EPIC2016

Case Studies 2 – Emergent, Underserved & New Markets

Finding a Voice in Opiate Addiction: Identifying the Role of Caregivers in the Recovery Process for VIVITROL

GAVIN JOHNSTON
InTouch Solutions

Opiate addiction is a significant public health crisis. In the past year, it has become a hot topic at all levels, including the political realm ahead of the presidential election. Triggers, treatment options and restrictions, the criminal justice system, and costs to society are all part of the discussion but the cultural milieu in which addiction occurs is poorly understood. This was a significant problem for our client, the maker of a monthly injectable that inhibits the ability of an addict to get high. Our client, basing their marketing strategy entirely on quantitative data, realized that they needed to get a deeper understanding of addiction and the roles caregivers, friends, and family play in the treatment and recovery cycle. Our team convinced our client, who was inherently nervous about executing qualitative work, that in order to create a meaningful marketing plan, they needed to understand the complexities at a deeper level than data could provide. Working with the client and our design teams we executed an initial ethnographic pilot study to identify the best avenues for reaching the audience and providing information that would have an actual long-term impact on the success of treatment. Over the course of a month, our team combined participant observation in three US cities with the caregivers of people battling addiction (some of whom had lost) with in-depth interviews that incorporated a series of semiotics techniques.

The end result was a completely new strategy for the client. A new campaign was developed, new messaging channels were identified, and a clear three-year road map was developed to help them change the conversation and expand their reach. Perhaps as important, the client's entire perspective on addiction and research changed, leading to developing a plan for further research in a broader range of settings.

BACKGROUND

Opioid addiction is increasingly becoming a talking point in society as the rates of dependence, incarceration, and abuse climb. Typically, treatment choices have been somewhat arbitrary and haphazard, driven by the structure of the criminal justice system, a range of philosophies that are often grounded in assumptions rather than data, and individual needs (Faupel, Weaver and Corzine, 2014). Suboxone and methadone, both of which are addictive, are the most common medications prescribed in medically assisted treatment (MAT) protocols. They are well known, have a large amount of marketing dollars to put behind them, and are comparatively cheap ($4 per pill on average vs. $1000 for a monthly VIVITROL injection). Unfortunately, they also have high rates of abandonment over time, leading, in part, to relapse (Raikhel and Garriott, 2013). In addition to MAT protocols, most addicts typically go through either a treatment center or Narcotics Anonymous (NA), or both. Unfortunately, there is no standard practice for in-patient treatment and so they can range from faith-based processes to standard twelve-step program. As with the most common MAT protocols, there is an extremely high rate of

relapse. Patients frequently feel isolated and out of place in these settings, caregivers have a limited role in the treatment process, and because of insurance limitations, patients are often released after detox without any kind of meaningful treatment plan (Manufo, 2006). Rather than addressing the system as a whole and the roles of various actors within it, treatment options tend to target health care professionals (HCPs) and patients exclusively.

Two key strengths for VIVTROL are that it is 1) non-addictive and 2) requires use only one a month, rather than as part of a daily regimen. The result is that rather than focusing on the physical treatment day to day, the patient, the HCP, and the caregiver can focus on the underlying causes of the addiction. The drawbacks, however, are that it is costly and the HCP administering the drug needs both certification and new equipment to store it. From a marketing perspective it's largely a matter of name recognition – Suboxone and methadone have been the standard for years (Koetzle and Hartman, 2011). HCPs and patients alike are very aware of the drugs, as are most people in the criminal justice system and treatment center industry (Carr, 2012). That said, VIVITROL has received strong interest from patients and HCPs alike when they learn about the treatment option, but they are only one part of the treatment cycle. Marketing efforts had come to something of a standstill, but the VIVITROL consumer marketing team believed that there was a substantial strategic opportunity to activate caregivers to help support the key business objectives of increasing demand and improving continuity of care.

Based on the limited involvement many caregivers encounter in the treatment process (Yardley, 2012) the team hypothesized that an activated and engaged caregiver could be a pivotal force in helping opiate addicts into and through the treatment cycle and a champion for getting them on VIVITROL once they understand the efficacy and non-addictive properties. Additionally, they believed that the caregiver would be able to add clarity and sound perspective to counteract the addict's compromised state throughout the addiction and treatment cycle – from problem denial through the fragile early days of recovery.

Since marketing research dollars had been primarily focused on consumers and HCPs, the team lacked research data to support this hypothesis. Again, awareness and conversion among HCPs and patients had largely plateaued. Alkermese, the company owning VIVITROL, hoped to grow sales by as much as 7% over the next two years and needed to broaden their marketing efforts. Adding to the need to break new ground was the very real problem that there are other non-addictive treatment options in the works and the company estimated a two year advantage before these other products were introduced to the market. That meant securing a strong brand presence before the competition exploded.

So, deeper saturation, increased brand awareness and affinity, and developing a messaging strategy that could speak to a broader group in a contextualized manner, regardless of channel, meant needing to understand the social, cultural, and psychological dynamics of addiction in a broader sense. Given the lack of research among caregivers, they opted to start the research process with broad caregiver ethnography research to allow for the research process to organically reveal insights and opportunities that could then be further tested through focused qualitative and quantitative studies.

Well aware that we could not possibly address every problem in the addiction treatment cycle, we realized we would need to focus our efforts and keep our goals limited to a few key areas. Our objectives were:

- Understand the relationship between addicts and caregivers over time
- Understand needs, wants, pain points and patterns for caregivers
- Uncover triggers, motivations and barriers in the treatment journey
- Identify points of influence within the treatment process

METHODOLOGY

Our research team worked directly with the VIVITROL stakeholders on the study design, objectives and target profiles. The field research itself consisted of traditional participant observation, in-depth interviews, and elicitation techniques.

The questions and observations during the fieldwork focused on the histories and current practices of caregivers in relation to the addict, the culture of addiction, and how their lives had been shaped during the addiction cycle. Participants were given free reign to direct the conversations and places we visited. Questions asked during the in-depth interviews were more structured, though still open-ended, and focused more narrowly on the addiction and treatment journeys. Both processes were intended to uncover information and contradictions about early childhood, identifiable and potential triggers, substance types, lifestyle and emotional impacts to addict and caregiver, past and current treatments, perception of addiction before and after personal experience, perception of treatment landscape, emotions experienced throughout the addiction and treatment journeys, and current statuses of addict and caregiver.

INTO THE FIELD

The caregivers we met were a broad mix in terms of age, relationship to addict, education level, income level, current addiction mindset, depth of knowledge about addiction, presentation. The addicts to whom these caregivers were connected varied, as well, in terms of addiction trigger, age, addictive substance(s), current addiction status (using, in treatment, recovered, passed away), employment status, previous/current use of MAT and motivation

level for helping themselves. As we prepared to enter the field, we had no idea how open our participants would be about such a sensitive subject, but it quickly became evident that they wanted to tell their stories. What we assumed would often be 2-3 hour visits in homes quickly turned into all-day sessions that involved visits to support group meetings, going through old photo albums, and even a visit to a grave.

ADDICTION AS A WAY OF LIFE

Every entry point into addiction is unique, but there are generally signs along the way (Page, 2010). Caregivers rarely recognize problem signs before addiction spins their lives out of control:

> "I found out that David [her son] had a problem when I got a call from the hospital. He'd overdosed after he bought heroin from someplace downtown. He was an addict but he was still competing on the track team. It was a total shock when I got to the hospital and he told me he'd been driving in to town to buy heroin for over two months."

Once we entered the field and began to get to know our participants, this issue emerged again and again – by the time they recognized the signs, the loved one, whether a child, a spouse, a sibling, or a friend, was in serious trouble and the caregiver was forced to jump in and learn about addiction, treatment, etc. and an unrealistically fast pace. In addition to being caught in a state of "catch up", resources were as varied as the people accessing them. As one participant told us as we flipped through a photo album with pictures of her son (he had recently relapsed for the fourth time and was in a in jail awaiting release to a treatment center), "Each treatment center, each doctor, each person giving you advice has their own agenda. It's methadone or Jesus or some bullshit twelve-step program. You don't know where to turn and you're scrambling to put things in order."

It's also worth noting that where participants lived and what was considered acceptable or expected in relation to drug use had an enormous impact on how addiction was perceived. The higher the income, the more inclined caregivers were to see addiction as something that could be battled and compartmentalized. Because they had greater access to treatment and information, their role became much more like a job with specific times and steps that could be applied. The lower the income, the more likely the caregiver and his/her network was to rely on guesswork. Dealing with addiction, domestic violence, arrest, etc. became part of an ongoing process throughout the day. They generally had far fewer resources and simply didn't know where to begin in terms of information. The result was that they often were reliant on social media, blogs, and the conversations they had with friends for advice rather than medical websites, input from treatment professionals, or drug manufacturers. This group also generally had a much more resigned view of the drugs and drug abuse. It was simply part of the reality of growing up poor or lower middle class – drug use was almost inevitable and accepted as long as it was kept in check. Conversely, middle

class and upper middle class households immediately went into crisis mode and treated both the drug and the addiction as something to be overcome and driven out of their lives. It wasn't part of the fabric of daily life, but an intrusion into it.

Ultimately, how the addiction was triggered, the type of relationship the addict and caregiver share, the genders of the actors, and the duration of the addiction journey all factored into how caregivers perceive and address the addict, the addiction, relapses, treatment and their own involvement throughout each stage. Personal history, regional cultural norms, and access to resources all work together to define the roles each actors adopts and how they search out and respond to battling the addiction. The result is that treatment becomes a long-term series of events, with no sense of an end point. As one of our participants told us, "It never stops. It never will stop. Not until she's dead or I am."

Addiction eventually becomes a way of life, not just for the addict, but for the people helping manage it. It defines every waking moment. It leads to the irrational, the ugly and the destructive becoming the norm. Manipulation, codependence, guilt and desperation are the lenses through which both addict and caregiver view everything. Rationalizations and justifications run rampant to defend behavior by both addict and caregiver. Caregivers exacerbate the problem by allowing themselves to be guided by feelings rather than logic.

GUILT WITHOUT END

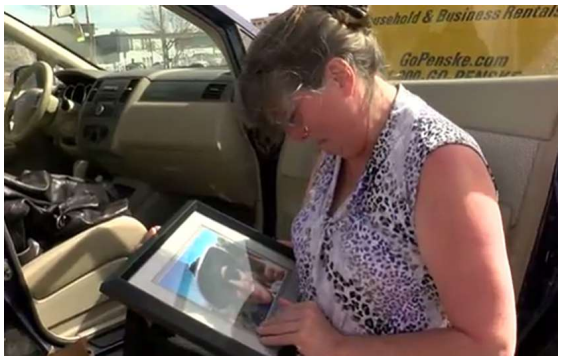
There is a spectrum of caregiver guilt. For many, seeing the addict's life out of control is better than seeing them dead. Having the addict alive, even with the addiction and codependent relationship, means they are in this together, while the addict's death means the guilt is the caregiver's alone. Caregivers spend their time shifting from one type of guilt to another and constantly doing things to alleviate this guilt. The sense of guilt was generally broken down into early childrearing failings, missing the signs of addiction, and post-addiction treatment relapses. There was a constant need to pinpoint a single moment where things went afoul and the addiction "began" or "returned". This constant sense of guilt leads to an inability to help forge a clear course of action, with the caregiver rationalizing the addict's behavior and enabling their actions.

> "I think I just hit a point where everything we tried failed and I couldn't stop blaming myself. I couldn't move forward, I couldn't do anything. He's been dead for almost two years and I still can't help blaming myself. Two years of therapy and I still blame myself. I'm his mother, I was supposed to protect him. I don't know what happened that he got hooked on this poison, but I can't shake feeling that I could have prevented it somehow at the very beginning."

Two significant issues arise because of the constant undercurrent of guilt. First, caregivers neglect to realize that they themselves need help. The extreme stress they live with on a daily basis drives them to focus solely on the addict. When they do talk to other people about their situation, they often edit it. Several caregivers indicated that our interview was very beneficial to them because it allowed them to unload to an unbiased, uninvolved third party. Their lives are defined and taken over by addiction through no choice of their own. They become so focused on alleviating guilt and surviving the chaos that they often ignore their own needs.

Second, they see each new low point as a personal failing. Rock bottom is not a singular event, and it means something different to everyone. There are several rock bottoms for the addict and for the caregiver. Each person can experience subsequent rock bottoms, each of which is lower than the previous one. And with each new low point, the caregiver tends to look at what they should have done differently. The problem becomes internally focused, the sense of guilt becomes more firmly entrenched, and the cycle of treatment and relapse become that much more normalized.

CHANGING DUTIES



Obviously, this constant cycle of rationalization, guilt, and manipulation eventually becomes too exhausting to manage. Consequently, roles change and a spectrum of caregiver involvement emerges. Often, addicts have more than one caregiver over time and responsibilities are handed back and forth between people involved in helping in treatment. These are generally immediate family members or significant others, though extended family members and friends can and do fill in when no one else is willing or able to assume the duty. Multiple people are actively involved during the discovery phase of addiction, but as the addiction's duration grows longer, the role of primary caregiver switches hands. Caregivers detach due to frustration, anger and feeling overwhelmed, then tend to resume a more active role once they have either had time to mentally regroup or if a major issue happens with the addict. One participant told us, "I just couldn't keep doing it, I had to hand her off to her aunt when no one else wanted to deal with it anymore. You just get so worn down."

It was clear that those with parent, child or sibling relationships to the addict felt elevated levels of obligation and commitment to be and stay involved, as compared to spousal and significant other relationships, but burnout is a constant problem. Treatment and recovery involve a series of on-again, off-again activities. Often, the same things are attempted over and over, resulting in a repetitive addiction-treatment cycle. This leaves caregivers hopeless, surrounded by a never-ending cycle of using, treatment and relapse.

In order to give the information structure and make it more manageable, we broke the relationships and their associated behaviors into categories:

- **Parent/child:** Parents are most likely to stay for the duration of their child's addiction and treatment journeys, no matter how long it spans. Manipulation, guilt and enabling were very prevalent in these relationships.
- **Child/parent:** Children of addicts are often on one end of two extremes. Some seem to feel an obligation, born out of allegiance and guilt, to stand by their parents throughout the course of their addiction and treatment journeys. This scenario is most likely when the parental addiction begins during or after the child's teenage years. Alternately, children who grew up with addicted parents seem to have more

anger and resentment toward the parents for robbing them of a normal childhood. These children have higher tendencies toward also becoming addicts, ending up in relationships with addicts, and suffering from psychological issues such as anxiety as adults. They tend to deal with the addiction in a more detached manner and are fueled by resentment for being "forced" into taking on a parenting role with their own parent while they have their own adult responsibilities to tend to. Guilt, obligation and resentment were very prevalent across all child/parent relationships.

- **Sibling/sibling**: They feel obligated to be in it for the long haul, but their primary motivator is often alleviating stress on their parents. They repeatedly switch back and forth between levels of involvement with the addicts. Resentment was prevalent in these relationships, driven often by an ongoing battle for their parents' attention beginning as early as infancy and lasting through adulthood.
- **Marriage/dating:** These relationships consistently showed an accelerated timeline from initial meeting to moving in, getting married and having children. The acknowledgement that they had a choice to leave and abandon the relationship was more evident than in other relationships. The couples' children are both key motivators and barriers to leaving the relationship. Codependency, enabling and violent behavior were most prevalent in these relationships.

A WORLD OF CONTRADICTION

Caregivers are learning to cope with new hard truths. They are bridging the gap between how they once perceived addiction and realities of addiction. However, contradictions abound and while they may talk about "the disease" in very rational tones one minute, they quickly fall back to myths, misperceptions, and their own personal hurt the next. They cannot reconcile the addict's self-focused, "I'm only hurting myself" view of addiction and the greater, more devastating impact it actually has. In broad terms, caregivers were divided on whether addiction is a choice, a sign of weakness, an environmental issue or a progressive brain disease. Some thought of it as something that began as a choice and ended up as a dependency or brain disease.

Regardless of how they perceive the disease, the net result is that both addicts and caregivers create and cling to assumptions and theories in order to explain, rationalize and justify the addiction, triggers and irrational behaviors displayed by themselves and each other. As an example, one participant said, "I read it's partly from all the stuff they put in food now. It alters our chemistry and makes us more likely to get addicted to stuff." People believe addiction is genetic, or that the addict has a "void" he/she was trying to fill, or that it all stems from a single tragic event, etc. This behavior, this rationalization and reliance on urban legends as a source of information, continues as the addict/caregiver relationship dynamic turns codependent (Yardley, 2012). And it sets the stage for the caregiver and addict alike to feed off of each other's drug mythos. But within all the misinformation and urban legends revolving around addiction, there is an opportunity to meet people where they are actually seeking answers.

Knowing this would mean taking an approach a communication and marketing that was outside traditional processes. The result is that messaging doesn't always appear in places the audience frequent or is overly scientific in its voice. But in addiction, there is a plethora of misinformation that either has to be combatted outright or has to be acknowledged in the

marketing mix. Rather than running from the myths that surround addiction, we chose to build from them and meet people directly in the places they were encountering these myths. By tapping directly into the sources that often foster behavior that perpetuate the cycle, it's possible to change perceptions and break through contradictory behavior earlier.

As time passes and relapses occur, manipulation and guilt become the foundational cycle by which the relationship functions. Caregivers try to make sense of the situation in rational terms when all behavior is irrational and beyond a person's control. The new normal is marked by chaos, erratic behavior and emotional turmoil. And while they crave some sense of stability, they are unable to put a plan into action. Caregivers often verbalize nostalgia and longing for life as it was before the addiction. They may want to resume activities and experiences they shared with the addict before the addiction, or they may just want to be free from the emotional turmoil they constantly experience now as a result of the manipulation and guilt cycle. Regardless of how they express what they want to the relationship to be, whether focused on the past or projecting into the future, they are often unable to formulate a way positive way forward.

The outcome of all this is that caregivers start hoping for miracles and begin grasping at straws. Treatment perception is driven by speculation more than reason, and caregivers put faith in single solutions rather than thinking about the system of recovery in its entirety, and so the addiction treatment cycle is perpetuated.

KEY INSIGHTS

You can't solve every problem and you can't address every issue. With that in mind, we needed to refine the wealth of information into something the client and marketing teams could grasp and act upon. While there were a number of areas we could explore, we chose to boil the findings down to four central insights. Knowing that our goal was to find new growth opportunities outside of HCPs and patients (again, awareness and sales had largely flattened), establish brand awareness, and develop brand affinity, we chose to focus on areas where they were most primed to be looking for information. With that as a starting point, we defined mindsets at these stages of heightened stress and what caused the situation (relapse, an overdose, an arrest, a domestic dispute, etc.). The other piece in making our determinations was to define times and situation wherein they were most primed to act. Caregivers actually have a tremendous amount of influence on every actor in the addiction cycle, whether it's the patient, the doctor, or the judge. They have little direct power, but these other parties will frequently defer to their input about treatment since ultimately, they are the ones, for better or worse, responsible for much of the treatment.

As we developed our key insights we also had to be aware that our client and internal audiences (creative teams, UX, account management teams) needed to be able to glean the central message of each at a glance. Whether we were talking to the CEO or a new copywriter, the goal was to provide simple, clear, thematic ideas that could then be used to drive innovation sessions, creative brainstorms, and strategy sessions. On a more self-serving note, we also meant for them to build curiosity and drive the people reading them deeper into the findings. Particularly in advertising, there is a tendency to dismiss anything seen as too academic. "Too academic" is code for "more than 100 words". So getting teams to dig deeper into the information requires breaking down information into bite-sized pieces they

can easily digest. With that in mind, our presentation, full report, and strategic framework centered on the following:

INSIGHT #1: Caregivers unknowingly use feelings instead of logic to navigate their way. Feelings tend to dominate the Caregiver. They struggle to keep a pragmatic view of the world and situation. Educating themselves about addiction is coupled with the harsh realities of the addict's behavior, further muddied by the baseline understanding they have developed about how addiction works.

INSIGHT #2: Caregivers are aware, but not knowledgeable of, available treatment options. Stabilization for the addict is paramount. Thus, the treatment journey is approached with preconceived notions, lack of/too much information, and skepticism. Everything is the same in the eyes of the caregiver. They need a trusted resource.

INSIGHT #3: Rock bottom is not a singular, defined event, and it means something different to everyone. Not every rock bottom is a point in time where the addict decides "it's time to get clean", but it is a time when messaging has the greatest opportunity to break-through to the caregiver. Life changing events (i.e. emergency room, incarceration, divorce, etc.) are where caregivers are most receptive and likely to take action.

INSIGHT #4: Caregivers need treatment, too. Caregivers often don't seek help for themselves. Their lives are redefined and taken over by addiction. They become so focused on alleviating guilt and surviving the chaos that they often ignore their own needs. This chaos can cloud their minds so much that it becomes a barrier to them seeking out solutions. Caregivers benefit from the stories and experiences of those who come before them. Addiction is a spectator sport – until it happens to you.

Armed with four strategic insights as our creative pillars, we were able to conduct a number of workshops, each with a different audience and outcome in mind. Based on the outputs of the workshops, we crafted brand messaging specific to caregivers, tools to help move them from awareness to sale to advocacy, and lay the groundwork for a year-over-year marketing approach.

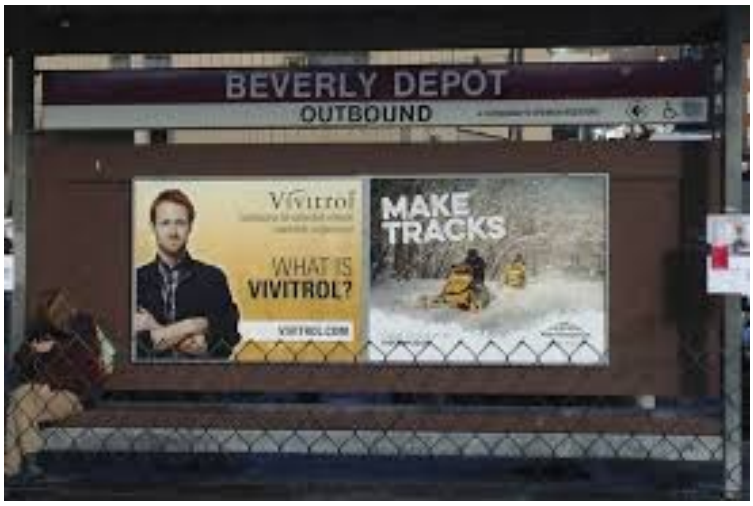
OUTCOMES AND NEXT STEPS

As a result of the research, our team was able to work with the client to developed several caregiver pilot programs in hopes of reaching the caregiver audience and driving more patients to trial. Based on our findings, we worked across multiple marketing, brand, and distribution teams within their organization to craft a three-year roadmap and marketing ecosystem reflecting all of their existing and future message delivery channels. All of this would strategically lift incremental brand awareness, market penetration, and sales. The caregiver initiative has centered on three basic areas: content, search, and support programs. Caregiver content was developed to fall into three overarching categories: Inform, Support, Readiness. "Inform" was designed to begin with brief, pithy video and text that called out specific addiction myths and countered them. As users interact with the content they are provided with richer, more detail material about treatment types, addiction as a disease, and

specific details about VIVITROL. We also included infographics and gamification elements (e.g. quizzes) to keep users activiely engaged. "Support" content included user-generated content and secure, online support groups where caregivers could interact, share their experiences, and seek advice. This content was curated with the intent of giving users a sense of ownership and long-term connection to the brand. Finally, "Readiness" content focused on helping caregivers determine were they and the addict were in the addiction recovery process and how the company might help move them along the path at a quicker pace and with a higher rate of success. Because relapse is the norm and addicts average five attempts before breaking free of the addiction, our goal was to help people determine 1) if abstinence was a likely outcome, 2) what barriers stood in the way, and 3) what treatment type would be most likely work. Once a caregiver completed the assessment, he/she would be directed to a physician locator and/or treatment program that would reflect the addict's and caregiver's needs.

The new content has been a great success. Site traffic has doubled, inquiries about medication access have grown by 30%, and prescriptions have increased by 9%. Additionally, shares of caregiver-focused content in social media has been over 200% great than was initially projected and organic search traffic has nearly tripled. Rather than focusing exclusively on doctors and patients (or potential patients), the content is designed to help caregivers find resources (doctors, lawyers, and support groups) that will help them. The majority of the content centers on psychological and social needs of this group rather than treatment and the results have been extremely positive. In addition to impacting the bottom line, caregiver dialog on the site has grown to over 2000 participants and referrals to support groups has become the number two activity after learning about where to get access to the medication.

Caregiver paid search has taken center stage. By recognizing that caregivers are frequently the driving force behind treatment management, VIVITROL has been able to tailor their messaging to caregivers at different stages of the addiction cycle, the number of times the addict has been in treatment, and the catalyst for seeking treatment (e.g. arrest, hospitalization, or intervention).



Caregiver support programs were tailored to the cultural norms and access to treatment of specific regions. So, the Boston area, for example, is designed around the fact that the criminal justice system is now focused on addiction treatment, has greater access to public transportation, and has a higher percentage of doctors trained specifically in addiction treatment. Southern Ohio, by contrast, tends to lack the support systems needed to ensure access to care, has a criminal justice system based on punishment and release, and has fewer HCPs trained in addiction treatment. For much of the Southeast, drug sales are a significant income, the result being that in addition to addressing the problems of addiction, we had to design content and messaging that acknowledged we putting some people out of business. Based on region language, economics, how drugs treatment was perceived, etc. we developed a strategy that applied a two-pronged approach – national marketing focused on the benefits of the drug in terms of case management and relapse prevention, and guerilla-esque marketing that was tailored to eight regional plans (New England, Midwest rust belt, Southeast, Central states, Northwest, California, Southwest, Atlantic states). The result is that's each program is adaptable to the process of addiction treatment per the area and the specific obstacles caregivers encounter in each.

CONCLUSIONS

Going forward, we will be working with VIVITROL to refine marketing and advertising based on how the medication performs in the market. We also anticipate doing further research, qualitative and quantitative, to gain a deeper understanding of addiction, the roles of the people involved in its treatment and management, and how to address the subtle challenges of treatment messaging. Based on the data the client will be able to measure the successes and shortcomings of both individual campaigns and the long-term strategy of the VIVITROL marketing efforts.

Gavin Johnston has over 19 years brand consulting, strategic planning, and consumer research experience, with 16+ years experience in digital research & planning. His expertise lies in uncovering insights for strategic cross-channel marketing and design applications. He has conducted research and strategic development projects for a broad range of clients including Bayer, Chrysler, Ford, Kellogg's, American Century, Kashi, Gatorade, GSK, Kimberly-Clark, Edward Jones, SAP, Cars.com, MillerCoors Brewing, H&R Block, Hostess, Eli Lilly, Motorola and Sprint.

REFERENCES

Carr, E. Summerson
2012 Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety. Princeton University Press. Princeton, NJ.

Faupel, Charles, Greg Weaver, and Jay Corzine
2014 The Sociology of American Drug Use. Oxford University Press. Oxford, UK.

Ksir, Charles and Oakley Ray
2012 Drugs, Society, and Human Behavior. Charles Kris and Oakley Ray. McGraw Hill. NY, NY.

Munafo, Marcus
2006 Cognition and Addiction. Sage. London. UK.

Page, Bryan
2010 Comprehending Drug Use: Ethnographic Research at the Social Margins. Routlage. NY, NY.

Raikhel, Eugene and William Garriot
2013 Addiction Trajectories. Duke University Press. Durham and London, UK.

Shaffer, Koetzle and LJ Hartman
2011 "Outcomes Among Drug Court Participants: Does Drug of Choice Matter." *International Journal of Offender Therapy and Comparative Criminology.*

Yardley, Tom
2012 Why We Take Drugs: Seeking Excess and Communion in the Modern World. Routlage. NY, NY