want the world to go, you want it to end. It's all mental [he grabs his head], it's like a big thunder and lightening storm in there. Your neurons are banging out of order so bad. Its sickening . . . and the weed helps me get to a sunny day. Sometimes the weed is not that great and there is a little rain here and there. But it's really damn good." He reported that each joint gave him about two hours of relief, and he smoked about five joints a day.

Marijuana "cleared up the storms" for Jim. He believed it made him normal. "I want to be normal. I want to get all my [criminal] charges cleared up. I want to be a dad. I want to have a relationship. I want to get through school. I want to make something of my life." I asked him if he saw marijuana as a part of all of these new goals and the new life that he had been creating. He said, "Yes, for sure," but then clarified that he would consider giving up marijuana if the Ritalin he was hoping for works. He acknowledged that he did not see himself ultimately free from medication of one sort or another.

As the interview came to a close, I asked for any final statements. "I think that if doctors get over their fears of it being an illegal drug, if it became legalized, it would really be helpful for many people with ADHD. If they could learn to ration it out so that people have just what they need. Well that's what I think anyway. It works for me."

From this statement, I was left with a curiosity that I shared with Jim. I pointed out that I had heard him say that he was happy to be off of the crack cocaine and the heroin, that he wanted to be off the methadone and cigarettes, and in all those drugs, all of them pretty heavy duty, I had not heard him say that he wanted off of marijuana. His response was, "You see, I like it. It brings me peace. It makes me not hate everything. Hating sucks. You know what I mean? I love my girlfriend. I love my rabbit, I love my mom and I love my dad." He acknowledged that it was within the anxious state, brought on by the ADHD, that he hated. I reframed hate into losing touch with love. Jim agreed and stated, "Yeah, it helps me to get back in touch and be able to do something productive and be a regular person."

As I walked away from this session, I felt the sense of desperation that Jim had experienced in his life, just as I had felt for Tom after my interview with him. The sense of what they call normalcy seemed elusive to these two men. Jim portrayed a man who was anxious and unsettled. He knew that life could be different than it was. He knew that other people seemed more relaxed and contented. They get up and go to work, they achieve their goals, and they maintain their relationships with honesty and integrity. They are stable, and perhaps most importantly they have a sense of belonging. He wanted that, but he could not quite grasp how to get there. His extensive experience with substance abuse implied that he had been trying to alter his reality, but his use of cocaine and heroin seemed to have gotten him into more trouble than he could handle. He still saw marijuana as being the answer to his problem. He saw it as a non-addictive substance that mellowed him out, with minimal side effects, and he had found temporary solace from the anxiety and lack of control that dominated his existence.

Jim: Second meeting.

It took me approximately five months to get back in touch with Jim again. As I had done for the other participants, I had sent the story of the interview to Jim. We met again so I could get his feedback. This time I picked him up outside his home and we went to a restaurant. He had changed his residence three times in the past five months. He had also spent three weeks with no fixed address, sleeping in the doorway of a community center. As he told me about his current situation, it was clear that he still believed that marijuana was the answer to his problems. He reported that he had recently received support from various doctors who had prescribed medication for depression and sleep. In spite of all this medical support, his main focus in our discussion was how he was going to procure his "herb" for the day.

When I asked for feedback about the story I wrote, he said that he had cried when he'd read it. He had never told anyone the whole story about his feelings, his life, and his struggles. For once he had actually felt like he, or his life, "meant something".

As we shared our meal, Jim once again communicated his frustration with not being able to afford the marijuana he felt he required. Each day he struggled to find the money to afford one joint, when indeed he believed that he required five to sustain the experience of being "normal" throughout the day. "I want to be normal. Joe Somebody, out there making money. I don't want to be a bum on welfare."

As we concluded this last meeting, I asked Jim if he had a final statement that he wanted to make. He replied, "I hope people understand and take it to heart. We struggle. We do what we have to. Just like a lion out there on the range, he does what he has to. I have to do what I do to feel normal."

As I walked away from this meeting, after having completed all the narratives, I saw Jim in a slightly different light than the other four participants. He seemed to have constructed a self-image of one who is "sick" or living with a disease, whether that be ADHD or addictions. I recognized that, even though he had described his feelings of remorse about when his behaviour had hurt others, he expected to be excused because his needs overruled any sense of morality.

In reflection now, I remember what it was like to work with Jim in my home. He was perhaps one of the most difficult challenges in my work. I believed then, and still do, that I, as his caregiver, had been attempting to remind him of values and ethics that he did not actually have. I used to challenge my boys with statements like, "A man is only as good as his word." This phrase had appeared to have very little impact on Jim, as he had been raised in an environment where adults had never followed through on their word. Jim used to tell me stories about how his mother would say she would be back in an hour and then return a week later. Having been raised in an environment where the code of conduct was "do what's necessary to get the drugs of your addiction", Jim had missed out on values such as honesty, integrity, fairness, privacy, and respect for others. His stated goal in life at that time had been to become a pimp, not because he had wanted to sell women in the sex trade, but because this had been the highest position held in his world. He had wanted the money, gold chains, leather coat, nice car, and ultimately what he had seen as respect from everyone else. However, even in this street world, his ADHD and inability to plan beyond the next day had stood in the way of his goals. While Jim was in my home, we had tried to realign these goals with education and the possibilities beyond the street world. In a controlled, consistent, and nurturing environment, he had done quite well for a while. We had attempted to address his ADHD with diet, naturopathic

medicines, and activities such as marshal arts. The effects had been too slow and subtle for Jim to feel any locus of control over the "storms in his head". Ultimately, he had reverted back to the behaviours of manipulation, theft, and violence to get what he needed. Consistently, throughout the two years that he was in my home, marijuana had been the one substance that had seemed to offer him some sense of peace.

Brian

Brian is another participant who had been previously unknown to me. A colleague mentioned that she knew someone who fit the criteria for the study. When she had approached Brian, he had expressed interested in helping out but had been unsure about meeting me on his own. The solution that worked best for him was to have my colleague present for the interview. The three of us agreed to meet at a local coffee shop; however, at the last minute Brian's plans changed and he invited us to his home.

Brian was 23 years old at the time of the interview, a handsome, dark-haired young man of English descent. He lives in his parents' home in Langley. He welcomed us into his home, introduced the three small dogs that were excited to see us, offered us refreshments, and we settled into the interview process. My colleague sat quietly in the corner and remained focused on her own work while we talked.

As with the other interviews, we started by talking about Brian's understanding of his ADHD. He shared that he had heard the term ADD throughout elementary school.

The first thing that struck me about Brian was his ability to speak only for himself. Unlike some of the other youth I have spoken with, he insisted that he was only speaking from his personal point of reference. "I can only tell you how it was for me. I am who I am and so I

can't relate to how you see it. I can only tell you how I see it. I don't know any other way. The way I learn is the way I do it. I don't know any other way."

Brian had been 13 years of age when formally diagnosed with ADHD. He had been given Ritalin, which he had taken for only two days. His parents had introduced the Ritalin as a possible solution to his problems, but had not put pressure on him to continue to take it. In his words, "Ritalin is ridiculous." He had had a negative experience with the lack of sleep from this speed-like drug. I asked him how the hyperactive part of ADHD had played out in his life. He admitted that he used to be very hyper as a child. "Oh, I was just always on the move, bouncing off the walls, always had to be fidgeting with something. Had to push this, pull that, run here, duck that, you know, jumping on the couch, doing back flips, whatever. And then when I got mad and mixed the two, it was really bad. I used to have really bad temper tantrums. But, like I said, I did not know any other way how to be." He recalled having had great difficulty in school and reported that it had given him more pleasure to throw a pen than to listen to the teacher. One day, in grade five, he had been sent to see the principal four times in one day.

Brian had smoked his first joint of marijuana when he was 14. He had gotten very stoned from this experience. This had "freaked him out", and he had not smoked it again for almost a year. Then, at 15 years of age, he had tried again and had become "comfortable with it". "It just calms you down and it's something like smoking a Valium or something. Well, not really a Valium, but it's . . ." [He breathed out as if he were releasing all his stress and relaxing.] "So now I don't have to go and pick on anyone." When I asked for clarification about whom he had picked on, he acknowledged that he hadn't really picked on people to be mean. He had done it to amuse himself. He would focus on someone and amuse himself by bugging them. "I was hyper-

active and there was nothing I could do. I constantly had to do something to amuse myself and I chose to bug others to get a reaction."

He had first started smoking marijuana to be social, and then had started really enjoying it. The more experience he had had with this substance the more he had felt in control of it. He had started experimenting with different types of marijuana and believed he had become a bit of a connoisseur. "It was like a hobby and a saving thing at the same time. Like I can't go five days without smoking it. I am not saying that I am addicted, but it's like my mind will go [he gestures anger] . . . and it takes it away . . . with me anyway, I don't know what's in it but [my anger] is gone."

I asked him if he felt he had a consistent habit. "Oh yeah, I guess you can call it a habit. If I don't, then I go back to being hyperactive. Bad temper tantrums. Like when I was a kid I used to put my fist through windows and all kinds of crazy stuff. When I was 14, I first started to figure it out. I was already in a group home and I was kicked out of school and I tried it and it slowly started to help me out. It helped me see how things really are." He offered a short story about how he no longer became upset about small things. "I see things differently now. It gives me a second to step back. That's what it is. It allows me to step back and re-evaluate the situation."

I asked him how much he currently smoked. "I have been known to smoke up to six joints in one night, and that's just in the night time. But that is a reckless way to smoke it. If I only had a little bit then I would strategically smoke it, and in the places where it would do the most good." He went on to talk about the availability and stated that 80% of the kids in his

community smoked marijuana. He felt that it was important to demonstrate respect for the substance and for the law by using discretion.

I shared with him the story about the participant who stated she needed marijuana to enable her to eat. He agreed that marijuana had that effect. "I mean, I am the biggest I have ever been. I used to be really skinny because my metabolism was really fast and when I smoke pot I would eat. Yeah, I gained weight, it makes food taste so much better. It's not that I can't eat, but I prefer to smoke a joint about an hour before I eat. I used to be wrestler in school and I had to gain weight . . . It helped me to gain 15 pounds over the last year and that is good."

I asked him if there was anything bad about marijuana, in his opinion. "Sure, like anything, there is bad in it. It de-motivates you. It is illegal. When you are dealing with it you are dealing with criminals. And yeah, that motivation goes right away." He spoke about his belief in responsible smoking. He would not smoke before he went to school because it would turn his brain to "mush". He would wait until he had finished his important tasks and then smoke a joint. "But the good parts outweigh the bad. I am in tune to it right? Some people get all loopy, then they should not smoke it until they got their shit done. Do stuff first. Like I said if you are responsible with it then you should have no problem. Just be responsible."

He went on to speak about his experience at school. "They just did not know how to deal with me. I don't do well in school. Academically I am not good. And you can't tell me that that is because of the pot, 'cause I have been like that since I was a kid. The only enjoyment, I shouldn't say that, the only relief I get from it is from pot. And if people were not so ignorant and could see that it helps [me] with life, and give it a chance, it would be so much better."

He moved on to describe his experience with smoking marijuana. "The way I figure, when you puff on a joint its like a fog comes into your head and just slows everything down. It's so nice." He makes a distinction between getting high and getting stoned. He believed one gets stoned from marijuana, not high. He said one gets high from drugs like acid or mushrooms or cocaine. "Getting stoned is so much better. Whatever I am [angry] about is gone." [He moved his hand over his head to demonstrate the anger leaving his body and leaned back as if to relax.] "I am not [angry] anymore. I can think about it and figure out what to do."

I asked him about short-term memory loss and, like some of the other participants, he saw this as a positive outcome. "That's why I smoke pot. Seriously. I have so many problems in my life and when I smoke I can forget about them all for about two hours. I know what marijuana does, and I say to anyone who wants to smoke it, who wants to do any kind of drug, research it. Ask questions. Find out what it does. Find out what is in it and then make your decision . . . I just use it for medical purposes. Like I say, I smoke pot and I am going to smoke it until I am an old man."

I asked him to go back to his description of getting stoned from marijuana. "Ok sure, you puff a joint, and you get a cloud behind your eyes. It just slows everything down and I can think. There is no rush. My head is like a wheel, going all the time. Imagine a big projector. And then on the wheel there are these little captions, like in the movie theatre. And my eyes are the lens . . . and each little caption is a thought. And it goes really fast. And when I smoke a joint it just slows it down and I don't have to think of everything all quick, fast. 'Cause my head goes fast, thinks of stuff fast, goes fast all the time . . . and I get tired of it. And [the marijuana] will slow it down and I can step back and just think. It does not make me giggle like a girl or go all funny. It

is like a symbiotic relationship. It is just there. It is like a hobby of health, well not so much health, it is a hobby of mental health. That's it, it's a hobby of mental health. Because it does help you out a lot." He went on to repeat that it is important to respect marijuana, to work it into your life so that it helps you out, and to be careful because "it does involve criminals and not everyone is nice, you know."

He offered another example of marijuana's effects on him. "When I go to bed it's like two a.m. and I am in bed and my eyes are wide open and I can't sleep and I lay in bed just thinking. And my head will go and go and go and [marijuana] just slows it down. It just slows it down . . . I have to have one late at night. Well I don't have to, but I prefer to have one late at night, that is for sure. It all comes down to having respect for it. I don't smoke before meetings and appointments. It doesn't make me smarter. But in my head, in Brian's world, it will slow everything down and I can think and breathe and whatever. It's like it was custom made for me. And my mom knew it a long time ago. She knew it. Good for her, that she was enlightened enough and smart enough to realize it."

The conversation moved at this time to talking about Brian's life. The subject of video games came up. Similar to what I had discovered about other participants, Brian excels in video games and sees them as an important aspect of being ADHD. "It is good hand-eye coordination and you are doing something with your hands and looking at the screen. A good way to turn off your brain. I think it is the only thing an ADHD person can excel in, because you need to be able to handle the action. The video games have the ability to help these people focus for three to four hours at a time, because it is constantly changing."

At the age of 15 Brian had spent one year in a group home, which he described as a "joke". Following that, he had moved back with his mom and then had lived with his aunt for three years. "I jumped around from house to house. I have lived all over the lower mainland."

I asked Brian if there had ever been a time when he had felt that he needed to smoke marijuana. He responded quickly with, "Usually when I am angry . . . it helps immensely. I remember times where everything will get on my nerves. Just the simplest things . . . and it will build up and it will be like steam . . . [after a joint] I will just relax." [He exhaled and leaned back as if to relax.] "I would go nuts without pot."

I asked him if he made a distinction between anger and anxiety, and he indicated that he thought the distinction was significant. "With anxiety . . . I used to go to the mall. . . I am walking and I start to look at the people and start to think that there is not enough air for all of us to breathe. I start sweating and panicking and bumping into people and it gets so hot and it's like breathing in a sauna . . . Lots of times I have to leave the mall and go outside, open the doors, and take a little puff and I can go back in and chill out. I am still a little on edge but not as much. I am not sweating. I am not shaking, 'cause it slows your head down."

At this point Brian thought it was important to make a distinction between a physical addiction and a mental addiction. He believed he had a mental addiction to marijuana. "'Cause if you could have something that could help you out and slow you down all the time, don't you think you would want it? It's not like I need it, I use it to slow my head down. I am not going to let it own me. As soon as you let a drug own you then you are addicted. I don't consider pot a drug. I consider it a herb. It grows wild. It's not made in a lab."

I asked Brian whether depression played a role in his life, and he stated that it was not an issue for him. He expressed his rather positive outlook on life, explaining that he had developed the ability to look to the positive when beginning to feel depressed. He did not think that marijuana had any influence on his experience of depression.

As the interview drew to an end, Brian spoke about his tolerance for pot and his ability to get things done. "Me and my buddy, who is also ADHD, he has the exact same thing and it sure helps him too. It is a global thing. If the government was not so ignorant about it, it would help out a lot of people and a lot of kids. It's too bad that they can't extract out of the pot what helps people, put it in a pill form or whatever, if it is the smoking that bothers them. . . . But there should be an age limit so that kids do not do it. The age should be 17 or 18. If they were smart they would. A good portion of society has ADHD or a learning disability and it could help them out. Then there are those ignorant parents that are filling their kids with Ritalin all day. That stuff is far worse than smoking grass. The side effects are gross. If God put [marijuana] on the earth, then it can't be that bad. There are so many good benefits."

When I asked for any final statements, Brian repeated his advice that anyone doing drugs should do their research first and have respect for the substance. "Don't smoke it 'cause [your peers] are doing it. Know what it is going to do to you and be prepared. Have respect for it. If you have respect for it you should reap the benefits. It is good and I have respect for it."

As I and my colleague left the interview, I was aware of how different his interview had been from those I had had with the other participants. Brian's hyperactivity had not been as apparent as it had with the other four. He had apparently not needed to tell numerous stories to support his statements. The interview process had been much shorter and to the point. I

wondered if it had been because my colleague had chaperoned the interview and her presence had had an influence on his presentation. Alternatively, perhaps it had been because this was my last interview. Throughout the course of the inquiry I had refined my questions to "get to the point". Or, perhaps it had just been the difference that Brian himself had brought to the interview.

Brian presented as being very self-aware. Like the other participants, he seemed quite convinced that marijuana offered him some sense of peace that other drugs, prescription or otherwise, did not offer. The other difference that set Brian apart from the others was his own sense of stability while growing up. Although he spoke about the challenges of controlling his energy and his anger, and moving from home to home, he had not seemed to experience the level of chaos that the others had shared. I was aware throughout the interview that Brian felt some sense of pride in adding his voice to what he considered to be an important message, that marijuana does work to help some people cope with the stresses of everyday life.

Brian: Second Meeting

As I had done for the other participants, I had sent Brian the transcript from the initial interview along with the above narrative. When I had called Brian up to set up another meeting, he had stated that he liked the write up, thought that it had captured the essence of his story, and did not see any reason to meet with me again. I accepted his refusal. He did, however, state that he was interested in reading what the other participants had said. I assured him that he would get a complete copy of the thesis upon its completion.

## Chapter Five: Discussion

### Introduction

In the process of conducting this research I have shared my own story of interviewing these five participants. In addition, I have provided descriptions of my own experience of this journey. The narratives reflect the linear progression of each interview. My intent was to share with the reader how young people living with ADHD narrate their relationship with marijuana. I feel that I have accomplished this goal. Ultimately, each reader will interpret these narratives from their own perspective. They will determine for themselves how, and what part of, the stories they will allow to influence their beliefs about youth, ADHD, marijuana, addiction, upbringing, abuse, delinquency, resilience, normalcy, and so on. These descriptive narratives are rich with opportunity for analysis and interpretation. Without attempting to influence the reader's independent interpretive lens, I am drawn to speak about my own interpretations of these richly articulated experiences.

It is important to acknowledge that my interpretation has already begun within the accounts presented in this paper. Indeed, several authors have suggested that my interpretation would have begun during the interview process itself as I formulated the questions from the discourse that went before (Kvale, 1996; Rubin & Rubin, 1995; Wolcott, 1994). A second level of interpretation took place as I massaged the direct transcript into the above narratives. Although I tried to offer a descriptive account of the interviews, I did select which parts of their stories I would include or not include. Wolcott (1994) suggested that, "In the very fact of constructing data out of experience, the qualitative researcher singles out some things as worthy of note and relegates others to the background" (p. 13). Tom's transcript was 45 pages in length,

and a few of the stories he had shared seemed off track and not related to the topic of his relationship with marijuana. I acknowledged the telling of these stories but did not include them.

Wolcott (1994) made a distinction between description, analysis and interpretation. Although I see no clear distinction between the three, I understand that each builds upon the one before it. The first, description, which has already been offered here in the form of rich narratives, is close to the data originally recorded. I have used the informants' words so that "informants themselves seem to tell their stories" (p. 10). The underlying hope is that the data will "speak for itself". The second, analysis, according to Wolcott, should move beyond the purely descriptive account and identify key factors and relationships within the data. The third, interpretation, should seek to "make sense of what goes on, to reach out for understanding or explanation beyond the limits of what can be explained with the degree of certainty usually associated with analysis" (p. 11). The following is the analysis and interpretation that I have taken from these rich descriptions.

Results

Analysis, from this perspective, is seen as more scientific, structured and logically deductive, a process of looking for patterns within the data. As I transcribed the interviews, I found that common themes began to emerge. The overall subject of self-medication began to move into the forefront. It was after I created the narratives, however, that the patterns became more evident. After completing the narratives, I began to read them over several times, highlighting their stories for commonalities and differences. An analysis of these lived experiences lead me to such conclusions as:

- All 5 of these participants grew up in an urban experience.

- 4 of the 5 participants had been diagnosed with ADHD between the ages of 8 and 10.
- 5 out of 5 reported having had difficulty in school.
- 5 out of 5 reported a tumultuous or chaotic childhood.
- 3 out of 5 reported having been beaten or abused as a means to control their behaviour.
- 5 out of 5 reported having been placed on medication for their ADHD: 4 on Ritalin, the other was unable to name his prescription. The period of Ritalin use had lasted from two days to two years.
- All 5 participants had become involved with marijuana between the ages of 9 and 14.
- 5 out of 5 reported a sense of calmness after smoking marijuana.
- 4 out of 5 reported that marijuana had assisted them in recovering from an addiction to cocaine.
- 5 out of 5 reported that marijuana had offered some help with their sleep.
- 5 out of 5 reported that marijuana had helped them with their ability to focus.
- 1 out of 5 reported that she could not eat without the aid of marijuana; the other 4 reported that it had assisted or enhanced their eating experience and/or weight gain.
- 2 out of 5 reported that the use of marijuana had clearly supported their ability to be in a personal relationship; the other 3 inferred it.
- 5 out of 5 reported a reduction in stress and/or frustration and/or anger and/or anxiety after smoking marijuana.
- 5 out of 5 suggested that an intake of 4 to 5 “joints” per day was the necessary amount to maintain a sense of calm.

- 5 out of 5 stated that their daily use of marijuana had caused them to develop a tolerance, which had allowed them to maintain a level of control and normalcy. They do not get "baked" or "loopy" like an infrequent smoker would. 3 of the 5 stated it was like smoking cigarettes.
- 5 out of 5 predicted long-term marijuana use in their lives, although one admitted that he would give up pot if prescription drugs offered the same relief.
- 2 of the 5 admitted to a lack of motivation, described as a-motivational syndrome, with the use of marijuana, but later acknowledged that the consequence of being unmotivated and sitting still for a period of time was actually a benefit.

These statistics suggest that these five individuals experience positive effects from the daily use of marijuana.

Interpretation

Throughout this research process I have developed a curiosity about certain themes that emerged from these stories of their experiences. The following themes seemed to "speak" to me more than others. I believe that my awareness of certain themes reflects my own personal experience. My work as a practitioner with youth for so many years has influenced my ability to empathize and understand the experience of the adolescent subculture and the influences upon this period of development. These stories are not uncommon to me. They reflect the sense of separateness often experienced by youth labelled as having "problems". The influences of culture, addictions, and the underlying desire to be accepted as normal are the three themes that stood out for me.

Culture

I could not help but notice how culture seemed to play out in these narratives at many levels. Three stood out in particular: the culture of living with ADHD; the marijuana culture; and the over-riding culture of our Canadian society and its attitude toward the ADHD and marijuana cultures. Each of these cultures has distinct norms, values, and language, although these vary in degree of rigidity. ADHD presents a cluster of behaviours that are gathered together to create a common language. What the professionals call "hyperactivity", the youth call "off the wall". The behaviour they are all describing is the same; only the terminology is different. However, each group is referring to a way of being that is distinct for them. These behaviours, and the language used to describe them, set people living with ADHD apart from others in our society. Several of the participants used the term "us" or "we" to speak on behalf of those living with ADHD. Tom gave a "thumbs up" to others who share his experience. I am curious whether they feel a connection to others with the same disorder when they are away from the interview, or if this stated connection was a result of having been acknowledged as one of five participants who all live within a similar situation.

There is a very distinct marijuana culture reflected, in part, by the language throughout the narratives. The numbers of names used for this one substance is evidence of the codes that have been created to keep this culture safe. The fact that marijuana is deemed illegal separates it into a class of its own. It seemed apparent from their discourse that the participants also saw marijuana users as separate from the culture called "hard drug users". One does not need to have ADHD to be a member of the marijuana culture in our society. This culture spans all age groups and socio-economic levels.

Another aspect of distinguishing a culture is by its norms or codes of conduct. Each participant seemed to have his or her own rules about marijuana: "Make sure you roll your own so you know what is in it." "Smoke it one hour before you eat." "Smoke it one hour before you go to bed." "Don't smoke it before your important appointments." "Be discrete." "Research it so you know what you are smoking." From my own past experience, I can say that there is a bond created, a common "knowing" in the ritualistic communion when two or more people share a "joint". There are also rituals around preparing the marijuana, rolling the "joint", and sharing it with others. Although the focus of these discourses seemed to remain on the more "medicinal" reasons for marijuana use, several of the participants acknowledged the "social" connection among their initial reasons for smoking marijuana. I am curious about how much they were influenced by the rituals and the communion, and how much they were influenced by the desire to be outside the law. All of them seemed to take pride in knowing their drug: the different kinds of marijuana, different ways to imbibe, and how to be in control of it so that it brought them the most benefit. They all seemed to respect both the substance and the culture. I believe that terms like "pride" and "respect" imply a degree of self-esteem, something that these young people living with ADHD may not have experienced in the developmental years of their childhood. As well as the stated benefits of mood management, their own perceived state of inclusion as a member in this culture may be one of the few ways in which these individuals have experienced a sense of acceptance and success.

From a societal perspective, throughout my interpretation of their stories is the notion that there had been no room for a tolerance of their differences among others in their lives. Christine stated that the adults may not have correctly diagnosed her disruptive behaviours. Tom, Bill, Jim,

and Christine reflected that the parents and teachers in their world had not known how to handle them. They had been labelled, medicated, and placed outside the "norm". In the broader culture, there was also no room for a tolerance of how they were currently choosing to manage their disorder with the use of marijuana. All five participants requested a shift in society's perspective from marijuana as a bad "street drug" to a recognition that it can be beneficial and supportive for some. That is to say, if you take morality out of the equation, they have simply all learned a coping mechanism. This same shift of societal perspective would move their use of marijuana from the perception of being just another form of delinquency to a more acceptable image of their management of a mood disorder. It was apparent that constructing their "now" seemed to include the belief that they needed assistance to cope with their world. They all appeared to want people to know that marijuana was helping them, but they were fearful of being judged for using it for this purpose. Bill appeared to be less fearful and more impatient. He wanted society to "hurry up and smarten up".

I encountered this same need for a shift in society's perceptions at the Vancouver Compassion Club. Hillary stated that there is very little literature on the effects of marijuana on the symptoms of ADHD. She reported that many parents have come into the Compassion Club looking for information because their child with ADHD had started smoking marijuana.

Tom's story stood out the most for me as an example of the struggle one can experience with addictions. He was clearly proud of himself for having moved away from his cocaine addiction. The drug and alcohol counsellors had convinced him that he needed to be free from all substance use in order to be truly cured of his addictive tendencies, and yet he had kept returning to the solace that he found with marijuana. More so than the other four participants, he had

struggled between these two constructs, attempting to be drug free and therefore free of judgment from society, but at the same time needing support with his disorder. His hyperactive behavior had also not been within the boundaries of acceptable conduct. Either way he had not fit in. He spoke of investigating and adopting the more naturopathic and holistic approaches to wellness in the hope that he could find support there. It seemed to me that Tom has been trying to do the right thing by attempting to be completely free from drug use, prescription or street drug, yet he has been falling short of the mark. His need to quiet the anxiety and frustrations he experienced from the ADHD would apparently overcome the fear of judgment or failure.

Addiction

Another theme that caught my interest was the theme of addiction. The notion of addiction, of whether marijuana is addictive, or of whether the participant was addicted, came up in every interview. I did not introduce this topic; it was introduced into the discourse by the participants. Each seemed to have a need to bring it up. Each appeared to have their own answer about addiction, which implied some personal construct about it. Four of the participants had experienced an addiction to cocaine and made a distinction between their relationships with the two substances. This begs the question of how one sees addiction and speaks to the conflict created by the need to manage the ADHD along with the desire to fit in. The participants each expressed a need to be "normal", while knowing it was not normal to medicate to become so. The literature I have read spoke to the notion that these youth have been raised to believe they can manage their ADHD behaviours with medication. They had moved into the realm of self-medication to find the substance that they believed worked best for them, and this had been

judged inappropriate. As they had already spent their lives being judged as inappropriate, the use of a medication outside the approved norm fitted within their life world.

Our society is filled with people who are medicating their moods with prescription drugs. How do these drugs fit into the construct of addiction? Among my participants there appeared to be a distinction between needing the drug and wanting the drug. Christine was the only one who stated that she could not eat if she did not smoke. She was also the only one who was clear that marijuana is addictive and that she was addicted to it. The others discussed the notion of it being habitual or or that they had developed a psychological or emotional addiction to this substance. Even the four who introduced the notion of harm reduction, by stating that marijuana had helped them overcome their addiction to cocaine, made the distinction that the relationship they experienced with marijuana was much different than the one they experienced with harder drugs. They did not need the marijuana; they wanted it to help them manage their life better. Tom clearly stated that he wanted to control his ADHD so that he could just use marijuana recreationally, rather than needing it. As with the use of prescription medication, they seemed more "addicted" to the outcome of the drug; they were addicted to being normal. As Brian so eloquently put it, "Marijuana is a hobby of mental health."

What is Normal?

The concept of "normal" came up in every interview. I wondered what it would be like to be in their life world, looking out, perceiving others as setting the standard for normal and seeing themselves as lacking normalcy. I can only venture to guess from their descriptions that their definition of a normal person was one who is calm, able to focus on one task for a period of time, does well in school, can get and hold down a job, partakes in a long term relationship, and,

perhaps most importantly, controls their feelings of impatience, anxiety, fear, and frustration. From Tom and Jim especially, I got the sense that they saw normal as peaceful, that they were desperately striving for a sense of peace. They both seemed to be very focused and working hard to get their life sorted out so they could get on with living it in a normal way. While Tom was focused on getting "off" drugs, Jim's goal was to get "on" them.

As this inquiry was coming to a close, I had the honour of attending a presentation entitled "Beyond the Medical Model—A New Look at Childhood Disorders", by Dr. Gabor Mate. As mentioned in my review of the literature, Dr. Mate is a leading expert on ADHD. During his presentation he offered an explanation for one of the mysteries of medication for ADHD. Why do they give hyperactive kids speed-like medication? He offered a rich metaphor by suggesting that the human brain is like a busy intersection. There is traffic of every description coming and going. For the "normal" person there is a traffic cop diligently at work in the middle of the intersection making sure that order and progress are maintained. He suggested that, in the brain functioning of someone with ADHD, this traffic cop is asleep and the result is the chaos that these individuals experience. By giving them speed, the traffic cop is stimulated into action again and order is created out of the chaos. I ventured a question at that time, explaining my research on the affects of marijuana. He responded by saying that, instead of waking the traffic cop up, marijuana slows the traffic down. He cautioned, however, that because marijuana is a depressant, with long term use there is the risk of depression. I thought this rich metaphor correctly described the experience of someone living with ADHD as well as the effects of marijuana on such a person. His metaphor was similar to ones shared by the participants as

they described how marijuana slowed down the movie projector, quieted the stormy weather, and decreased the fear and anxiety of facing the world.

Reflections on the Use of Story

With their use of language and stories, the participants created a descriptive reality of their lived world. Morgan (2000) reminded us that, "The stories we have about our lives are created through linking certain events together in a particular sequence across a time period, and finding a way of explaining or making sense of them" (p. 5).

Throughout the narratives I was aware of the statements the participants had used to describe themselves: "I am fidgety." "I am flighty." "I am hyper." "I am always on the run." "I can get out of control." "I am anxious." "I am terrified." "I don't do well in school." "They don't understand me." "They don't know how to control me." The participants offered these statements as the truth of who they were. I could not help but wonder whether these statements of self-image were initially presented by the adults in their world. It was clear to me during the interviews that the participants were all at varying stages of counter balancing those more negative self images with their own statements of strength and determination: "I am brilliant." "I did not think I would ever be in a relationship." "I have learned so much being a mother." "I had to phone and apologize to several different people I had hurt." "I completed my grade 12." "I have goals." Perhaps with the exception of Jim, during each interview I was left with the sense that they felt there were gaining control of their lives.

The participants described their pasts, what they had experienced, and what they had taken from those experiences to become who they were or currently presented as themselves. During this inquiry they also described what marijuana meant to them. For example, statements

like "marijuana is not a drug, it's a herb" counteract society's claim that it is a harmful psychoactive substance that leads to severe drug abuse. By declaring it as an herb, or a gift from God, the participants reframed the negative image of this substance and gave the individual permission to smoke it without judgment. They also used terms like "it saved my life" and "it's a cure-all" to describe their belief in what this substance can do for them. The most powerful of these statements, which seemed to be voiced in various ways by each of the five participants, was "Marijuana helps me to be normal." These types of statements affirmed their beliefs that they were making the right choice for themselves, regardless of what society thinks.

The participants also used stories about other people to support their beliefs. I heard stories about how marijuana had aided acquaintances with seizures, arthritis, pain, addictions, relationships, etc. It was within Christine's narrative that I noticed this the most. After she had shared her own childhood story, each time I asked her a question she answered by telling me a story about someone else. I found these stories to be significant in their support of her belief system. Rubin and Rubin (1995) reminded us that, " . . . a story is often thought out in advance and designed to make a point, usually one that cannot be made in a direct way" (p. 231). Christine's stories supported her belief about herself as resilient, responsible, intelligent, and caring. Her stories about others seemed to strengthen the belief that marijuana is a supportive and undervalued substance in our society.

Other participants also used stories about self and others to establish and support their beliefs. They too used metaphors to share their beliefs. Kvale (1998) suggested that, "A study's main point may be more easily understood and remembered when worked into vivid metaphors. . . . A metaphor is richer, more complete than a simple description of the data" (p. 275). Jim

referred to his turmoil as “a big thunder and lightening storm, and weed helps me get to a sunny day”. Depending on the quality of the weed, he may have had a little rain here and there, but marijuana’s ability to control the internal “weather” was “really damn good”.

Rather than something that cleared the storm in his head, Brian likened the experience to a fog rolling in and slowing everything down. He explained his experience as being like viewing a movie projector with the small captions of the film flashing by his eyes; each caption on the film is a thought that moves very fast. He described this as being very tiring. When he smoked marijuana, a cloud came in and slowed the speed of the projector and the thoughts. He could then step back and think at a slower, more comfortable pace.

I found Bill’s use of metaphor the most interesting. He likened life to a play. He described himself as the actor, and marijuana as the costume that masked his fears and allowed him to act normal. He suggested that he did not go out into the world without his costume. He appeared to have become so attached to the costume that he saw it as the real person. “I act me when I am stoned. I act scared when I am straight.” This lends itself to the notion of what is “normal” and suggests that part of this illusion of normalcy comes from the belief that we all have a place of balance where we are centered, in control, and contented. The ADHD tips the balance towards chaos, stress, and a lack of control. The marijuana appears to bring their experience back to the center.

## Conclusions

I came into this inquiry with the belief that I would find a self-medication paradigm to be the explanation for the use of marijuana by these individuals living with ADHD. I did not, however, expect to find the depth of the participants' understanding of their disorder and the effects of marijuana on their life world. The purpose of this paper has been to illuminate the relationship between ADHD and the use of marijuana so that parents, practitioners, and educators may gain a better understanding of the everyday experience of these individuals.

The participants who shared their experiences in this study all believed that marijuana has been beneficial in helping them cope with their symptoms of ADHD and the stresses that this disorder can create in their lives. They reported that with the use of marijuana on a daily basis they were able to manage their anxiety, fear, frustration, anger, hyperactive energy, and addiction to harder drugs. They also reported that the use of marijuana enhanced their ability to focus, sleep, eat, and be creative. They have struggled with society's judgement and approach to both their "abnormal" behaviours and their method of managing these behaviours with the use of marijuana. Consistently throughout the narratives, the participants claimed that marijuana had provided for them the means to be "normal". This implied a desire to be accepted within society's norm, to experience an internal locus of control as well as the need to feel a sense of calm and peace.

I believe that this inquiry has merely begun to expose the complexity of the lives of these individuals and the choices that they have made to manage their chaos. It has been but an introduction to the complicated ethical, legal, and therapeutic issues at stake here. In the role of interviewer, I was able to feel the anguish in their experiences and the sense of separation that

they feel from the "norm". Dr. Mate (2004) proposed that many childhood disorders are a result of our North American culture and the lack of relationship, and atunement with a significant caregiver, that these youth experience at a very early age. It would appear then that their behaviour maintains this lack of connection as they are labelled, medicated, and placed outside the norm. The youth themselves are trying to find order within the chaos by using marijuana to "slow the down the traffic" and thus experience what they believe to be some semblance of normalcy. A connection is created within the drug culture and the sense of acceptance and esteem that it entails. The paradox is that their desire to be accepted as normal, calm, productive individuals is also compromised by the very substance they turn to for solace. Marijuana, by its very nature, separates them from their true selves even more. Behind the veil that slows down the traffic, calms the stormy weather, and masks the fears, they are not living the authentic life that could otherwise be available for them. They are caught in the battle between the anxiety and frustration resulting from this disorder and the risks of a lack of motivation and possible depression that come from their choice of medication. As a researcher and a practitioner, I do not claim to have a definitive answer. What is clear to me after this inquiry is that these five individuals believe that they have found the balance that works best for them.

References

Alexander-Roberts, C. (1995). *ADHD & teens—A parent's guide to making it through the tough years.* Dallas: Taylor Publishing.

Amen D. & Waugh, M. (1998). High resolution brain SPECT imaging of marijuana smokers with AD/HD. *Journal of Psychoactive Drugs, 30:2,* 209-214.

Biederman J., Wilens, T., Mick, E., Milberger, S., Spencer, T. J. & Faraone S. V. (1995). Phychoactive substance use in adults with attention deficit hyperactivity disorder (ADHD): Effects of ADHD and psychiatric comorbidity. *American Journal of Psychiatry, 152:11,* 1652-1658.

Biederman, J., Faraone, S., Spencer, T., Wilens, T., Norman, D., Lapey, K., Mick, E., Lehman B. & Doyle, A. (1993). Patterns of psychiatric comorbidity, cognition, and psychosocial functioning in adults with attention deficit hyperactivity disorder. *The American Journal of Psychiatry, 150:12,* 792-1798

Brendtro, L.K. & Ness A.E. (1983). *Re-educating troubled youth: Environments for teaching & treatment.* New York: Aldine De Gruyter.

Burcham, B. & DeMers, S. (1995). Comprehensive assessment of children and youth with ADHD. Intervention in school and clinic, *30:4,* 211-220.

Churchill, S.D. (2000). Seeing through self-deception in narrative reports: Finding psychological truth in problematic data. *Journal of Phenomenological Psychology, 31, No.1, 2000,* 44-62.

Clure, C., Brady, K., Saladin, M., Johnson, D., Waid, R. & Rittenbury, M. (1999). Attention-deficit hyperactivity/disorder and substance use: symptom pattern and drug choice.

*American Journal of Drug and Alcohol Abuse, 25:30,* 441-448.

Carr, D. (1986). *Time, narrative, and history.* Indianapolis: Indiana University Press.

Cortazzi, M. (1993). *Narrative analysis.* New York: Falmer Press.

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* London: Sage.

Degenhardt, L., Hall, W., & Lynskey, M. (2001). The relationship between cannabis use, depression and anxiety among Australian adults: findings from the National Survey of mental health and well-being. *Social Psychiatry Psychiatric Epidemiol, 36,* 219-227.

Denzin, N. & Linclon, Y. (1998). *The landscape of qualitative research; theories and issues.* London: Sage.

Denzin, N.& Linclon, Y. (1998b). *Strategies of qualitative inquiry.* London: Sage.

Fahlberg, V. (1991). *A child's journey through placement.* Indianapolis: Perspective Press.

Flory, K., Milich, R., Lynam, D.R., Leukefeld, C. & Clayton, R. (2003). Relationship between childhood disruptive behaviours disorders and substance use and dependence symptoms in young adulthood: Individuals with symptoms of attention-deficit/hyperactivity disorder and conduct disorder are uniquely at risk. *Psychology of Addictive Behaviours, 0893-164X, 2003 Vol. 17, Issue two,* 151-159.

Frazier, M. & Merrell, K. (1997). Issues in behavioural treatment of attention-deficit hyperactivity/disorder. *Education & Treatment of Children, 20:4, November*, 441.

Gall, M.D., Borg, W.R., & Gall, J.P. (1996). *Educational research: An introduction. (sixth edition).* New York: Longman Publishers.

Garfat, T. (1998). The effective child and youth care intervention: A phenomenological inquiry.

*The Journal of Child and Youth Care, 12:1-(2),* 5-169.

Garmzry, N. (1983). *Stress, coping and development in children.* McGraw-Hill.

Gray, R. & Thomas B. (1996). Effects of cannabis abuse on people with serious mental problems. *British Journal of Nursing, 13;5(4),* 230-3.

Grinspoon, l. & Bakalar, J.B. (1997). *Marijuana: The forbidden medicine.* New Haven: Yale University Press.

Gurley, R.J., Aranow, R.& Katz, M.(1998). Medicinal marijuana: A comprehensive review. *Journal of Psychoactive Drugs, Vol. 30 (2) 1998,* 137-147.

Hadorn, D. (1997). Cannabis and Violence. *New Zealand Medical Journal, June, 110(1045),* 216.

Hechtman, L. & Weiss G. (1996). Controlled prospective fifteen year follow-up of hyperactives as adults: Non-medical drug and alcohol use and anti-social behaviours. *Canadian Journal of Psychiatry, Vol. 31,* 557-567.

Herda, E. (1999). *Research Conversations and Narrative: A Critical Hermeneutic Orientation in Participatory Inquiry.* New York: Praeger Publications.

Hoskins, M.L. (1997). *Difficulties with discourse: A metaphorical readinf of reconstructing self.* Dissertation. Victoria, BC. University of Victoria.

Johns, A. (2001). Psychiatric effects of cannabis. *British Journal of Psychiatry,* 178, 116-122.

Kaminer, Y. (1992). Clinical implications of the relationship between attention-deficit hyperactivity disorder and psychoactive substance use disorders. *The American Journal on Addictions, 1:3,* 257-264.

Khantzian, E. (1985). The self-medication hypothesis of addictive disorders: Focus on heroin

and cocaine dependence. *American Journal of Psychiatry, 142:11,* 1259-1264.

Kvale S. (1996). *Interviews: An introduction to qualitative research interviewing.* London: Sage.

Lieblich, A., Tuval-Mashiach, R. & Zilber, T. (1998). *Narrative research: Reading, analysis and interpretation.* London: Sage.

Levin F., Evans S. & Kleber H. (1999). Practical guidelines for the treatment of substance abusers with adult attention-deficit hyperactivity disorder. *Psychiatric Services, 50:8,* 1001-1003

Lundqvist, T. (1995). Specific thought patterns in chronic cannabis smokers observed during treatment. *Life Sciences, Vol. 56, no.s 23/24,* 2141-2144.

Mannuzza, S., Klien, R., Bessler, A., Malloy, P. & LaPadula, M. (1993). Adult outcome of hyperactive boys. *Journal of General Psychiatry, Vol 50,* 565-575.

Mate, G. (1999). *Scattered minds: A new look at the origins & healing of the attention deficit disorder.* Toronto: Random House.

McGee, R., Bills, S., Poulton, R. & Moffitt, T. (2000). A longitudinal study of cannabis use and mental health from adolescence to early adulthood addiction. *Addiction, April: 95 (4),* 491-503.

Morgan, A. (2000). *What is narrative therapy?* Adelaide: Dulwich Centre Publications.

Milberger, S., Biederman, J., Faraone, S., Chen, L. &, Jones, J. (1997). Further evidence of an association between attention-deficit/hyperactivity disorder and cigarette smoking. *The American Journal on Addictions, 6:3,* 205-217.

Milberger, S., Biederman, J., Faraone, S., Wilens, T. & Chu, M. (1997). Associations Between ADHD and psychoactive used disorders. *The American Journal on Addictions, 6:4, Fall,*

318-329.

Miller, P.H. (1989). Theories of developmental psychology. New York: W.H. Freeman & Company.

Molina, B., Smith, B., Pelham, W. (1999). Interactive effects of attention deficit hyperactivity disorder and conduct disorder on early adolescent substance use. *Psychology of Addictive Behaviours, 13:4,* 348-358.

Mueser, K., Yarnold, P., Levinson, D., Singh, H., Bellack, A., Kee, K., Morrison, R. & Yadalam, K. (1990). Prevelance of substance abuse in schizophrenia: Demographic and clinical correlates. *Schizophrenia Bulletin,* 16, 31-56.

Nolin, P.C. & Kenny, C. (2002). Cannabis: Our position for a Canadian public policy. *Senate Special Committee on illegal drugs: Cannabis: Summar Report, 2002.* Retrieved October, 15th, 2003 from http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/ille-e/rep-e/summary-e.pdf.

Ogborne, A.C., Smart, R.G., Weber,T. & Birchmore-Timney, C. (2000). Who is using cannabis as a medicine and why: An exploratory study. Journal of Psychoactive Drugs; Oct.-Dec, 32(4), 435-443.

Paterson, A., Sunohara, G. & Kennedy, J. (1999). Dopamine D4 receptor gene: Novelty or nonsense? *American College of Neuropsychopharmocology, 21:1,* 3-16.

Phelan, T. (2000). *All about attention deficit disorder: Symptoms, diagnosis and treatment: children and adults.* Glen Ellyn: Child Management Inc.

Riessman, C.K. (1993). *Narrative Analysis.* London: Sage.

Rubin, H.J. & Rubin, I.S. (1995). *Qualitative interviewing: The art of hearing data.* London:

Sage.

Sibbald, B. (2001). A primer for patient's use of medicinal marijuana. *Canadian Medical Association Journal, 165(3),* 329.

Shelly-Tremblay, J. & Rosen L. (1996). Attention deficit hyperactivity disorder: An evolutionary perspective. *Journal of Genetic Psychology, 157:4,* 443.

Stassen Berger, K. & Thompson, R.A. (1995). *The developing person—Through childhood and adolescence.* New York: Worth Publishers.

Taylor, H.G. (1998). Analysis of the medical use of marijuana and its social implications. *Journal of the American Pharmaceutical Association, 38(2),* 220-227.

Thomas, H. (1996). A community survey of adverse effects of cannabis use. *Drug and Alcohol Dependence, 42,* 201-207.

Vorrath, H. & Brendtro, L. (1985). *Positive peer culture.* New York: Aldine de Gruyter.

Walker III, S. (1998). *The hyperactivity hoax: How to stop drugging your child and find real medical help.* New York: St Martin's Press.

Warner, R., Taylor, D., Wright, J., Sloat, A., Springett, G., Arnold, S. & Weinberg, H. (1994). Substance use among the mentally ill: Prevalence, reasons for use, and effects on illness. *American Journal of Orthopsychiatry, 64(1),* 30-39.

Wilens, T. E., Beiderman, J. &, Spencer T. (1996). Attention-deficit hyperactivity disorder and the psychoactive substance use disorders. *Child and Adolescent Psychiatric Clinics of North America, 5:1,* 73-91.

Wilens, T. E., Beiderman, J. & Mick, E. (1998). *Does ADHD affect the course of substance abuse? Findings from a sample of adults with and without ADHD. 7:2, Spring,* 156-162.

Wolcott, H.F. (1994). *Transforming qualitative data, description, analysis and interpretation.* London: Sage.

Wolcott, H.F. (1995). *The art of fieldwork.* London: Sage.

Wolin, S. & Wolin, S.J. (1993). *The resilient self: How survivors of troubled families rise above adversity.* New York: Villard Books.

Zablocki, B., Aidala, A., Hansell, S. & White, H.R. (1991). Marijuana use, introspectiveness, and mental health. *Journal of Health and Social Behaviour. Vol. 32,* 65-79.

Zimmer. L, & Morgan, J.P. (1997). *Marijuana myths, marijuana facts: A review of the scientific evidence.* New York: Lindesmith Center.

Appendix A: Glossary of Terms

The following definitions are taken, in parts, from the Senate Special Committee of Illegal Drugs, Cannabis: Summary Report (p. 2).

*Abuse*

A vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse. For example, the international conventions consider that any use of drugs other than for medicinal purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairments or distress as defined by one or more of four criteria. In the Report they use the terms "excessive use" or "harmful use".

*Addiction*

A general term referring to the concepts of tolerance and dependency. According to the World Health Organization, addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolution process preceding dependence.

*Cannabis*

Three varieties of the Cannabis plant exist: *cannabis sativa*, *cannabis indica* and *cannabis ruredalis*. *Cannabis sativa* is the most commonly found, growing in almost any soil

condition. The cannabis plant has been known in China for more than 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used in this paper to refer to cannabis are pot, marijuana, dope, ganja, hemp, herb, weed, smoke. Hashish is produced from the extracted resin. Classified as a psychotropic drug, cannabis is a modulator of the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. Delta-9-tetrahydrocannabinol, referred to as THC, is the principal active ingredient of cannabis.

*Clean*

To be free of all drug use.

*Drug*

Any chemical agent that alters the biochemical or physiological process of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects. The word drug is also used to refer to illicit rather than licit, such as nicotine, alcohol, or medicinal substances.

*Gateway / Gateway Theory*

Theory suggesting a sequential pattern in involvement in drug use, from nicotine to alcohol, to cannabis, and then to "hard" drugs. In regard to cannabis, the theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

*Intoxication*

Disturbance of the physiological and psychological systems through substance use. Pharmacology generally distinguishes four levels of intoxication: light, moderate, serious, and fatal.

*Joint*

Cigarette made of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC in their use are more difficult, especially to determine the therapeutic benefits of cannabis and to examine its effects on driving.

*Legalization*

Legislating under a regulatory system the culture, production, marketing, sale, and use of substances. Although no such provision currently exists in relation to "street drugs" a legislation system could take two forms: free of state control (free market) and with state controls (regulatory regime).

*Marijuana*

Mexican term originally referring to a cigarette of poor quality. Has now become a synonym for cannabis in popular language usage.

*Psychoactive Substance*

Substance which alters mental processes, such as thinking.

**Appendix B**

# Participant Consent Form

University of Victoria

**OFFICE OF THE VICE-PRESIDENT, RESEARCH**

**HUMAN RESEARCH ETHICS COMMITTEE**

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## How Youth with ADHD Narrate their Relationship With Marijuana

You are being invited to participate in a study entitled How Youth with ADHD Narratie Their Relationship with Marijuana that is being conducted by Debbie Verkerk. Debbie is a graduate student in the department of Child and Youth Care at the University and you may contact her if you have further questions by phone at 604-531-3808.

As a graduate student, I am required to conduct research as part of the requirements for a degree in Master's of Arts in Child and Youth Care. It is being conducted under the supervision of Dr. Marie Hoskins, You may contact my supervisor at 250-721-7982 or her e-mail at mhoskins@uvic.ca

The purpose of this research project is to examine the experience of marijuana for young people who have been diagnosed as having ADHD. The objective is to hear the stories and perspectives of these participants and to determine common themes and the "essence" of their experiences.

Research of this type is important because it is unique. In the review of the literature the experience of marijuana for those with ADHD has not before been studied. This inquiry will give a voice to the young people who are experiencing this disorder and to their experience of this substance. This inquiry will offer a greater understanding to parents and professionals who work with these young people, presenting them with insight into this disorder and the role and influence of marijuana.

You are being asked to participate in this study because you are between the ages of 19 and 32, and have been diagnosed as having ADHD during your childhood and you are still experiencing the symptioms of this disorder, and, you use marijuana frequently, approximately 5 times a week.

If you agree to voluntarily participate in this research, your participation will include a one-hour audio-taped interview with Debbie where she will guide a discussion to hear your stories about your life as someone who uses marijuana and experiences ADHD. Plus you will be given the choice to read over the transcript of your interview to ensure that Debbie has captured the story and ideas that you wanted to portray.

Participation in this study may cause some inconvenience to you, including attending the interview. If transportation is a problem for you then Debbie will supply you with bus fare.

There are some potential risks to you by participating in this reseach and they include the possibility that sharing your story may bring up some new insights or unresolved past issues, which could cause you some emotional or psychological discomfort. To prevent or to deal with these risks Debbie will check in to make sure that you are OK during and after the interview. If you feel that you require support or counselling to help you with these issues then Debbie will assit you in finding a counselling service that will meet your needs. It will be up to you to attend and bare the costs of this counselling service.

The potential benefits of your particpation in this research include educating parents and professional about how marijuana is experienced by people with ADHD. This in turn may lead to more studies about the experience of people with ADHD and what alternative might assist them in this disorder.

As a way to compensate you for any inconvenience related to your participation, you will be given a gift of $40.00. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to be a participant in this study, this form of compensation to you must not be coercive. If you would not otherwise choose to participate if the compensation was not offered, then you should decline.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequence or any explanation. If you do withdraw from the study your story will only be used if you agree to it. This data will not be used if you do not give your permission first.

In terms of protecting your anonymity we will create a new name for you to be used during the interview. Your real name will not be used at any tme in the data gathering process. It is up to you to share your involvement in this project with whom you feel comfortable. Debbie will not share your participation in this study with anyone without getting your permission first.

Your confidentiality and the confidentiality of the data will be protected by keeping all written and taped material in a secure locked filing cabinet. All data entered into the computer will be saved on a separate

disc and also kept in a locked failing cabinet. Debbie knows that the possession of marijuana is illegal in this country and she quarantees that all information that you share will not be used against you.

Data from this study will be disposed of. The audio-tapes will be destroyed or given to you when the transcribed text is complete. The written text will be destroyed in one year after Debbie has had an opportunity to determine if she is going to go on to research this topic further.

It is anticipated that the results of this study will be published in a professional journal so that parents and professionals can gain access to these findings. A copy of Debbie's thesis will also be held in the library at the Univeristy of Victoria for other students to read.

In addition to being able to contact the researcher and the supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the Univeristy of Victoria (250-472-4632).

Your signature below indicates that you understand the above conditions of particpation in this study and that you have had the opportunity to have your questions answered by researchers.

| ______________________ | ______________________ | ______________ |
| --- | --- | --- |
| Name of Participant | Signature | Date |

**A copy of this consent will be left with you, and a copy will be taken by the reseacher**