They were distant, disposable, or similar: why drug users discuss hurtful topics with people they do not consider close

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Abstract. A large and growing body of literature has examined the social networks of drug users. For at least 30 years, researchers who study abstinence have argued that 'close' people can provide support to drug users seeking soberness. Nevertheless, these researchers have consistently ignored the support that people who are not close, i.e., weak ties, can provide. Weak ties can listen to drug users vent without judging or patronizing them. Thus, weak ties can strongly support drug users. Based on seven months of fieldwork at New Beginnings, a sober living home in Chicago, I found that drug users do not share hurtful topics in detail with people they consider close. The findings indicate that the discussion network includes fleeting friends and fleeting partners, health professionals, strangers, and distant people with whom they shared common characteristics. I examine the topics that participants consider hurtful and why they approached weak ties to talk about them. Highlighting the reasons participants disclose hurtful information, I present three theoretical perspectives that focus on the conditions that shape how drug users identify with whom to share and under what conditions. Findings suggest that drug users disclose hurtful information with non-close people because it is less risky, because they are not halted by alters, and because they do not have a long-standing relationship with alters. Results are consistent with recent findings on the nature of weak ties and open the discussion to new perspectives in rehabilitation strategies.

Keywords: Support networks · Drug Use · Weak Ties · Hurtful topics

1 Introduction

"Social networks" has been one of the most important and widely-used approaches to the study of substance use over the past thirty years (Panebianco et al., 2016). A social network approach focuses on the relationship individuals have with others and how that relationship shapes their drug-using behaviors. The social network approach has allowed researchers to study concepts as different as social support, stigma (Birtel et al., 2017), neighbor characteristics (Van den Berg and Timmermans, 2015), social capital (Inkpen and Tsang, 2005), and changes in personal networks (Min et al., 2013). In particular, 'social support' or the "cognitive appraisal of being reliably connected to others" (Barrera

1986, pg. 416; the definition was used by Polcin and Korcha 2017), has been widely considered one of the most important aspects of abstinence.

A possible explanation for the widespread use of the concept of social support is that it has allowed researchers to study abstinence as a multidimensional phenomenon. Brooks et al. (2017) have found at least five different types of social support among severe alcohol users. Social support has proven to promote abstinence-related self-efficacy (Stevens et al., 2015), to be negatively associated with relapse (Panebianco et al., 2016), and to help both men and women to abstain (Jason et al., 2007). And at the same time, with support from others, individuals can obtain money to buy drugs, information to purchase, or a place to consume (Panebianco et al., 2016). Thus social support can help or hinder recovery efforts depending on social, contextual, and behavioral factors (Brooks et al., 2017). In other words, the existence of social support or lack thereof social support shows a complex scenario that has allowed scientists to understand why people relapse after completing a rehabilitation program.

While drug abuse studies have focused on the effects, positive and negative, that social support has, they have assumed that primary networks, or people who are 'close' to the drug abuser, are their primary source of social support. Consequently, they have explored what strong ties can do to help or hinder recovery efforts.

Early authors as Gordon and Zrull (1991) were clear in their belief that networks of "close" people would support drug abusers. As the author points, "The approach of networks makes it possible to specify the people who are meaningful, important, and potentially influential for the patient" (Gordon and Zrull, 1991, pg. 143). This understanding of social support seems to have remained consistent since the 1990s. However, researchers have paid scarce attention to the support provided by weak ties, i.e. people who are not close to the drug user. Moreover, documented evidence does not confirm the view that close ties are more supportive than weak ties. Weak ties, or people who are not close to the drug user, have been consistently overlooked as a source of support.

As I discuss in this paper, other literature suggests that weak ties can be supportive (see Small, 2017; Desmond, 2012). Weakly tied individuals are more prone to listen to the drug user disclose stressors, thus making the drug user feel understood and supported. In fact, when it comes to talking about deeply hurtful topics, drug users seem to regularly confide in people to whom they are not close. In other words, drug users might be supported by a set of people who they do not consider close –which undermines the scholarly assumption that strong ties are the main source of support for drug users. Venting has been theorized as one of the most important components of soberness by mainstream rehabilitation programs in the US. And yet, we do not yet accurately know with whom drug users vent about issues that hurt them most. My thesis, thus, suggests that drug abuse literature is missing an important aspect of social support networks.

The present study is driven by a simple question, with whom do drug users talk about hurtful topics, and why? I suggest that examining the process through which drug users approach others to discuss hurtful topics leads to an alternative

conclusion about the composition of support networks. I propose that drug users are more prone to discuss hurtful topics with people they do not consider close because the stakes of the conversation are low. When talking to weakly tied people, drug users are at lesser risk of being scolded or patronized by others. As this paper suggests, close people actively discouraged users from talking about hurtful topics. In this case, the networks of social support of drug users were not composed by close people.

In what follows, I discuss three theoretical perspectives on what close people represent. One traditional perspective used by substance use literature. A second perspective on weak ties that I derive from other existing research. And a third perspective on the nature of discourses of hurt among drug users. After generating hypotheses, I discuss the data I produced during fieldwork and draw some conclusions out of it.

Methodologically, the present study mirrors the mode of argument that Small (2013) used to study discussion networks. Instead of employing a survey and a quantitative approach, as Small did, this study relies on qualitative data and an ethnographic approach. I decided to mirror Small's mode of argument because it generates a set of hypotheses about the talking behaviors of participants. Producing hypotheses proved to be fruitful to understand with whom and why drug users talk about hurtful topics. Small's approach allowed me to challenge notions of support in drug use literature. Between February and July 2019, I studied the lives of members of New Beginnings North, a sober living house for men in the north side of Chicago. I draw from 8 interviews with its members that I performed in the house, my observations of in-house meetings, and from an interview with a drug counselor. I found that participants did not rely on close networks to talk in detail about hurtful topics. Weak ties, on the contrary, did not scold or help participants and encouraged them to share. Furthermore, expectations of trauma discouraged participants from venting hurtful topics in spaces designed to discuss them[1]. After the analysis of the findings, I conclude by presenting an alternative approach to the study of support among drug users that focuses on weak ties. I also call for greater attention to how scholars theorize social support, trauma, and social connection. Finally, I open the discussion to new perspectives on rehabilitation strategies.

In what follows, I discuss three theoretical perspectives on what close people represent. One traditional perspective used by substance use literature. A second perspective on weak ties that I derive from other existing research. And a third perspective on the nature of discourses of hurt among drug users.

[1] It is important to bear in mind the possible bias in the language used in this thesis. As the reader will notice, I refer to vent as a need. The word need implies that the drug user should disclose hurtful topics to achieve some wellbeing. And while I present evidence that suggests that venting is intrinsically positive, the discussion of what wellbeing means is outside of the scope of this work. To argue for the positive effects of venting, I can only rely on the reports of participants. And as I came to realize after private conversations with professor Summerson Carr, reports of drug users are scripted by discourses of addiction.

2 Theoretical perspectives

Social support studies have extensively used instruments as the Important People Inventory (IPA) (Zywiak et al., 2009). The IPA asks for network members who are partners, friends, family, members of self-help groups, people at work, and other important people. Then, it asks the participant, "Who, if anyone, on this list would you consider to be your primary relationship?" (Allen and Wilson, 2003, pg. 437). After that, participants describe the relationship they have with important people. Participants indicate if network members consume alcohol, if they consume with network members, if network members support their sobriety, and other questions related to support of sobriety. Designers of the IPA might believe that the questionnaire will elicit ego's [2] ties of social support. In what follows, I discuss the theoretical foundations behind that perspective and discuss one alternative based on research about weak ties.

2.1 Close ties as a source of support for drug users

Many researchers who study networks of support among drug users believe that close ties are the primary (and sometimes only) source of support. This view is influenced by seminal works on the nature of social networks. Granovetter's "The strength of weak ties" (1977) indicates that ego's networks are primarily composed of strong ties. Ego shares an identity and spends time with these strong ties, allowing for emotional attachment. Ego can easily connect with other ties (friends of friends) who also share a somewhat similar identity. Strong connections enable people to support each other and provide resources when needed. In the same vein, Ell (1984) argues that networks of support are crucial in positive health outcomes and suggests that supportive networks are small. "However, access to social network resources does not ensure that individuals will be supported. On the contrary, research shows that only a few network relationships are significantly supportive" (Ell, 1984, pg. 134). Thus, for both Granovetter and Ell, the networks of support are expected to be composed of people who are close or who share an emotional relationship with ego.

This perspective can be seen in the intention behind some early works. For their study on networks of recovery, Gordon and Zrull (1991) used the Pattison Psychosocial Inventory. Patients were asked to list those who were important to them at the time of the interview. Gordon and Zrull (1991) explains the motivation behind the approach:

In the 1970s, mental health practitioners grew aware of the potential for support from the "personal" or "core" social network. These networks are composed of people who have intimate relationships with an individual, who may effect the quality of life, who may offer support or prove a deleterious influence (Gordon and Zrull, 1991, pg. 144).

Other early works also consider social support of close networks. El-Bassel et al. (1998) examined networks of support as people who were close to the

[2] This thesis describes an individual who has networks as ego. And the people who compose those networks as alters

individual. Participants named contacts with whom they had frequent contact during the last three months. As El-Bassel et al. (1998) points, "Respondents were encouraged to provide as many names as they wished; however, we selected only the first five kin and five nonkin contacts for more detailed analyses" (El-Bassel et al., 1998, pg. 383).

Later authors adopt the same perspective. Beattie and Longabaugh indicate that "Support, particularly from an intimate relationship, has direct effects on health and well-being" (1999, pg. 593). Just as Ell (1984), the work that Beattie and Longabaugh (1999) cites, only considers close relationships as a source of support. Additional recent works are framed in a social networks perspective but only ask for close people. Tracy et al. (2010) asked 86 women in substance abuse treatment to list network members and asses support. Best et al. (2012) asked 176 former illicit drug users and drinkers to list up to 5 people for each of three types of support. For Beattie and Longabaugh (1999), Tracy et al. (2010), and Best et al. (2012), the measures of support are multidimensional and reflect a complex and long relationship between ego and alter. Participants were not expected to report weak ties.

Furthermore, many later studies use the IPA to study networks of support (Among these Davis and Jason 2005; Jason et al. 2007; Zywiak et al. 2009; Stevens et al. 2015; Zywiak et al. 2002; Manuel et al. 2007). As noted by Zywiak et al. "A strength of the IPA is that it assesses many different aspects of social support that may be important in substance use recovery and assesses them over a wide range of relationships" (2009, pg. 322). As argued by Zywiak et al., the IPA has proven to be widely successful[3].

In sum, many researchers believe that close ties are the primary source of support for drug users. Researchers who study emotional support in particular also seem to assume that close ties are the most supportive. As Lewandowski and Hill indicate, "Women who are heavily drug-involved generally identify parents and partners as their major providers of practical help and advice." (2009, pg. 2). However, the studies (Lewandowski and Hill, 2009) cites to back their claim only show that drug users rely on parents and partners for emotional support. But the studies do not show that partners and parents provide more support than other, different, ties.

Research on health discussion partners is consistent with the perspective of close ties as a source of support. Severe alcohol users report that they value close ties to maintain sobriety (Brooks et al., 2017). As Brooks et al. points, "Participants mentioned cutting off ties with friends who were actively drinking and re-building connections with individuals including family who would be more supportive to them being sober" (2017, pg. 2). Among non-drug users, ego prefers close ties to discuss stigmatized topics. Perry and Pescosolido (2015) has shown

[3] At least three studies that involved considerable resources used the IPA. The project MATCH (1993), the project COMBINE (Pettinati et al., 2006), and the United Kingdom Alcohol Treatment Trial (Ukatt, 2001) have yielded a variety of significant research findings. Nonetheless, these studies do not discuss models of network composition that justify the usage of the IPA.

that patients diagnosed with either depression or schizophrenia were more prone to discuss health with mothers and partners.

The assumption that close ties are the main source of support for drug users can be stated as a hypothesis. When it comes to talking about hurtful topics, drug users will rely on those who they consider close. They will trust these sensitive and hard to talk issues to only a handful of intimate people. As mentioned before, the hypotheses are general guidelines that allow us to map important attitudes and behaviors among drug users. Therefore, we can suggest:

Hypothesis 1: Drug users will tend to discuss hurtful topics with people they consider close.

While the expectation that close ties are the most supportive is widely assumed, it has not been consistently tested.

2.2 Weak ties as a source of support for drug users

I introduce one alternative model under which the networks of social support of a drug user are not necessarily composed of ego's closest ties. The alternative proposes that venting hurtful topics is a type of social support. Under the scope of this perspective, people who listen to drug users vent are supporting them because venting has been considered to have intrinsic positive effects for well-being (Tamir and Mitchell, 2012). The alternative conceives the network of social support as a realization of the process of discussing hurtful topics. And not as an inherently meaningful structure of relations. In other words, the discussion network is only composed of alters with whom users had meaningful conversations about hurtful topics. It is not composed of possible discussion partners that already share a relationship with ego, although actual discussion partners might indeed have a long-standing relationship with ego. Under this perspective, the networks of social support are the set of actors with which ego discusses hurtful topics. Hurtful topics are a set of conversation topics that are particularly hard to disclose for the user. Users are at risk of engaging in fraught discussions when disclosing these hurtful topics. For these reasons, the key to understanding networks of support is to examine the process through which ego decides to share.

The problem with the perspective is that interviewees are often forgetful and report an inaccurate set of ties (Marsden, 1990). Consequently, this study does not set to accurately map the discussion network of participants. Rather, it sets to answer why drug users pick some people over others to talk about hurtful topics. This study is justified by the critical importance of hurtful topics. Disclosing these topics carries a big risk. Users can engage in fraught discussions that might worsen an already unstable life. But it also offers a big reward. In some cases, venting can help to initiate a period of sobriety for drug users (Gramsch-Calvo, 2018).

Research relevant to this process arises from health disclosure literature and recent research on weak ties as a source of support. Researchers have studied

with whom and why people disclose HIV status and traumatic experiences. Both of these topics are considered stigmatized and hard to talk about. As well, recent sociological literature has argued that people constantly rely on weak ties when they need support. In particular, the work of Small (2017; 2016; 2015; 2013) focuses on the networks with whom ego discusses important matters.The work of Desmond (2012) focuses on how the urban poor constantly rely on disposable ties to survive. While studies on HIV and trauma disclosure have not focused specifically on studying the strength of ties, they offer insight that can inform drug user's talking behaviors. Moreover, Small and Desmond both offer models of support that can be a useful starting point.

Venting networks among drug users While Small (2017) and Desmond (2012) study different social phenomena, they share the idea that actors will seek help from those who are not close to them. In the right occasions, actors will specifically seek help in weak ties. Small (2017) shows that graduate students tend to rely on people not listed as confidants to vent debilitating stressors. Students vented to individuals who shared empathy for the specific stressor they needed to vent. Small suggests that ego discusses important matters with non-important alters because they are known to be knowledgeable and because they are available when the issue arises (Small et al., 2015). On a similar note, Desmond (2012) shows that poor urban evicted people rely heavily on new acquaintances instead of kinship networks. These 'disposable' ties facilitated valuable resources that allowed families to make it through the day. Desmond indicates that there is mounting evidence against the saliency of kin support among the urban poor. The work of Small and Desmond both question the idea that close networks are the primary source of support of people in need.

From this focus on weak ties as a source of support, an alternative to the strong ties perspective can be derived. Drug users would seek people who they do not consider close to discuss hurtful matters. By extension, the discussion network would be the network that results from the process of finding and talking topics that drug users find hurtful. The discussion networks are independent of the emotional attachment they feel with alter. For example, a drug user will confide stressors to alters in an Alcoholics Anonymous meeting without necessarily knowing these alters. My undergraduate research provides evidence consistent with the idea that drug users seek non-close alters to discuss hurtful topics. I interviewed a small cohort of Chilean drug users who reported that they do not disclose 'deep topics' to people they considered 'close' (Gramsch-Calvo, 2018). The interviewees engaged in stressful conversations with family and friends when they tried to talk about deep topics. The people who interviewees considered close, shamed and judged the interviewees when they tried to talk. Particularly during the period in which they consumed the most, these drug users felt as if their networks discouraged them from sharing hurtful experiences. Interestingly, they would talk in consuming contexts while high. Other literature indicates that women drug users describe family members as offering less emotional support for healing from trauma than friends (Savage and Russell, 2005). Savage

and Russell (2005) call for caution to consider women's existing social support networks to help heal trauma.

Moreover, research on health discussion partners supports the weak ties perspective. Literature suggests that ego will disclose intimate or stigmatized information to those with similar characteristics (known as the homophily principle). That is, to the extent drug users find drug use topics hurtful, they will consistently talk to other drug users about it. Small (2013) has proposed that ego mobilizes networks to share stressors when they are known to be knowledgeable in the discussion topic. Shelley et al. (2006) found that seropositive people tend to disclose HIV status to people with similar characteristics to protect them from infection. Shelley et al. (2006) also found that the frequency of contact was not a significant predictor of HIV disclosure. I.e., participants would not share with old family members or friends.

This perspective leads to two different but associated hypotheses.

Hypothesis 2.1: Drug users will tend to discuss hurtful topics with people they do not consider close.

Hypothesis 2.2: Drug users will tend to discuss hurtful topics with people who share similar characteristics.

It is important to mention that these hypotheses do not contradict each other, but they do stand in opposition to the strong ties perspective.

Finally, trauma literature and stigma literature suggest two additional predictions. The topics drug users consider hurtful may be related to trauma. Saunders et al. (2015) argue that there is a plethora of evidence that reports that post-traumatic stress disorder (PTSD) is prevalent among people with substance use disorders among the general population[4]. As (Saunders et al., 2015) argue, drug users might witness or experience trauma while engaging in activities such as obtaining, dealing, using, or withdrawing from cocaine use. Drug use, therefore, contributes to the development of PTSD. If trauma is as ubiquitous as described by the literature, drug users will probably need to vent about it.

Furthermore, drug addiction might be among the most stigmatized behaviours in western societies today (Pokrajac et al., 2017; Feldman and Crandall, 2007). Singer and Page (2014) have shown that, as a general cultural narrative in the US, drug addicts have been historically depicted as a 'useless' group and as a natural target of discrimination. Stigma on mental illness, including addiction, can cause family discord, job discrimination, and social rejection (Feldman and Crandall, 2007; Lefley, 1989). Drug users might feel particularly judged if they are currently consuming. To test this idea, I introduce the concept of the Period of Most Consumption (PMC). The PMC is the period in which drug users believe they are consuming the most. As I have shown in other works (Gramsch-

[4] Other literature suggest that it is even more prevalent in treatment settings. See Helzer et al. (1987); Kessler et al. (1995, 1996); Brady et al. (2004); Johnson et al. (2010); Farley et al. (2004)

Calvo, 2018), the PMC is a period in which drug users are especially silent about hurtful or traumatic issues. As users indicate, it is a period in which they do not trust alters. If drug users are sober in the present, the PMC will allow me to compare the talking behaviors of users while they were consuming and while they are not consuming. It is possible that drug consumption is the factor that makes them silent, and not the relationship they have with close people. The PMC will allow me to test that idea[5].

Literature on trauma and the concept of PMC allows me to generate two new hypotheses.

H3.1: Hurtful topics among drug users will refer to trauma.

H3.2: Drug users will not disclose hurtful topics during PMC.

2.3 Scripted venting

Finally, I introduce a third perspective that follows from a critique of the therapeutic practices of mainstream American addiction treatment. This critique derives from "Scripting Addiction: The Politics of Therapeutic Language" (Carr, 2010). Carr critiques the highly ritualized world of American addiction treatment, which evaluates 'healthy' talk as a sign of therapeutic progress. As long as patients use the language of 'inner reference' specialists consider them closer to rehabilitation. The language of inner reference abides by the principles of Honesty, Openness, and Willingness. According to specialists, the addicted speech is filled with a thick layer of denial, anger, and shame that prevents patients to access their inner or sober truth. Carr argues that patients are prone to 'flip the script' and utilize healthy language to obtain benefits such as shelter, food, and child custody.

Carr (2010) has articulated an argument that can be used to generate an alternative to the network's perspective. As noted by Carr, some drug users deceive rehabilitation specialists by talking about 'exactly what they want to hear' – as noted by one of Carr's interviews (Carr, 2010, pg. 191). An alternative to

[5] Footnote: There is evidence supporting that individuals with PTSD are less likely to disclose traumatic events than non-traumatic events (Ullman, 2012). Greater detail in trauma disclosure predicts better emotional processing, but it also leads to adverse reactions against the discloser (Ullman, 2012). Individuals with PTSD show more interpersonal sensitivity, feelings of inferiority, and feelings of self-deprecation (Southwick et al., 2000). They tend to avoid disclosing trauma because they might get shamed or criticized for it. Bedard-Gilligan et al. (2012) have shown that individuals with PTSD report more difficulties to disclose trauma and positive experiences than both non-PTSD individuals and non-trauma-exposed individuals. While individuals with PTSD disclosed as much and as detailed than those without PTSD, events of a sexual nature and childhood assaults predicted more difficulty with disclosure because of a more significant stigma of these topics (Bedard-Gilligan et al., 2012). Trauma and stigma might work together to make addicts especially reserved and unable to share hurtful topics.

the network's of support model is that drug users flip the script when venting hurtful topics. They might talk about things that are hurtful without having emotionally meaningful discussions. In that case, networks would not be emotionally supporting a drug user venting, as venting is utilized for other material or economical purposes. In that case, the discussion networks expect certain behaviors from the drug user. Thus discussion networks might script the way drug users vent about hurtful topics. This perspective can be summarized in the following hypothesis.

H4: Venting will be scripted by discourses of addiction.

Note that this hypothesis does not stand in opposition to the networks' perspective. Rather, it allows us to remain critical in front of the idea that venting stressors is always positive for the drug user.

Table 1: List of Hypotheses

H 1	Drug users will tend to discuss hurtful topics with people they consider close
H 2.1	Drug users will tend to discuss hurtful topics with people they do not consider close
H 2.2	Drug users will tend to discuss hurtful topics with people who share similar characteristics
H 3.1	Hurtful topics among drug users will refer to trauma
H 3.2	Drug users will not disclose hurtful topics during PMC
H. 4	Venting will be scripted by discourses of addiction

3 Data

Addressing these questions requires an original questionnaire and observations that explore the venting preferences of drug users. These must measure who are the close alters of the drug user and how they talk about hurtful topics. Additionally, the instrument must measure the topic of venting and the venting preferences during PMC and the present. The observations must capture how drug users behave in contexts in which they talk about hurtful topics.

To fulfill the requirements, I produced a novel interview guide and decided to do fieldwork in a sober living home. Broadly, the interview guide asked for trauma, venting networks during PCM, venting networks during the present, and interviewee characteristics. The study was carried in New Beginnings North, a sober living home located in Edgewater a low criminality neighborhood in the northside of Chicago. There, I applied the interview guide to 7 members of the house and participated in 8 in house 12-step meetings. As recommended by one of my interviewees I also interviewed a drug counselor called Beth. The study was approved by the IRB at the University of Chicago.

I met participants by asking the manager to mention my study during in house meetings. I called those who were interested in participating and met some personally. As I was going more to New Beginnings, I was better known

by residents. I participated in in-house 12 step meetings, learned about the weekly drug tests, and had several conversations with the manager. As I got more involved, I started talking with some members about topics outside the scope of the study. These conversations are interesting and allowed for a richer interpretation showed in the results. I finished fieldwork in July 2019, when I considered I had enough data to process.

I interviewed 7 members of the house during the span of the field-work, all of whom were men. The interviews were semistructured, around 1 hour long, and held in the house. To start, I asked participants questions that referred to their childhood. Then I asked for the PMC. Participants narrated the important events that lead to PMC. I asked for the people who were close during PMC. In the second part of the interview, I asked if they had experienced trauma. If not, I asked for other deeply hurtful experiences. Then, I asked if they shared those experiences during PMC. In the third section, I asked about close people in the present and whether or not they talk hurtful topics. To close the interview, I invited the participants to share their thoughts and asked for demographics.

In the results, I will present my analysis of the observations and interviews. Following a procedure proposed by Freeman (2016), I categorize the interviewee's narratives and draw conclusions from those categories. To present the results, I show who are the participants and what are their life trajectories. I then present how their narratives seem to support some hypotheses over others.

The reasons to pick New Beginnings and its characteristics require further clarification. I have picked a sober living environment to make sure drug users are currently sober and not living the PMC. That way I can discern if the talking behaviors are explained by consumption or not. Furthermore, New Beginnings might provide members with a set of alters with whom to talk about hurtful topics[6]. New Beginnings North is composed of males over 18 who are asked to remain sober, complete in-house tasks, and help new members to find 12 step meetings. Members pay around $700 per month and stay in shared bedrooms. They must complete urine drug tests every two weeks and test positive to remain in the house.

New Beginnings North hosts 12-step meetings twice a week. 12-step meetings follow the traditional Alcoholics Anonymous (AA) model. This consists of 12 steps and 12 traditions to recovery that promote a culture of honesty regarding drug use. During New Beginnings in-house meetings, in which the manager does not participate, a guest speaker who has experience with the 12 step model is invited to talk about sobriety or the program. Participants can share their thoughts once the speaker is over. Members of New Beginnings are encouraged to attend the meetings but are not mandated to do so. Finally, New Beginnings actively promotes members to have a sponsor, an experienced guide who can help the member complete the 12 steps.

In what follows, I will argue that comparing networks of important people to networks of actual discussion elucidates why drug users prefer to vent with

[6] Among literature covering the effect of rehab homes Stevens et al. (2015); Kirst (2009); Spohr et al. (2019); Min et al. (2013); Rice et al. (2011); Li et al. (2011)

weak ties. This supports the hypothesis that weak ties are a source of support for users.

4 Findings

I now present a summary of the participant's narrations and my observations. The summaries allow me to discuss who participant's considered close and why they talked about hurtful topics with non-important alters. Furthermore, it will let me discuss the prevalence of trauma and the importance of the Period of Most Consumption (PMC). Table 2 summarizes the narratives that directly inform the hypotheses. I will then discuss it's importance.

Table 2: List hypotheses informed by narratives

Participants	Casey	Matt	Dan	Sal	Kurt	Jack	AP	Beth	Meetings
H 1	■	■	■	■	■	■	■		
H 2.1	■	■	■	■	■	■	■		
H 2.2	■	■	■		■	■	■		
H 3.1	■	■	■	■	■	■	■		
H 3.2	■	■	■	■	■	■	■		
H. 4		■		■		■		■	■

4.1 Narratives

In March of 2019, the manager of New Beginnings North sent me the number of Casey, a house member interested in interviewing. I contacted Casey and a week later I went to New Beginnings to interview him. From there on, I interviewed the rest of the participants, participated in house AA meetings, and met Beth. The full list of participant's characteristics is presented in the table showed below.

	Casey	Matt	Dan	Sal	Kurt	Jack	AP
Age	44	45	38	48	65	21	35
Drugs consumed during PMC	Alcohol, Ghb, 'k', crystal Meth, cocaine	Alcohol	Heroin	Heroin, Xanax	Alcohol	Marijuana, Alcohol, Lsd, Mushrooms, Cocaine, Benzos, Methamphetamine, Adderall	Alcohol
Frequency of consumption	Daily	Sporadic, between 1 and 4 times a week	Daily, every 8 hours	Daily, "several times a day"	One to two pints of liquor		A bottle of liquor daily
Reported race	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian
Religious preference	"In search of"	Christian, Lutheran	None	Atheist	Agnostic	Catholic	Raised Christian, no practice
Sexual orientation	Gay	Hetero-sexual	Hetero-sexual	Hetero-sexual	Hetero-sexual	Hetero-sexual	Hetero-sexual
Current prescribed medications	Fluoxetine, hydroxyzine, Mirtazepine, Truvada	None	Suboxone	Seroquel, suboxone, by-meds	None	None	Anti-depressants
Reported last date of consumption	2 years ago	5 months ago	2 year ago	1 year ago	4 days before interview	5 months ago	Not disclosed
Current occupation	Server	Broker	Salesman	Account executive	Retired	Air conditioner technician	Not disclosed
Occupation during PMC	Restaurant management, contributing writer for a magazine	Coach, office jobs	Carpenter	Bookie for his father	Bar owner, truck driver	Student	Not disclosed
Homeless period	Yes	No	No	No	No	No	No
Highest level of education	Graduated high school	Graduated bachelor	Graduated high school	College dropout	Bachelors' of art in journalism	College dropout	Not disclosed
Marital status during PMC	Had boyfriend, then single	Had girlfriend	Had girlfriend	Had girlfriend	Had girlfriend	Single	Had girlfriend
Marital Status in the present	Single	Engaged	Single	Single	Single	Single	Single

Casey I met Casey short after. Casey is a 44-year-old gay white male who was raised in a small town near Jackson, Michigan. There, he graduated from high school. Throughout his life, Casey consumed alcohol, Ghb, 'k,' crystal Meth, and cocaine. Today, Casey is taking Fluoxetine, hydroxyzine, Mirtazapine, and Truvada as prescribed medications. He is currently single and working as a server in a restaurant. At the time of the interview, he reported that his last consumption was nine months ago.

Casey had a sad childhood. His parents were abusive and provided little care for him. Even though he had a big family and his grandparents loved him unconditionally, he felt isolated. For Casey, it was hard to recall fond childhood memories. "I tried to commit suicide when I was five because I didn't want to be in that much pain for the rest of my life. I tried to hang myself. I was five and thank goodness it didn't, wasn't successful. The rope didn't hold". Throughout his life, Casey experienced physical violence from people who were close to him. As he narrated, Casey was attacked, molested, and demoted. Casey bore a strong emotional weigh from trauma. One which, later in life, he needed to vent. As hypothesis 3.1 suggests, drug users might indeed need to vent trauma related to highly upsetting experiences.

Casey consumed drugs from a very early age –his father made him smoke marijuana when he was 8. Throughout his upbringing, drug consumption escalated quickly until it was uncontrollable. From the age of 37 to 39, Casey consumed the most. During that time, Casey was abused by his ex-boyfriend. "I had a partner that was very physically and mentally abusive. He had dislocated my shoulder, broke three of my ribs, [put] cigarettes out of my face. Broke my middle finger, used to bite me, give me staples in my head." Casey tried to talk about the abuse he was experiencing, but his consumption friends halted him. "Some people just thought I was blowing out of proportion. A couple other people said, well that's what happens when two guys get together and drink [...]" The nature of the topic was not well received by the people Casey considered close. Friends thought the outcome of the relationship was evident and did not want to get involved in the situation. "I had people that said that they didn't want to hear it anymore and they were done with me and the relationship." Casey was also discouraged from talking about abuse with his boyfriend. Evidently, the perpetrator did not lend a sympathetic ear to Casey. Close people actively discouraged Casey from sharing hurtful topics, undermining the hypothesis that drug users target close people for disclosure.

Casey's boyfriend died short after. It was a very hurtful experience for Casey, which led him to even more consumption and to housing uncertainty. "Sometimes, I would have a roommate, they would make me sign a lease there [...] I was staying there for so long and not pay rent and they asked me to leave. And so I couched surf for a while. Then I was homeless." Casey depended on many people during this Period of Most Consumption (PMC). His old friends were brittle and cut ties shortly after they met. Besides his boyfriend, it is not clear who were the people close to Casey during the PMC. Regardless of the closeness of Casey's friends, Casey never shared hurtful topics during the PMC.

The topics he needed to share were too controversial, and the networks he could have mobilized were not suitable to listen. In his own words, Casey "internalized" hurtful topics. Hypothesis 3.2 is thus supported: the speedy and brittle life of PMC gave no conditions for Casey to talk.

Casey opened up for the first time in a 12-step meeting. "It came time to share and then all of a sudden it just started flowing out [...] And it just kept going and I was sobbing and I was in so much pain leading up to that that I didn't realize how much I needed this stuff out. I didn't realize exactly how broken I was until I started talking about it and then it just couldn't stop." That was the first time Casey talked in detail about abuse and homelessness. Shortly after, he shared for the first time his suicide attempt during childhood. Who were the ones at the meeting? Mostly strangers who Casey never met. He only knew one of the participants, an acquaintance who told Casey to come. After Casey was done venting, the acquaintance offered him a place to stay and helped him to get to a rehab home. Casey found a place to be heard and understood among strangers who lived similar experiences. Hypothesis 2.1 and 2.2 are thus supported. Non-close alters listened without judgment to Casey vent. They understood Casey's account because they experienced something similar and understand how important it is to talk about it.

Today, Casey is sober and has lost contact with all his past consuming friends. He managed to improve the relationship with his parents, who are now considered close. Furthermore, Casey feels close to friends from the house, people from support groups, and his AA sponsor. Since the first time he opened up, Casey has been able to tell many people that he was an addict. However, the level of detail of these conversations vary. Casey can talk about hurtful experiences in detail with his sponsor, but only "PG13" topics with his parents. "I'm completely open and honest with my sponsor [. . .] I try to protect them [parents] as much as I can, and I don't want them to know how hurt some of the things from the past have caused." Casey reserved the most hurtful topics for those who were not involved in those experiences. The most hurtful topics are reserved for AA members who share an identity, i.e., past drug use. This narration indirectly supports Hypothesis 2.1 and 2.2. Casey does not talk in detail with long-lasting close people. Instead, he can talk with newly acquired friends that he now considers close. Past drug use gives them a reason to help each other and share hurtful topics.

Matt After the interview, I organized a meeting with Matt, a 45-year-old straight white male who was raised in a small town in rural Indiana. Matt's drug of choice was alcohol and, during PMC, he would consume between 1 to 4 times a week. Today, he works as a broker, and he is engaged. At the time of the interview, he reported that his last consumption was five months ago.

Matt had a family of 7 growing up. They were sports-oriented, traveled, and never faced financial turmoil. In Matt's words, "I got the whole spectrum of life." Growing up, Matt's friends knew that he had a capability for sports and amiably eschewed him whenever they were smoking or drinking. The first hurtful

memory Matt recalls is her mother getting diagnosed with cancer and the later decease. "I was just 21, I was definitely a mommas boy, the baby of the family growing up. It was tough man. I was really resentful." During that period, Matt wanted to join the NFL. The pressure from the high sports standards and the death of his mother took a toll on Matt, who started drinking and smoking marijuana in College. With some hesitation, Matt defined losing his mother and later his father as traumatic. These events and isolation were hurtful topics Matt needed to talk about. Thus, hypothesis 3,1 is partially supported. Even though he hesitated, Matt's hurtful topics referred to the trauma of losing his parents.

Matt's PMC occurred around the 2008-2013 period. Matt remembers those years as turbulent: he had to find a job outside of football, and his father was diagnosed with cancer. During PMC, Matt had drinking friends and an ex-girlfriend. These people fulfilled the role of friends for short bursts of time and would then leave Matt's life for good. With his friends, Matt never shared hurtful topics "It would start [the conversation] 'hey, what's up bro? You good?' Yeah, yeah [...] I didn't want to show that vulnerability we're not allowed to show as men." Contrarily, Matt indeed shared stressful topics with his girlfriend. However, he never felt understood, and their conversations ended in fraught discussions. Matt's close people during PMC closely resemble what Desmond (2012) called "disposable" ties. According to Desmond (2012), the urban poor regularly rely on fleeting people with whom they have an intense exchange of resources and emotional support. These ties are quickly disposed of after the exchange, hence the name disposable. Matt's friends and girlfriend were brittle and lost all contact after their interactions, just as disposable ties described by Desmond. Hypothesis 2.1 is thus supported. Matt would talk only with a fleeting tie, his ex-girlfriend, who was then disposed.

During PMC, Matt conserved his old friends from when he was young. They did not talk consistently and never shared hurtful topics. Matt also considered his brothers close, and he did not vent with them. He did not want to concern them. "They got kids, they got like... don't be concerned about me because you guys got other shit going on." When Matt's brother took the initiative and asked Matt about what was wrong, Matt diverted the conversation, "If anybody was like, 'hey how's it going?' You know, it was not like they put me on the spot, but I felt like I was put on the spot." Matt acted as if he was okay. Whether it was Matt not approaching close people or Matt stopping close people from asking, he did not share hurtful topics with them. Hypothesis 1 is thus undermined.

During PMC, Matt participated in AA meetings. He was never convinced "I just thought it was storytime in there. [...] You go in, you have a speaker 'Hey, I remember waking up in the garbage can and tarararah' and I'm like, this is not what I want. This is not what I need." The stories shared by AA members were repetitive and deeply traumatic. Matt did not feel adequate. His rather ideal childhood was too different from the stories shared in AA meetings. Matt felt he was expected to contribute to the conversation. But he had no memories that referred to the kind of trauma shared at meetings. Matt was discouraged from venting because he could not share those narrations. That is to say, the

expectations of talking about trauma scripted Matt's venting. As Hypothesis 4 suggests, drug users are expected to vent topics that refer to trauma in AA spaces. As discussed below, other observations further support this hypothesis. Furthermore, this narration indirectly supports Hypothesis 3.2. Matt did not identify with the rest of the members. He did not share because of was not among equals.

Matt's life stabilized in recent years. He started dating a woman who is now his fiancé. When they began dating exclusive, around a year and a half ago, Matt "poured it out" during a simple game of personal facts "One fact about oneself [such as] I had braces when I was 6". As they kept stating facts about themselves, Matt finally told her about his drinking and the pain of his deceased parents. In this unexpected scenario, Matt and his girlfriend created a strong bond of trust. It was the first time Matt shared in detail hurtful topics. Matt disclosed hurtful topics in detail with a weak bond that became strong. Indeed, Matt talked with someone considered close. But that person became close after disclosing hurtful topics. Just like Casey, Matt did not target longlasting close people to talk -undermining the assumption of H 1.

Dan After Casey, I set a meeting to interview Dan. Dan is a 38-year-old straight white male who was raised in Wisconsin. There, he completed Highschool education. Dan consumed Marijuana, Alcohol, Lsd, Mushrooms, Cocaine, Powder Cocaine, Crack Cocaine, Adderall, Vicodins, Opiates, Heroin, Ketamine, Meth, "anything I got my hands on I basically did abuse." During PMC, he consumed daily, and every 8 hours to "keep the sickness away." Today, he works as a salesman and is single. He is currently consuming Suboxone to reduce craving. At the time of the interview, he reported that he has been sober for two years.

Dan was raised by both of his parents and had two siblings. His father was a combat veteran from Vietnam who worked as a carpenter. His mother was a mail service carrier. Dan's family was sports-oriented, and Dan's friends were the "right crowd." His parents encouraged family activities, and they never experienced economic turmoil as a family. Dan was not exposed to drug use during his childhood and has plenty of fond memories from it. Dan started consuming in high school and "graduated rapidly" to heroin when he was 20 years old. By the age of 30, he consumed regularly. Around that time, Dan's father was sick and was expected to die soon. Dan's consumption spiked when his father passed away. "We were using heavily, smoking crack, using Adderall, things like that. And I just didn't care, you know, I was trying to bury the pain of my father passing away [. . .] I didn't really give a shit at all." Dan had a pleasant childhood free of hurtful experiences. And, even though his father's passing was hurtful, it was not traumatic. Contrarily to what Hypothesis 3.1 suggests, Dan's hurtful topics were not associated with trauma.

When his father passed away, Dan moved back to Wisconsin to live with his girlfriend. That is the period in which he consumed the most. During PMC, Dan felt close to his girlfriend, his mother, his father (until he passed), and his siblings. Dan never shared in detail the hurt of his father passing with close people. Dan

tried to talk to his girlfriend. However, she gave advise that Dan did not receive well. Dan's girlfriend was an ex-medic of the air-force who "went through a lot": the suicide of her first husband, the overdose of her second husband, the tragic death of a brother, and PTSD. Dan's girlfriend knew from experience how to handle a loss. She instructed Dan and pushed him to make amends with his father before his death. Ultimately, Dan was discouraged from talking about his father's death with his girlfriend. "I never brought it up [father's passing] like, hey, this is bothering me. What am I going to do? I knew what was happening. Look, right he is going to fucking die. And he knows it, shit. But she [girlfriend] would kind of like: 'look, this is how it's gonna go.' And she's there to support, I get it. But then it would turn into her telling me 'Oh, you should do this or you're going to regret it' like oh fuck, here we go again." Dan's girlfriend was the only person to hear part of what hurt Dan. Yet, Dan never shared in detail because he did not want the unnecessary advice of the patronizing girlfriend. Hypothesis 1 is thus undermined. Close people were not confidants of Dan's hurt.

Dan was incarcerated during PMC for producing a car accident, and his mother bailed him out under the condition that he would start treatment. With reproach, Dan accepted the deal. The initial reluctance transformed into acceptance as Dan realized that the rehabilitation center he attended did not shame him. He then moved to Chicago and has been living sober for two years in New Beginnings. Through his recovery journey, Dan did not talk in detail with other people about his father's passing. "Not really. Shit, I guess if people would have asked, because a lot of the family knew what I was doing as far as drugs. So a lot of them chose not to talk to me about anything really [...] I didn't really have an outlet to talk to about it, if someone asks me, sure we get into it. But no, I never really did [talk]. No." Dan's family knew Dan was a drug user and would not engage him to talk about important matters. They never asked Dan if there was something wrong. Not even Dan's mother, who showed comprehension and support, served as Dan's confidant. Hypothesis 3.2 is supported, Dan did not disclose hurtful topics during the PMC.

Now that he is sober, Dan feels close to some people in the house, his mother, and he remains friends with people he met during the recovery journey. Dan believes he can share about hurtful topics if he is adequately prompted. "I just figure if someone asked me about it, I'll tell them anything they want to know. But for me to like go up to someone and just announce all this shit. Why the fuck did they want to hear about this shit? But as someone asks me, I'll tell them anything they want to know." Has anyone asked Dan what hurts him? Probably not, as he is yet to share in detail hurtful topics. His narration does not properly inform Hypothesis 2.1 or Hypothesis 2.2. It is unknown if Dan has a propensity to share with distant people. All that it is known is that he faced several barriers that discouraged him from sharing with close people. Furthermore, this narration questions if H 3.2 is an appropriate hypothesis to study drug use. The talking behaviors of Dan did not change once the PMC was over, suggesting that drug use did not explain his silence. The talking behaviors

of Dan's family did not change either. Even though Dan is not consuming any longer, he has not approached anyone to talk. And one has prompted him to talk.

Sal Right after interviewing Dan, I met Sal and immediately interviewed him. Sal is a 48-year-old white heterosexual male who was raised in the suburbs of Chicago. He dropped out of college. Sal consumed mostly Heroin and Xanax to a lesser degree. During PMC, he consumed several times a day and worked as a bookie for his father. Today Sal is consuming Seroquel to sleep, suboxone for heroin withdrawal, and by-meds for ADHD. Sal is currently single, and his last consumption was around one year ago.

Sal's father was a bookmaker who made a living in organized crime. Nonetheless, Sal's childhood was far from violent or stressful. Sal was the only sibling raised by both parents. His parents, who were sometimes neglectful, gave him everything he needed. Sal went to a good school and had "normal" friends. In his own words, there was no physical abuse and no "overarching traumatic incident that I could look back to [that can] inform my addictive behavior." Sal brought the topic of trauma even though I did not ask for traumatic experiences, as if he was expecting me to be interested in trauma. Even though I was indeed interested in trauma, because the literature claims it is ubiquitous among drug users, I was surprised that Sal was quicker to cover the topic. Sal even correlated trauma with his addictive behavior, the exact issue I wanted to ask for. This narration shows that Sal expected to refer to trauma when talking about childhood. As I will cover later, other participants were also quick to mention trauma when narrating their non-traumatic childhood. Even though Hypothesis 4 is not directly supported, this narration shows that drug users are expected to have experienced trauma and that that expectation shapes their life narrations.

Later in life, Sal joined his father in the business of sports gambling. He graduated rapidly from pot to cocaine and finally to heroin. He was able to spend $100 to 300$ on heroin daily. Once the consumption picked, Sal left Chicago for Portland and tried to stay clean with his sister. He started a relationship with a medical student later surgeon. "It was like the Sid and Nancy playbook, and we fed each other's addictions." During that time, Sal's mild anxiety developed into stronger and almost daily panic attacks that he tried to "medicate" with heroin. Sal's intentions failed: he describes his period living in Portland as the PMC. During that time, he was close to his sister, two other siblings, and his girlfriend. Sal had a good relationship with his close people, even though he and his sister would get into each other's nerves from time to time. His girlfriend was a "highly functional heroin addict," and Sal had a high opinion of her, "we really enjoyed each other's company." At first, this narration seems to undermine Hypothesis 3.1, stating that hurtful topics will refer to trauma. It also seems to undermine Hypothesis 3.2, indicating that participants will not disclose hurtful topics during PMC. However, Sal's case is unusual. Sal was the only participant who had a somewhat pleasant PMC. There was nothing deeply hurtful that needed to be shared. Apart from the growing anxiety, Sal was in good company and genuinely

enjoyed being an addict. In Sal's case, high amounts of consumption were not necessarily associated with hurtful experiences and did not discourage sharing hurtful topics. Nonetheless, Sal then experienced a highly traumatic situation that he did not share with close people. Even though it did not happen during PMC, it led Sal to despise those around him and to consume heavily to numb the pain of living.

In 2008 Sal came back to Chicago to convince his mother to get into a managed care situation. Sal took care of his parents for three years. His mother had Alzheimer's, and his father had other several health issues. "That experience with my parents, oh my God, it was soul-searing, gut-wrenching agony." Sal's mother "slowly lost her mind, and the only part of her personality that still existed was her combativeness." Sal remembers waking up to the screams of his parents. And having to carry both parents through the stairs because they were too debilitated to walk. Sal's mother would be desperate for a meal she just ate. His father broke his hip. To withstand the situation, Sal consumed heroin heavily. Finally, Sal's mother was taken to a care house. Sal started a "cold" rehab and stayed three days in a hospital struggling against withdrawal. "I was thinking that it might be nice to just shoot dope until I died" Sal reminded me that he did not experience trauma as a child but that those three years with his parents were definitely traumatic. "I can say that that experience with my parents was emotionally wrenching. As difficult to live as anybody could ever be asked to endure. I cannot imagine how anything could hurt more than that did". The hurtful topics that Sal needed to vent indeed referred to trauma, thus supporting Hypothesis 3.1.

The time Sal lived with his parents can be considered a period of heavy consumption just as PMC. Even though Sal could not tell me accurately when he consumed the most, I asked him if he shared hurtful topics with close people. Sal did not share with parents, siblings, nor his ex-girlfriend (who was still close). In his words, his credibility was diminished because he was a heroin addict. "My credibility and my ability to talk to people in my family was diminished." Sal was only able to share his traumatic experience later. While it was happening, he did not approach close nor distant ties. Thus, Hypothesis 3.2 is partially supported. Sal did not disclose hurtful topics during this period of heavy consumption that resembles the PMC.

Sal opened up and "unpacked" his traumatic experience for the first time with a therapist, four years after it happened. His girlfriend at the time knew about the three years Sal spent as a caregiver. But she did not know in detail the narration or what Sal felt. Sal did not have the words to describe what happened. Once Sal started therapy, he was able to start talking about trauma. It was harrowing and confusing for him to start talking. The memories were hazed, and the painful emotions vividly impressed. Talking with his therapist brought positive change in Sal's life, "It allowed me to process stuff that I didn't even know I needed to process. [. . .] it turned out to be a very positive experience. Like a real weight had been lifted." The first person Sal could ever talk to about his trauma was a therapist, a trained stranger whose job was to understand.

Sal did not target close people to discuss hurtful topics because he did not know where to begin and what to tell. Sal needed someone with whom he could thoroughly narrate the hazed painful memories that he experienced and make sense of them. Thus Hypothesis 1 is partially undermined, and Hypothesis 2.1 is supported. Close people were not targeted as confidants of a detail narration of hurtful topics.

Today, Sal does not feel close to anybody, and he is comfortable with that fact. After some negative experiences with people he considered friends, he cared less about friendship. Sal has been able to share trauma with an unexpected array of people. After Sal unpacked trauma with his therapist, he "quite unexpectedly" shared his story during a podcast organized by a friend from work (although his narration was less detailed). Sal also shared about trauma with a coworker during lunch. Moreover, he was able to share with me in detail during the interview. Sal was at the brink of crying. These unexpected confidants further support Hypothesis 2.2. People who are not close are trustworthy confidants of Sal's hurt.

Kurt After participating in my first in house 12 step meeting, I met Kurt. Kurt is a 65-year-old straight white male who was raised in the city and suburbs of Chicago. He completed a bachelor's in journalism. Kurt's drug of choice was alcohol, and during PMC he used to consume around 2 pints of vodka daily. During PMC, Kurt worked as a bar owner and as a truck driver. He has had a long-standing girlfriend with whom he recently broke up. Today, he is retired and single. At the time of the interview, his last consumption was four days ago.

Kurt was the firstborn out of five boys to a World War II veteran and a second-generation European immigrant woman. His father did well in business, and his mother took care of the children. Kurt was born in the Northwest of Chicago, but the family was doing well enough to move to the suburbs. There, Kurt was sent to a good school and attended church regularly. He never saw his father drunk. In his words, "I was given every privilege as a kid." After coursing journalism, he was convinced by his father to join the printing family business and learned proficiently about it. He worked for 12 years as an owner with his father but never felt he deserved it. "I really didn't feel I had stood up on my two feet, build a life for myself, carved my own life, and the drinking just picked up." Kurt never experienced anything he considers traumatic. The hurtful topics he needed to vent later in life were not related to trauma. Thus, Hypothesis 3.1 is undermined. Instead, hurtful topics were associated with feelings of shyness and lack of self-worth partially produced by his relationship to work.

Kurt's PMC was a long period of 15 years in which he lost and regained material possessions while consuming heavily. In his words, "If we planted a curve, [consumption] would spike up and down but trend ever upward, until most recently it ended on what you see now." Kurt's PMC started when Kurt was 35 and ended four days before the interview at New Beginnings. At 35, Kurt had everything: he was a licensed private pilot, with a condominium in the suburbs, and a brand new sports car. As the industry changed and the

business declined, they sold the company and Kurt decided not to represent their customer "I choose not to do it. I was tired. I was burned out really. And I was not proud of myself then, I didn't want to go forward." With money from his dad Kurt opened a bar, partied recklessly, and within two years, he lost his business, condominium, car, and plane. With some money left, he stayed with a dealer friend and then couch-surfed until he found a job as a bartender where he kept drinking. At one point, he could only control the shakes and the sweats with alcohol. He then transitioned to driving trucks and continued drinking, "finding the strength" to surpass the hangovers during the days to drink during the night. Kurt got his first detention DUI and was sent to jail. He stayed sober for four months, drank again, and finally got a second DUI. Now, after going through detox, he found a sponsor and hopes to stay sober in New Beginnings North. Kurt's PMC lasted several years and had periods of sobriety. The PMC may continue once Kurt leaves New Beginnings as he plans to. Therefore, it is not possible to discern if Kurt changed his talking behaviors now that he is sober. Kurt's narration cannot inform hypothesis 3.2. Currently, he has only shared what hurts him the most with a therapist and with me.

During PMC, Kurt was only close to his long-standing girlfriend. They have had a relationship for 25 years, which got particularly turbulent in recent years. Kurt and his girlfriend decided to buy a house three years ago. However, she locked Kurt out of the house after his DUI. Besides her, Kurt has three brothers and a handful of friends. "All of the people I consider friends know about my problem. They feel bad for me, wish me the best. I am actually very glad to say that I haven't kept secrets from them as far as my alcoholism and my struggle over the years." These people were close to Kurt during those many years of PMC and indeed knew about Kurt's consumption. Nonetheless, they do not know about what hurts Kurt the most. Kurt told his girlfriend that he was depressed, and she encouraged him to get help with depression. But Kurt never explained to her why he was depressed. His two brothers are close in "spirit and brotherly love" and are there to help, just like some other friends. And yet, Kurt has not reached them to talk. "There are still some people in this world that know me and love me but I've been reluctant to reach out [...] It's the damn shyness of mine." Kurt's close people wanted to help. They wanted Kurt to be better, less depressed, and sober. Because of Kurt's shyness and his desire to not be stopped from drinking, close people do not know what hurts him. Therefore, Hypothesis 1 is undermined. Close people were not trustworthy confidants of Kurt's hurt during PMC.

At some point during PMC, Kurt shared hurtful topics with a therapist. Kurt had a few sessions of therapy and then moved on. Besides his therapist, the only person that knows what hurts him the most is me. Close people still do not know that shyness and lack of self-worth are the most hurtful topics for Kurt. "It was very easy for me to share my story with somebody professionally trained. I'm too embarrassed to talk deeply with friends. I just met you [refers to me], so this is not threatening to me. But people that I am close to, I don't want to get so close... I taught myself, I don't know why." Kurt does not want

to appear flawed in front of close people "I don't cry in front of my buddies. So if I look back, maybe that's part of why I don't want to get too deep into things with people because I don't want them to see me cry [...] I don't want to be discovered. That I'll be found out that there's something wrong with me." Kurt feels comfortable with strangers and professionals because we cannot judge his fears. The long relationship Kurt has with his friends, girlfriend, and siblings, discouraged him from talking. Close people will change their opinion about Kurt if he talks about hurtful topics, particularly if he mentions that he is not comfortable with himself. Kurt is too shy to let that happen. Thus, Hypothesis 2.1 is supported. Kurt prefers to discuss hurt with non-close alters.

By the time of the interview, Kurt had been sober for four days. He has not opened up with his ex-girlfriend. As Kurt pointed "[she] would be deeply wounded" because Kurt held secrets even though "she's been trying to pull me over of myself over the years." Today, Kurt does not feel close to anybody, and he is reluctant to spend time with other people. Kurt told me that he was a shy kid and got even shyer when he started smoking marihuana. "It has been a lifelong struggle. I haven't really been content about who I am. Never quite lived up to some standard that I don't even know it's there [...] And drinking was a way to escape that pain, that self-doubt [...] You are the first people I've really explored this with." Even though Kurt has a sponsor today, he does not feel comfortable sharing with him. Kurt found a sympathetic ear in someone with whom he shared no characteristics and no common experiences. I was his confidant because I did not know about his past or his persona. Thus, Kurt tended to disclose hurtful information with people who did not share the same characteristics, undermining Hypothesis 2.2.

Jack Short after the interview with Kurt, I participated in other in house meetings and interviewed Jack. Jack is a 21-year-old straight white male who was raised in Iowa. He started but did not complete college. Jack consumed Marijuana, Alcohol, Lsd, Mushrooms, Cocaine, Benzos, Methamphetamine, and Adderall (prescribed in first grade). During PMC, he was a college student and used to consume "probably a couple of times a day," as he stated. Today, Jack is working as an air conditioner technician, and he is single. At the time of the interview, Jack reported that his last consumption was four months ago, but I know from other house members that he still consumes in the house.

As he stated, Jack had an "average American childhood." He grew up in Dubuque, Iowa, had many friends, and continuously played sports. Jack's family lived around the town, and Jack remembers his childhood with fondness. Without being asked, Jack told me that his childhood was not traumatic. "There wasn't anything really traumatic in my childhood. I guess if we're relating this to my drug use and whatnot, I would say it was really just kind of an average [childhood]. I got a big family. I was pretty good in school. I was put on Adderall in first grade, so that was kind of a troublemaker [...] But, other than that, my childhood was pretty good". Just as Sal, Jack talked about trauma without being prompted as if he expected me to be interested in childhood trauma. Like

Sal, Jack even associated drug consumption to the experiences of trauma. Discourses of addiction work as a set of expectations of what topic is appropriate for each context. The context of the interview, my presence as a researcher, and his own story as a drug addict led Jack and Sal to mention trauma without being prompted. In other words, the interview and the covered topics were 'scripted' by discourses of addiction (see Carr, 2010). As I show in the next section, the scripture of addiction led some participants to remain silent regarding hurtful topics, thus supporting Hypothesis 4. On the other hand, the hurtful topics that Jack needed to vent were not associated with trauma; they were associated with social rejection experienced during PMC. His narration undermines H 3.1.

Jack started drinking when he was 12 and tried other drugs has he grew up. His consumption peaked in college. During PMC, Jack's close people were his parents and some of his friends with whom he consumed. Jack could share his worries with them. "They were just in my life every day, and I talked to them. If I had something that was wrong, I talked to them about it". Jack also confided in her mother, "Yeah. I've always just been really close to my mom, we can talk to each other about anything. She wasn't really the person that would be strict with me [...] It was more my dad. So I felt just closer to her." Jack reported confiding in his mother who was a close tie with whom he had a long-lasting relationship. Nonetheless, I found later that he never talked about what was "wrong" in detail with his mother. "I talk about some stuff to my mom. But I mean, it wouldn't be stuff that I would want to get in trouble for, you know what I mean? She'd be disappointed in me" Jack only shared stressful topics with his consumption friends. But Jack disposed his consumption friends once he started the recovery journey. Like Matt, he had an emotionally intense but short relationship with people he considered close. Thus, his narration supports Hypothesis 2.1 instead of Hypothesis 1. Jack only disclosed hurtful topics with fleeting ties that then left his life for good.

Jack preferred consumption friends to share hurtful topics because he was reproved continuously by his family. In fact, Jack's family partially caused the hurtful topics Jack needed to vent. Jack was treated differently and was frowned upon because he was an addict. "Relationships that I've lost through being an addict would be some of the most hurtful things. People's views on me. I'd go to church with my family, and people would not talk to me the same as they would talk to my brother just cause they knew I was a drug addict." The first time Jack got alcohol poisoning, a family member scolded him heavily at a family meeting. Jack never shared the pain of rejection with his family. The family was causing pain whenever they pushed Jack to change his drug-using behaviors. The isolation and shame that Jack experienced led him to remain silent with people who shamed him. Jack also remained silent with his mother, who was patient and supportive. Close people did not lend Jack a sympathetic ear -undermining Hypothesis 1.

On some occasions, those providing a sympathetic ear to Jack were strangers. "I can remember a couple of times actually where I did [talk], and they were complete strangers. I wouldn't even talk to [them] when I wasn't using. If I

wasn't fucked up, I wouldn't have talked to these type of people." Drug consumption led Jack to talk about stressors in contexts of parties. Both Jack and the acquaintances were high or drunk, which led to sympathy between them. Sometimes, he spent hours talking to some of these strangers. Even though I could not figure the specific hurtful topic Jack talked about, these observations support Hypothesis 2,1 and 2,2. Jack opened up with a stranger who shared some characteristics with him.

Jack's PMC finished during Christmas of 2017 when his family decided to intervene. After the Christmas intervention, Jack moved to Chicago and has been living in New Beginnings for nine months. Today, Jack's close people are his roommate, his parents, and a coworker. He is not currently close to his old friends from Iowa. His parents never stopped supporting his sobriety and are proud of him. Jack thinks he can talk about any topic with his mother, "Yeah, I mean more than I would in the past. Like I said, I wouldn't want to talk to her about some of those things and I feel like I could tell her really anything now. There's nothing that bad that I couldn't tell her. Honestly." Nonetheless, I could not gather any evidence indicating that Jack can talk about his current drug use with close people. Or that he can talk about rejection with his mother. While Jack was in Iowa, disclosing hurtful topics was troublesome because he was experiencing what later informed the hurtful topics. The end of the PMC did not necessarily represent a change in his talking behaviors. Jack is still unable to share in detail hurtful topics. Hypothesis 3.2 is undermined.

AP Finally, I interviewed an anonymous participant (AP) who preferred not to be recorded. This section was written based on my notes and observations. AP is a well educated, straight white male with a Christian upbringing. He got his bachelor's in psychology and immediately started a Ph.D. track. He then moved to law school, which he finished in 2013. AP consumed alcohol and antidepressants. During PMC, he drank a bottle of liquor daily.

AP had a pleasant childhood. He was one out of five siblings, all who grew in a well-to-do suburb in Chicago. While his parents were strict and his brothers competitive, AP had a loving and supportive family. AP's family had enough resources so that all seven members can have vacations in Spain, and he remembers those times fondly. "I'm lucky and grateful" AP said, referring to the opportunities and memories his family gave him. When AP was sixteen, his grandfather died, a somewhat painful experience lessen by his family's support. Besides the decease of his grandfather, AP remembers no overarching painful experience. As he later narrated, AP experienced no trauma throughout his life -undermining Hypothesis 3.1.

AP drank for the first time in College. The change for him was significant: he went from not drinking to an exciting context of parties in which he was expected to get drunk. His parents were strict with alcohol and, in general, did not see him drunk (if they ever did). After he discovered alcohol in College, he began to drink in secret and was ever more secretive about his drinking. AP was ashamed to tell family members about his drinking. His consumption remained

fairly controlled until he finished law school. Once he finished studying, AP moved to his mother's house. AP felt stuck, shamed, and drank ever more in secret. After his mother drove him to the hospital because of alcohol poisoning, he moved to his girlfriend's house. Consumption spiked during the three years he was living with his girlfriend. It was an unbearable stagnation for AP. His girlfriend hardly noticed when he was drunk because he knew well how to hide it, and she was not particularly astute to notice. If she did, she asked AP to stop drinking. AP did not have a high opinion about his girlfriend's wits, he found her annoying, and by the end of 2018, he was there just for the housing. AP called himself a piece of shit. The three years living with his girlfriend were AP's PMC. As he narrated later, AP has not yet shared what hurts him the most. AP has remained even more silent than Kurt when it comes to hurt. For AP, the PMC made no difference. His narrative can not inform hypothesis 3.2.

During PMC, AP felt he was close to his siblings, his parents, and his girlfriend. He was especially close to his two younger brothers. AP did not talk about depression or drinking with his mother. He was too embarrassed to let her know that he was a mess. On the other hand, AP was able to talk about "profound things" with his brothers. These profound things referred only to drinking too much one night or missing a day at work because of a hangover. AP never shared why he drinks nor how he felt languished at his girlfriend's house. Part of the reason AP did not delve into hurtful topics is that he was scolded by his brothers whenever he mentioned drinking. When AP mentioned topics that refer to 'drinking too much' the discussion would divert to 'drinking is wrong' at the expense of AP feeling scolded. All of his family is successful in business and love life. They have well-paying stable jobs. Some siblings are married, and some siblings have kids. Even though AP was able to talk more in detail whenever he met his brothers in person, his brothers are taking care of their lives and lack time to meet. AP never felt prompted to talk about hurt with his brothers, and he never took the initiative to do so. AP was even more silent with his girlfriend. He would not talk to his girlfriend about isolation or drinking. AP's girlfriend encouraged him to go to AA meetings, meetings that AP disliked, and that made him crave to drink more. Going to AA made him feel more isolated and bored. To keep his girlfriend off his back, as he pointed, he told her that he went to meetings but instead went to the library. Close people never prompted AP to talk about hurtful topics. Instead, they tried to make him quit drinking. AP's narration undermines Hypothesis 1. Close people were not confidants of AP's hurtful topics because they would either scold or force AP to do things he did not want to.

AP had no friends during PMC and little people to talk about non-mundane topics. He felt isolated, and no one would "get him." From time to time, he had a good time talking with an ex-girlfriend he had years ago. Besides her, AP had no one with whom to talk. AP spent countless days starring drunk at the tv and never shared feelings of isolation, uselessness, or depression. When I asked him with whom he talks about deeply hurtful topics, AP quickly replied, "you, next question." We laughed and moved on. When I asked AP about the

typical context in which he shares, he said, "We are doing it right now." AP has not talked about hurt for several reasons. First, AP did not want to be seen as an unaccomplished member of the family. He felt embarrassed for consuming alcohol to escape a situation he was responsible for. Moreover, AP does not want to be identified by coworkers as a drinker. AP is smart, his childhood was close to idyllic, and he had plenty of opportunities and support. AP feels he does not deserve to have problems. That is why he "swallows his pride" and never appears vulnerable in front of others. Finally, AP does not want to hurt his parents by telling them the things he thinks or feels. Whether AP is taking care of other's opinion about his persona or whether he is protecting close people, he has only disclosed hurt with me. AP did not disclose as many details as Casey, Kurt, or Sal. AP only shared with me is because I properly prompted him to talk about hurt. Hypothesis 2.1 and Hypothesis 2.2 are thus not supported nor undermined. AP has yet to share in detail what hurts him the most.

Today, AP feels close to the same people he felt close to during PMC, except for his ex-girlfriend. He stills talks with his mother and his brothers. He spends "big chunks" of time with friends from the house and, apart from the lack of privacy, he feels the house has a supportive atmosphere. Tragically, a few months after the interview, AP overdosed on a combination of alcohol and antidepressants. I tend to believe that the overdose was associated with his inability to disclose hurtful topics. I wish him a soon recovery. AP's overdose illustrates why this study should be regarded as a critical case and not as a representative one (see Desmond, 2012). My results should not be considered a general experience of drug users. Instead, they should be considered as an opportunity to gain a new perspective on network dynamics among drug users. Venting is an event that can produce a significant difference in the user's life. Understanding with whom and why drug users talk about hurtful topics provide insight into a crucial form of social support, one that can make a difference between life and death.

In-house meetings I attended four in-house 12 step meetings during the time I was interviewing participants. A member of a 12 step program came to New Beginnings and spoke about topics of addiction, stressful life events, and the recovery journey. Members of New Beginnings voluntarily participated in the meeting and chose whether or not to voice their opinions once the speaker was over. As I discuss below, my observations during in-house meetings support hypothesis 4.

The first meeting I attended was held on April 13th, around 9 am. I was invited by Sal, who thought it would be fruitful for my research to participate in house meetings. I sat with the rest of the members of New Beginnings and listened to the speaker talk about his experience with alcohol and meth. The speaker was a white male in his forties. The speaker narrated how he lost everything because of meth. He was desperate, homeless, and wanted to die. When he hit "rock bottom," he tried to get sober, but his mind would "play tricks" on him so that he kept consuming. When he finally started rehabilitation, his life changed dramatically for the best. The speaker also covered the topic of

communication and how he could not talk about meth addiction with his wife, as she did not understand. Around one-fourth of the sixteen present members spoke after the speaker was done. They only commented about the impossibility of communicating when they were consuming. They did not comment on the tragic events the speaker experienced when he was consuming. Casey and Sal did not share any insights regarding the speaker's rock bottom, even though they experienced deeply hurtful situations. Sharing hurt required more time and a different context for house members. Others like Dan, Matt, and AP, who were also there, did not experience the type of rock bottom the speaker did. They were never homeless nor stripped from material stability. During house meetings, speakers vented about profoundly traumatic experiences that participants found hard to relate with. Thus, Hypothesis 4 is supported. Discourses of addiction expect people to vent about trauma and therefore discouraged those that were not traumatized from venting.

The three other house meetings were not significantly different except for a push against the 12 step program. It was clear that participants at the meeting were not engaged with the speakers nor with the program. On April 18th, the speaker was a male in his forties who talked about harsh life events. The speaker narrated that listening to himself meant to listen to an unwise person who would push him to drink or shoot heroin. The speaker would "tell excuses to himself" to consume drugs as if he embodied two different people. Once again, members did not comment extensively on what the speaker shared. During the meeting of April 25th, a 50-year-old man who used to consume alcohol and cocaine narrated how he had a good upbringing and how the thrill of drugs led him to abuse. The speaker narrated that his boyfriend got hospitalized for alcohol poisoning. The speaker found his boyfriend had HIV and that thus he also had it. Instead of doing cocaine, he called his sponsor. The speaker finally recalled that he constantly wanted to die and that he thought about the least painful and least gross way to kill himself. Finally, during the meeting of April 27th, the speaker narrated that he consumed alone until he found the program and a spiritual awakening that led him to sobriety. This last meeting led to additional discussion. Kurt commented that he drank similarly, that they were both lone drinkers. Other participants, including Sal, pointed they do not feel identified by the 12 step program. As Sal pointed, the only step in the program that is helpful is "one addict helping another." After the meeting was over, other house members expressed concerns to me about the program and the speaker. They wanted to hear advice on how to remain sober and not on how to follow the 12 step program or how speakers went from rock bottom to recovery. During meetings, participants who I interviewed did not share the stories they shared with me. Even though in-house meetings are a space designed to talk about hurt, members were discouraged from doing so. They did not feel identified with the stories being shared in meetings. They did not feel comfortable talking about what they considered hurtful in those meetings. Thus, Hypothesis 4 is supported, discourses of addiction discouraged venting that was not related to traumatic experiences.

Beth Before wrapping up the fieldwork, I interviewed Beth as recommended by Sal. Beth is a 29-year-old drug counselor who currently works in Symetria Recovery, an outpatient opioid rehab center located in Chicago. Beth was a psychology undergrad who later studied an MA in social work, and has experience with over 150 patients with drug abuse problems. Beth believes that the vast majority of her patients have experienced some trauma and that many of those experiences were related to abuse during childhood. ADHD is also typical among drug addicts. Many of them start consumption early and pick up when they are in college. After a failed attempt to stop consuming, they come to Beth's rehabilitation facility. "I mean, not everybody has a history of trauma, but a huge majority of them have a history of trauma. One of our initial questions in our assessment and in any assessment they've ever gotten is, do you have a history of any trauma or any abuse?" Beth expects her patients to be traumatized because of situations of abuse. She expects that the topics addicts need to vent are associated with traumatic experiences. Beth is, unknowingly, an advocate of Hypothesis 3.1. In what follows, I will show that Beth expects that hurtful topics are associated with trauma. And I will argue that her narration supports Hypothesis 4.

Throughout the interview, Beth revealed a set of beliefs about addiction that closely resemble the beliefs and behaviors of drug specialists documented by Carr (2010). As she pointed throughout the interview, addicts need to be "honest" and "transparent" with close people to achieve sobriety. "Some of our patients have a really close relationship with their families, but there's that barrier of not being fully transparent and authentic and honest" For Beth to "process" and overcome the lingering effect of trauma, addicts should disclose those traumatic experiences. To have "secrets" is an unbearable weight. "It's like this overpowering ongoing stressor that's there." According to Beth, addicts cannot control their consumption because they cannot be authentic and ask for support "You need a lot of support to be able to stop, it's not just an easy thing. So I think to an extent people can learn how to get into control of their thoughts and their feelings and being able to be authentic so that they get to a place where they identify why or how am I using, Why can I not stop using? what do I need in my life to be able to regrasp control of it." Carr (2010) documented that drug specialists promote a language that refers to authenticity as an inner sober state. Drug addicts cannot access that state because a thick layer of denial, anger, and shame impedes them from doing so. By changing the way they talk, they can achieve sobriety. Beth's narration further supports Hypothesis 4. As Carr argues, drug specialists heavily influence discourses of addiction. It is possible that drug specialists promote addicts to vent about trauma, and that their expectations of trauma influence what drug addicts can or can not vent.

Beth does not feel she has seen enough people open up with their loved ones to see a positive change in their lives. This "La la land" scenario in which "everyone is authentic and know that everyone's listening and accepting of each other" is rare. Even in the cases in which parents were involved in the traumatic experience, disclosing was positive. It is as if Beth believes that kin relationships

should be maintained and improved for the addict to recuperate. I challenged this idea by pointing that close people usually shame and scold addicts who try to disclose hurtful or traumatic topics. Beth indicated that the problem relied on the addicts' communication and not in the networks' response. "It's difficult sometimes to really put your thoughts into words and say them the way that you really want to say them. To actually say exactly what you meant, to say in a way that you like it to be received, and it may not be received that way. And I feel like that's probably what leads to that rejection." According to Beth, addicts must learn to be clear when they disclose trauma to be understood "Being able to communicate appropriately, authentically, honestly. You have to know how to do that. You have to learn how to say things, how to word things." That is why addicts fear rejection from their close ones and "mask" hurtful experiences. "That's my number one thing in treatment. You have to be honest or else you can't move forward, really". Hypothesis 4 is once again supported. Discourses of addicts must be delivered in a proper form so that close people understand why they can not stop consuming drugs. Beth expects addicts to work through their language so that they can be honest with close people. Not only this narration resembles what Carr (2010) documented, it further expands her findings and provides additional information about what specialists think regarding addict's networks.

4.2 Who was close to participants?

Participants reported that the people they consider close were family members, girlfriends, friends, or house members. Some reported feeling distant to close people during PMC or reported not feeling close to anybody. In half of the cases, it is not possible to discern the PMC and the present as two distinct periods. In those cases, participants reported that their relationship with close people changed once the PMC was over. Despite differences, all participants reported whom they felt close to during PMC and the present.

The first two hypotheses refer to the extent to which the networks of discussion were comprised of close people. As a whole, participants did not discuss hurtful topics with people they consider close. Those who did, disclosed little detail or terminated the relationship with the discussion partner. Contrary to hypothesis 1, participants discussed those topics that hurt the most with people they did not consider close. Moreover, participants seem to avoid some of their close people when talking about hurt. The complex relationship they shared and the fraught discussions they experienced, led participants to keep silent about hurtful topics.

4.3 Why participants vented with non-important alters?

The next set of findings examine why alters in the discussion network are not close by exploring why and whom participants approached to talk. For most of the analysis that follows, I turn to the narration of participants, which allows me to examine the reasons they had to approach some and not others.

The most persuasive argument that this thesis can make is that drug users avoided close alters to discuss hurtful topics. Close people actively discouraged participants from talking. Or participants did not approach close people to vent. Instead, ego found in fleeting ties an opportunity to be heard in a meaningful and detailed way. In this regard, the hypothesis that drug users tend to disclose hurt with non-close alters is supported. And the hypothesis that close people are trustworthy confidants of ego is undermined.

The first set of responses that support the statement above refers to personal reasons to not approach close ties. In some cases, participants did not want to hurt or worry people they considered close and thus did not share hurtful topics with them. In others, they did not have the confidence to approach close people because they were shy or expected an adverse outcome out of the conversation. Family and friends, particularly during PMC, were not mobilized by participants to discuss hurt.

The second set of responses that support the statement refers to close people discouraging participants from talking. In some cases, close people patronized the participant and offered unwanted advice. In others, close people tried to help participants by providing access to mental health services. Participants did not want advice or to be considered recipients of help. Close people also scolded participants and forced them to change their drug-using behaviors. Close people actively halted participants from talking about hurt.

The third set of responses refers to the relationship shared by participants and their networks. In some cases, close people produced the trauma or hurt experienced by the participants. The perpetrators were not trustworthy of disclosure. In other cases, close people were distant geographically, and participants did not find the right opportunity to talk. Finally, it was not common for close people to explore hurtful topics with participants. Some participants were clear to state that they can talk freely about any topic, that they are "an open book," as Matt indicated. However, close people did not prompt participants to talk about hurtful topics.

In all, the results suggest that all participants had reasons not to approach close people. In turn, participants actively sought distant alters to vent or found themselves in situations in which they were able to vent with distant alters. Participants preferred weak ties because there was a lesser risk of an adverse outcome from happening.

The first set of observations that support the weak ties perspective refers to the possible outcomes of the conversation. Participants did not expect weak ties to shame, judge, or scold them when they vented. Furthermore, weak ties did not offer patronizing or unwanted advice. Weak ties made participants feel comfortable to share in detail what hurt them. They were better at listening patiently.

The second set of observations that support this perspective refers to the role of the person listening. In some cases, the people whom participants talked to were professionals trained to listen and trained to prompt the participant to talk. In other cases, they were supposed to listen in spaces designed to vent, such

as 12 step meetings. Moreover, they vented with me because I directly asked them for hurtful topics. Finally, some weak ties shared similar characteristics or experiences that allowed them to understand, such as past drug use. Some participants felt comfortable talking among their homologous.

Finally, the third set of observations that support the perspective refers to presence. In some cases, weak ties were there to listen to the participant vent while close people were not. Face to face interaction was an important requirement to vent hurtful topics. And many times, old friends and other close people lived far, in other cities or parts of the country.

In general, weak ties were the only people who allowed participants to explain what hurt them thoroughly. Some of these weak ties became great friends after the participant vented. Other ties were completely disposed of after. No matter the later relationship, venting networks were composed of people who were not close, who were later disposed, or who became close after venting. In all cases, long-lasting relationships discouraged participants from talking about hurtful topics. Parents, siblings, and old friends were not mobilized to talk.

4.4 Trauma and PMC

Hypothesis 3.1 expects drug users to mention trauma as a hurtful topic. Hypothesis 3.2 expects that drug users would not discuss hurtful topics during PMC due to the overarching effect of stigma. Once the PMC was over, this perspective assumed that drug users would be able to freely discuss trauma with their networks. Nevertheless, the results suggest that trauma was not necessarily a hurtful topic and that PMC did not necessarily produce a significant change in the way participants disclosed hurtful topics.

The first set of observations that support the statement above refer to the prevalence of trauma. Most participants do not consider to have experienced any trauma. Even Casey, who had an objectively traumatic childhood, never mentioned that what he experienced was traumatic. Other participants were hesitant to call their experiences traumatic. And while some participants indeed needed to vent trauma, most hurtful topics referred to non-traumatic experiences such as depression, loneliness, or shyness.

The second set of observations that informs this perspective refers to the change PMC made in the participants' lives. The PMC was ubiquitously a period of instability, in most cases, one in which participants suffered emotional and physical pain. The PMC was also a period in which participants did not talk about hurtful topics with others. In all cases, they kept hurt to themselves. Once the PMC was over, some radically changed the way they addressed hurtful topics and are now able to share with an extensive array of people depending on the level of detail and context of the conversation. But for others, the end of the PMC meant little change. They are still unable to share hurtful topics.

In sum, these observations suggest that the prevalence of trauma was overstated and that thus, Hypothesis 3.1 is only partially correct. On the other hand, Hypothesis 3.2 proved to inform all cases because no participant disclosed hurt-

ful topics during the PMC. But not all participants were able to openly discuss hurtful topics after PMC. Some still struggle to talk.

4.5 Scripted addiction

The observations strongly support Hypothesis 4, which indicates that venting is scripted by discourses of addiction. According to Hypothesis 4, drug users are expected to vent specific topics in contexts of addiction. The observations suggest that participants were expected to have experienced trauma and that they needed to vent trauma in 12 step meetings.

Several observations support the statement above. First, some participants mentioned that they had non-traumatic childhoods without being asked for. These participants expected to be asked about trauma because they were drug users. Second, speakers narrated deeply traumatic experiences during 12 step meetings and thus discouraged those who did not embody those experiences to share. Meetings were adequate for those who experienced trauma. Finally, Beth was clear to point that drug addicts need to be honest about their trauma in order to recuperate from addiction. As a specialist in the field of addiction, she was confident that most drug users experience trauma and that they have to disclose it to close people to be sober.

5 Conclusion

The analysis has shown that the discussion network, if existing, consists of alters whom respondents do not consider close for a long time. It suggests that weak ties are more prevalent to be a source of support for drug users. Weak ties were there when participants needed someone to share with. Research on drug abuse has not thoroughly considered the motivations that drive drug users to seek support. It has assumed that close people will be the primary source of help. However, as this thesis shows, drug users consistently rely on weak ties and consistently avoid close ties when they need to vent. To conclude, I present the implications of these results.

First, the evidence undermines the scholar assumption that close people are the primary or only source of social support for drug users. The discussion network, which is crucially supportive for drug users, is not primarily composed of close people. Instead, it is a combination of fleeting friends and fleeting partners, health professionals, strangers, and distant people with whom they share common characteristics. Closeness was not part of the factors that motivated participants to seek confidants. It was, in fact, discouraging to share hurtful topics. While questionnaires as the IPA are widely used to elicit a network of support, these cannot capture the full extent of support networks because these do not measure the help that distant people can provide. The scope and meaning of the IPA require revision.

Second, participants had a strong tendency to discuss hurtful topics with those who were distant, disposable, or who shared common experiences. The

results suggest that drug users tend to trust those who cannot further hurt them when they disclose hurtful topics. Those people proved to have a short-lived relationship with ego or became close as a consequence of venting. As I discuss below, this finding has important implications for developing a better interpretation of the drug user's networks of support. Adequately addressing the extent and variety of the user's support networks requires new questionnaires and broader datasets.

Third, most of the hurtful topics did not refer to trauma, and some participants were no longer consuming drugs. Even when experiencing no direct stigma from their networks, some participants did not disclose hurtful topics. What explained their silence was the relationship they shared with close people. Thus, network factors seem more adequate than stigma to explain why participants remained silent about hurtful topics.

Finally, the results suggest that the findings of trauma studies should be interpreted with caution. These studies argue that trauma is widespread among drug abusers. Contrarily, the results of this study show that participants were not traumatized. And that expectations of trauma discouraged them from venting. Taken together, these results suggest that drug users try to fit expectations by reporting trauma. If that is true, then research overstates its prevalence -intuition shared by Carr (2010). The conceptualization of what trauma means and how drug users report it needs revision.

To highlight the implication of these findings, consider the recent debate on networks opened by Desmond (2012). Desmond's ethnography shows that the urban poor constantly rely on disposable ties to survive. His findings cast doubt on Granovetter's (1973) classical suggestion that reciprocity is a factor of tie strength. Contrary to Granovetter, Desmond shows that disposable ties tend to show more reciprocity than strong ones.

The results of the present study cannot speak to whether participants behaved as the urban poor, as reported by (Desmond, 2012). However, the findings do suggest that the discussion network of hurtful topics has similarities with disposable ties and further undermine Granovetter's (1973) tie conceptualization. Firstly, participants confided in distant people with whom they had emotionally intense conversations. Just as disposable ties, discussion networks were brittle, and relationships were short-lived. Secondly, participants faced some of the same barriers faced by the urban poor. Most importantly, the urban poor fought pettiness coming from kin when they needed help —just as drug users fought pettiness coming from close people when they needed to vent. In support of Desmond, this study suggests that people showed reciprocity because they were distant. And not because they were close, as suggested by Granovetter (1977). In other words, distance does not fully explain reciprocity between people in need. The present findings seem to be consistent with other research (see Small, 2017) that question Granovetter's classical approach to network formulation.

Finally, these findings corroborate the ideas of Small (2017), who suggests that people are prone to vent with weak ties. Furthermore, it opens the discussion for a broader understanding of what social support means. In some cases, Small

considers that venting is a type of support because ego can receive emotional appraisal or good advice. For example, Small describes how graduate students actively search for supportive advice when they vent stressors. However, contrary to students, drug users refrained from venting because they were going to be advised on the topics they needed to vent. For drug users, receiving advise was patronizing. Perhaps it is better to understand that the mere act of venting, that is, to simply narrate stressors, is a type of social support. One that allows ego to process stressful information, and that only requires that alter listens silently. Under this scope, venting can lead to other types of social support that depend on the motives of venting. In some cases, alter will further support ego by giving some advice. In others, alter will further support ego by asking for a more detailed narration. Additional research is needed to account for the varying motives behind venting and how it shapes what social support means.

In all, this research extends our knowledge of the process in which drug users seek support. The results suggest that drug users choose confidants according to discernible motivations that deserve greater attention. A policy priority should, therefore, be to study with whom and why drug users talk about hurtful topics. Such priority might lead to new perspectives in rehabilitation strategies that highlight the support given by those who are distant, disposable, or similar.

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