JOURNAL *of* EXTREME ANTHROPOLOGY

Treating Addictions: On Failures, Harms, and Hopes of Success
Guest editors: Aleksandra Bartoszko & Paul Christensen

Vol. 3, No. 2. (2019)
ISSN: 2535-3241

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Journal of Extreme Anthropology
Vol. 3, No. 2. (2019)
ISSN: 2535-3241

Front cover image: Paul Christensen, 2019.
Design: Tereza Kuldova (with support by Eirik Hanssen)

Published by the Extreme Anthropology Research Network with the support of OsloMet - Oslo Metropolitan University (Work Research Institute)

Editor-in-chief: Tereza Kuldova, OsloMet - Oslo Metropolitan University, tkuld@oslomet.no

EXTREME ANTHROPOLOGY RESEARCH NETWORK

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This issue is published in print with the financial support by VID Specialized University, Faculty of Social Studies. We would like to express our thanks for supporting the *Journal of Extreme Anthropology*.

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ISSN: 2535-3241 Vol. 3, No. 2 (2019): i-iii https://doi.org/10.5617.7634

Editorial

Treating Addictions

On Failures, Harms, and Hopes of Success

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Treating Addictions is a special issue that emerged out of conference panels at the 117th Annual Meeting of the American Anthropological Association (AAA) in 2018, San Jose, California. The panels, titled *Questioning Addiction and Contextualizing Treatment I* and *II*, were organized and chaired by Aleksandra Bartoszko and Paul Christensen. Additionally, participants of the Executive Session panel *Anthropological Interventions in the U.S. Opioid Crisis*, organized by Jennifer Carroll, joined this project. The panels, as shown in this special issue, has intellectually attracted additional scholars and advocates.

In this issue, readers will find a range of articles questioning many prevailing assumptions surrounding the labels of addiction as well as the pervasive methodologies of 'treatment' and 'recovery'. The authors are astutely critical of the oft corrosive logics that dictate and organize these conceptual frameworks, offering innovative and informative insights, while questioning the ways in which care and treatment(s) can reproduce the very realities they purport to address or even cause harm. Highlighting the paradoxical conditions of institutional approaches to drug use, they document often life-threatening consequences for individuals struggling to realize institutionally and culturally dictated criteria of success. Doing so, they challenge the established understandings of 'addiction treatment' as inherently good and ask if there are other ways of social inclusion or of bettering life quality for persons who use drugs.

The issue begins with a critical examination of the principles of the Recovery movement as adopted by Methadone Maintenance Treatment (MMT) programs in the United States. In *'We're gonna be Addressing your Pepsi use': How Recovery Limits Methadone Maintenance Treatment's Ability to Help People Who Use Drugs in the Era of Overdose*, **David Frank** outlines the ways in which this particular model of recovery organizes treatment as abstinence-based self-help and simultaneously facilitates a greater degree of surveillance and intervention into patients' nutrition, public service, and spirituality. Such efforts, coupled with punishment, often fail to reduce the potential harms of drug use. Since many of the MMT participants do not seek the Recovery as it is conceptualized by this specific discourse, but join the program to avoid criminalization, Frank recommends a policy shift that would truly consider the diversity of treatment goals among the people on the program. Harms of care remain central in the following article. In *Gendered Triple Standard and the Biomedical Management of Perinatal and Maternal Opioid Use Disorder in the U.S.: Investigating Bodily, Visceral, and Symbolic Violence*, **Alice Fiddian-Green** considers associations of stigma among pregnant and parenting women with opioid use disorder (OUD) in the northeastern United States. She deftly shows how a variety of institutional settings tasked with managing OUD simultaneously enact violence that becomes a form of embedded trauma for women enrolled in these programs. Examining the many forms of violence, she shows that the institutionalized and often conflicting ideas of legal, social, and medical care cause harms to both mother and child. Remaining in the United States, **Mark Chatfield** reveals the frighteningly pervasive abuse of patients at residential treatment programs for young people. As demonstrated in *Totalistic Treatment Programs for Young People: A Thematic Analysis of Retrospective Accounts*, these programs, exempt from Federal safety standards, are frequently sought out by distressed parents and loved ones on behalf of their children. But instead of help, they can end up creating a disturbingly widespread setting for abuse. Documenting the numerous 'thought reform techniques' and 'coercive persuasion' used within such programs, Chatfield opens for a needed, and, so far missing, discussion on the luring dangers of institutional treatments. Engagements with youth's experiences continue in *The Experimental Trajectories of Young Users of Psycho-active Prescription Drugs in Urban Indonesia*, in which **Nural Ilmi Idrus** and **Anita Hardon** study marginalized youth across the urban centers of south Sulawesi's. Contrasting their experiences with a treatment designed to target politically constructed problems, such as illicit heroin use, they illustrate the limitations of the harm reduction efforts in Indonesia and the failure of the methadone program to deal with poly drug use. Considering these limits and the ongoing War on Drugs, they propose and engage in educational interventions, which address the desires and aspirations evident in the youth's precarious lives. Discrepancies between individuals' needs and treatment opportunities are further explored by **Ingrid Amalia Havnes** and **Thea Steen Skogheim** in the context of the aftermath of legislative changes that made anabolic-androgenic steroid (AAS) use illegal in Norway in 2013. As they show in *Alienation and Lack of Trust: Barriers to Seeking Substance Use Disorder Treatment Among Men Who Struggle to Cease Anabolic-androgenic Steroid Use,* few individuals with AAS-related health problems seek treatment.

In their examination of the situation, Havnes and Skogheim document that men using steroids consider their drug use in terms of healthy lifestyle and healthy identity. They see their addiction as different to, for instance, heroin addiction, which they consider as the opposite of health and well-being. Havnes and Skogheim demonstrate that physicians' lacking knowledge of using and ceasing AAS shapes patients' distrust towards health care and hinders treatment seeking. Finally, **Shana Harris** offers a methodological reflections based on her study of the use of psychedelic substances at drug treatment programs in Baja California, Mexico. In *Narrating the Unspeakable: Making Sense of Psychedelic Experiences in Drug Treatment*, she points out that the use of psychedelic substances is often described as 'unspeakable primary experiences.' At the same time, narration and narratives are considered essential in anthropological research, as well as in therapeutic settings. In this context, Harris asks: How does narration work if the psychedelic experience is truly unspeakable and how can we study it? Harris does not offer a conclusion. Rather, she invites the reader to explore innovative ethnographic approaches more suitable to the study of experience resisting conventional narrativization.

In two shorter essays, **Aleksandra Bartoszko** and **Allison V. Schlosser** offer reflections on the established ways of (thinking of) inclusion of persons who use drugs. Bartoszko, in *Patient Is the New Black: Treatmentality and Resistance toward Patientization*, questions the political desire to form new identities and social innovations, which aim at liberating the 'addicts' by redefining them 'patients.' She shows that participants in Opioid Substitution Treatment in Norway are not always comfortable with such redefinition, which complicates the current discourse advocating for shift 'from criminal to patient'. In *Recovery in the US Opioid Crisis*, Schlosser illustrates the individual struggles to navigate between the conflicting articulations of 'recovery', emphasizing that its moral good is often taken-for-granted. Examining 'recovery' as a space not necessarily suited to supporting the social inclusion and moral recognition desired by individuals labelled 'addicts,' she asks: 'Can we, as anthropologists of the extreme, resist the moral panic of the "opioid crisis" to find and foster such alternative spaces?' Remaining in the context of 'opioid crisis', **E. Summerson Carr** offers a thought-provoking commentary on the use of the concept of 'crisis' as a descriptive term in addiction scholarship.

Treating Addictions includes also book reviews of the following titles: *Addicted to Christ: Remaking Men in Puerto Rican Pentecostal Drug Ministries* by Helena Hansen (reviewed by **Jennifer Carroll**), *War on People: Drug User Politics and a New Ethics of Community* by Jarrett Zigon (reviewed by **Shana Harris**), and *Narcocapitalism* by Laurent de Sutter (reviewed by **Tracy Brannstrom**). The reader will also find an interview with **Laurent de Sutter** conducted by Tracy Brannstrom. The issue's final piece is a visual essay on Ibogaine treatment by **Sagit Mezamer**.

Last, but not least, we would like to express our thanks to the anonymous reviewers for their thorough engagement and critical work with all the contributions to this issue of the *Journal of Extreme Anthropology*.

JOURNAL of EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 1-20 https://doi.org/10.5617.6737

Article

'We're Gonna be Addressing your Pepsi Use'

How Recovery Limits Methadone Maintenance Treatment's Ability to Help People in the Era of Overdose

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Abstract

Methadone Maintenance Treatment (MMT) in the United States has recently adopted an approach based on the principles of the Recovery movement — a view of treatment informed by addiction-as-disease models but also incorporating social, psychological, and spiritual components. Although organizations that administer drug treatment services claim that the shift represents a more client-centered, individualistic approach, it may not meet the needs of the many individuals who use MMT to reduce the harms of drug use, like overdose, rather than as a way to become abstinent. In this article, I use interview data from treatment providers to argue against institutional claims of Recovery as an individualistic model. My research demonstrates how — despite the wide variety of treatment goals among people on MMT — the Recovery discourse positions and organizes treatment strictly as abstinence-based, self-help. Moreover, I show how the Recovery model serves as the justification for an expansion of clinics' ability to surveil and intervene in aspects of people's lives which had previously been seen as outside of MMT's purview, including nutrition, public service, and spirituality. In conclusion, I argue that Recovery restricts MMT's ability to reduce harms, like overdose, in the lives of people who use drugs, and recommend that MMT adopt a more open-ended, low-threshold approach to treatment.

Keywords

Methadone Maintenance Treatment, recovery, addiction, overdose, harm reduction, abstinence

'Recovery encompasses an individual's whole life, including mind, body, spirit, and community.'

(SAMHSA 2012, 5)

Introduction

Opioid-involved overdose rates in the United States are currently at unprecedented levels (NIDA 2018; Rudd 2016; Peterson 2016). According to the National Institute of Drug Abuse, overdose rates for heroin, natural and semi-synthetic opioids, and synthetic opioids (other than methadone) have all increased every year for the past five years (2018). Substantial research also demonstrates that Methadone Maintenance Treatment (MMT) is among the most effective means of reducing risk of overdose as well as many other harms associated with illegal opioid use (Sordo et al. 2017; Schwartz et al. 2013). Despite this, MMT in the United States recently adopted an approach to treatment informed by the Recovery movement that could potentially make accessing treatment more difficult for those not pursuing Recovery as defined by the discourse.

People on MMT conceptualize their treatment goals in a variety of ways, including many who use it as a strategy for reducing the harms of illegal drug use, such as overdose and arrest, rather than as a means to become abstinent (Frank 2018; Harris and Rhodes 2013; Mateu-Gelebert et al. 2010). Yet, the Recovery model is based on an abstinence-only approach that often results in increased surveillance and punishment for such individuals, potentially leading to cessation of treatment (Frank 2018). Moreover, Recovery is based on a holistic conception of addiction that includes hard-to-define aspects such as spirituality and community involvement (SAMHSA 2012; White et al. 2012; White and Mojer-Torres 2010). This more comprehensive view significantly expands clinics' ability to surveil and intervene in patients'[1] lives beyond their use of illegal drugs. Thus, Recovery could increase rates of patient dropout and discharge as well as discourage people not currently in treatment from signing up (Frank 2018). MMT in the U.S. is already criticized for its strict rules and time-consuming, intrusive approach (Parpouchi et al. 2017; Callon et al. 2006) as evidenced by its consistently low rates of use and retention, particularly when compared to other countries using less-regulated approaches (Saloner and Karthikeyan 2015). Thus, the use of Recovery in MMT may make an already over-regulated and overly-cumbersome treatment even more so precisely when it is most needed.

[1] It is important to point out that the term 'patients' is considered problematic by many people and has been criticized for its tendency to medicalize individuals on MMT, many of whom do not conceptualize themselves as sick (Frank 2018; INPUD 2014). Although I considered using less specific language, I felt it was important to describe the population within the discursive context of Recovery-based treatment. Thus, my use of the term, 'patients' throughout the paper, is as a socially-constructed label that is often resisted by people on MMT.

This article uses semi-structured interview data from treatment providers that administer MMT in the U.S. to argue that Recovery restricts MMT's ability to reduce harms, like overdose, in the lives of people who use drugs, and recommends that MMT adopt a more open-ended, low-threshold approach to treatment that acknowledges the diversity of treatment goals among people on the program.

Access to MMT

MMT is a form of substitution-based treatment for opioid addiction whereby individuals are maintained on methadone, a synthetic opioid similar to, but less euphoric than heroin (and other illegal opioids). Methadone reduces the cravings and withdrawal that accompany cessation of opioid use and has proved to be an effective form of treatment (Ball and Ross 2012; Joseph et al. 2000). Its use is associated with reduced rates of illegal opioid use, overdose, transmission of blood-borne viruses, and recidivism as well as generally improving the stability of people on the program (Sordo et al. 2017; Schwartz et al. 2013; Brugal et al. 2005). Conversely, leaving treatment – either voluntarily or involuntarily – is associated with an increased risk of overdose (Cousins et al. 2011; Brugal et al. 2005; Magura and Rosenblum 2001). Despite its benefits, MMT in the U.S. has consistently maintained low rates of use and retention (Joseph et al. 2000). Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that in 2014, 41% of people in Medication Assisted Treatment dropped out of treatment and that the median length of stay among that group was only 114 days (2014). In addition to those that dropped out, a further 11% were terminated from treatment by the facility meaning that less than half of the patient population remained in treatment throughout the year (SAMHSA, Treatment Episode Data Set 2014).

Research that examines patients' perspectives on treatment demonstrates that strict regulations, an abstinence-only approach, and the time consuming, intrusive character of MMT in the U.S. is inconstant with the needs and treatment goals of much of the patient population (Strike et al. 2013; Peterson et al. 2010; Joseph et al., 2000). For example, Mateu-Gelebert and collaborators found that instead of pursuing abstinence, many people use MMT as a pragmatic strategy for avoiding withdrawal, which in turn reduces the likelihood of risky activity such as syringe sharing or committing crimes in order to obtain money for buying drugs (2010). Similarly, many use MMT as a temporary means of reducing tolerance and physical wear-and-tear; as a way of dealing with instabilities of the illegal drug market; and as a strategy to avoid overdose and transmission of blood-borne viruses such as HIV/AIDS or Hepatitis C (Harris and Rhodes, 2013; Mateu-Gelebert et al. 2010; McKeganey et al. 2004; Drucker et al. 1998). Scholars have also pointed out that many people use, and conceptualize MMT as way of moderating risks more associated with criminalized drug use than with drug use itself (Frank 2018; Harris and Rhodes 2013; Koester et al. 1999).

Comparatively, low-threshold models, that are used in parts of Canada and Europe and prioritize easy access to methadone over the promotion of abstinence,

attract a greater diversity of clients, have higher retention rates, and are associated with a reduction in injection-related HIV risk behaviors, overdose, and mortality in general (Nolan et al. 2015; Strike et al.2013; Millson et al. 2007; Langendam et al. 2001).

Emergence of Recovery

Recovery has recently gained strength in the U.S., both culturally, and as a bedrock principle meant to undergird the creation of policy in substance use treatment, including MMT (SAMHSA 2018; NYS OASAS 2018; White and Mojer-Torres 2010). As SAMHSA notes in the Recovery and Recovery Support section of their website: 'The adoption of recovery by behavioral health systems in recent years has signaled a dramatic shift in the expectation for positive outcomes for individuals who experience mental and/or substance use conditions' (2018). Recovery has its roots in the 19th century when temperance societies and related groups began discussing socially unacceptable alcohol use as a disease (Levine 1978). However, research – particularly in Australia and the UK – has linked the current recovery discourse to the emergence of twelve-step groups (e.g. Alcoholics Anonymous, Narcotics Anonymous) that formed in the late 20th century around a variety of practices including drinking, smoking, and narcotics use as well as to the context of neoliberalism that emphasizes practices of individual governance and surveillance (Fraser et al. 2017; Neale et al. 2015; Fraser et al. 2014).

Although the term 'recovery' can mean different things to different people, 'Recovery' is a specific, and institutionally-proscribed, discourse that refers to a commitment to abstinence as well as a focus on more general notions of health and well-being, including community involvement, spirituality, and nutrition (Duke, 2013; Best and Lubman 2012; White 2007). The Betty Ford Consensus Panel — on which most modern definitions of Recovery are based — defined it as 'a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship' (The Betty Ford Consensus Panel 2007). SAMHSA uses a similar definition, based on abstinence and including 'a voluntary, self-directed, ongoing process where patients access formal and informal resources; manage their care and their addiction; and rebuild their lives, relationships, and health to lead full meaningful lives' (2010).

Recovery is also positioned institutionally as a more inclusive approach to MMT. Government organizations like SAMHSA specifically describe Recovery as a more patient-centric model that empowers individuals to structure treatment according to their own goals. For example, SAMHSA's Second Principle of Recovery, that 'Recovery is person-centric' states that:

> Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by

> leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives (The Second Principle of Recovery, SAMHSA's Updated Working Principles of Recovery 2012).

However, drug-user rights and harm reduction organizations have been critical of Recovery (AIVL 2012; INPUD 2014). Although such groups do not oppose the rights of individuals to identify as 'in recovery', or pursue recovery-based goals, they argue that by elevating such personal choices to the level of policy, it becomes a standard that is forced upon everyone rather than a choice. Moreover, they are critical of addiction-as-disease narratives, and argue that rather than a disease, drug use is a social phenomenon, characterized by a high level of diversity, not 'sameness' (AIVL 2012, 3). From this perspective, the Recovery discourse necessarily implies 'that drug use is a disease from which people could or should be cured' (INPUD 2014).

Methods

This article is based on two years of qualitative research, conducted as part of my doctoral dissertation in sociology, from 2014 through 2016. Data collection involved conducting semi-structured interviews with stakeholders and ethnographic observations in New York City methadone clinics, as well as elements of autoethnography. My interest in this issue and the development of research questions were based initially on my own experience as an illegal opioid user and someone who has been in MMT for 15+ years. Research questions were further developed in the context of relevant literature. This article focuses primarily on data from 10 interviews with treatment providers, which refers to individuals working either in government organizations that administer MMT such as SAMHSA or the New York State Office of Alcoholism and Substance Abuse Services (OASAS), or in methadone clinic settings. Participants were recruited using a combination of convenience and snowball sampling based initially on contacts I had through my own experience as a person who uses drugs and as someone on MMT. All participants provided informed consent, and interviews lasted approximately one hour and were recorded and later transcribed. Data were then coded for themes and analyzed in a process informed by Critical Discourse Analysis (Weiss and Wodak 2007; Fairclough 2013). All participants are referred to by pseudonyms.

Theoretical Position

This article is informed by a social constructionist perspective that sees knowledge production as an inherently political act that carries with it a set of fixed identities, power relationships, and codes of behavior (Conrad and Schneider 2010; Berger and Luckmann 1971; Foucault 2003; Bourgois 2000). Thus, terms like 'drugs',

'addiction' and 'recovery' are seen as socially-contingent categories that reflect, and re-produce, existing power structures rather than as universal truths. Scholars have used this position to deconstruct medical and cultural knowledge about addiction, such as the disease model of addiction, often pointing out how such concepts function as forms of social control (Tiger 2013; Campbell 2011; Keane 2002). As Fraser and colleagues point out, 'addiction operates as a powerful therapeutic and political discourse which classifies, normalizes, and disciplines subjects' (Fraser et al. 2014, 5).

Recovery as Self-evident

Responses from treatment providers closely aligned with the institutional position by describing Recovery as patient-centered, individually-focused and empowering. In every case, Recovery was seen not only as an improvement in how treatment was organized but specifically as one that would increase the ability of patients to affect, and make choices about their treatment. They referred to it as 'less of a cookie-cutter approach' and a move away from a model where patients 'were not partners in the process'. For example, Sandy, an administrator for the OASAS emphasized that:

> number one is that the person is center and everything to do with [their treatment] is person-centered. They're included in all major decisions about their treatment, the direction of their recovery, and all of that is explained. It's about what *they* want to do (Sandy, OASAS 2014; emphasis in original).

The patient-centric character of Recovery was seen by treatment providers to be demonstrated most notably by the fact that the Recovery model accepted MMT (and other forms of Medication Assisted Treatment (MAT)) as a legitimate form of treatment for addiction. Treatment providers explained that programs using medication, like MMT, have historically been seen as fundamentally distinct from those using 'abstinence-based' treatment, defined here as programs not using medication (Hunt et al. 1985). As a result, people in MMT have often been stigmatized and denied access to many recovery spaces because of their use of methadone, seen as a drug and not a medicine (Earnshaw et al. 2013). Thus, part of the current Recovery discourse involves the institutional re-construction of methadone as a 'medicine' and an effort to frame all treatment choices as different 'paths to Recovery', which were seen as equally legitimate. The following responses reflect this shift:

> In a lot of the 'drug-free' programs, they don't consider someone in recovery if they're taking medication, methadone being one of them. But we certainly are a Recovery-based program, and if somebody is being maintained on methadone and they're not using any illicit substances or abusing any prescription sub-

> stances [then] that is recovery (Michele, Clinic Administrator 2014).

> I think there's been a lot of gains over the years of people talking about their recovery from addiction. But not as often do we hear about peoples' recovery using medications and utilizing methadone specifically. So, when you listen to peoples' recovery stories, oftentimes there is no medication element at all to treat the addiction. Or you may hear 'Oh I was in a methadone program but now I'm no longer in a methadone program, now I'm drug free'… There shouldn't be that kind of thinking where one person's pathway to recovery is better than others. The path to recovery is unique and all paths are acceptable. It doesn't matter if you haven't even been in treatment and you've recovered through a faith-based intervention or on your own (Karen, OASAS employee 2014).

> Our patients become very stigmatized. They're looked at as drug seekers whether or not they are. Their families continue to have difficulty accepting that people are on methadone or 'why aren't you getting off this?'… As a treatment community we really empower that [seeing MMT as Recovery] and every year [we] do more things and get more education [out to the community] (Marguerite, Clinic Program Director 2014).

However, by positioning MMT in this way, treatment providers' responses reflected a view of Recovery as the universal and proper goal of treatment. Although people were seen as increasingly able to choose from different types of treatment — including MMT — they were all conceptualized as strategies toward the singular goal of Recovery (see also Fraser and Valentine 2008). This contrasts with many harm reduction and drug-user rights narratives that justify MMT through pragmatic benefits, such as the elimination of withdrawal and reducing harms, that are not necessarily linked to an over-arching concept of self-improvement.

Moreover, the Recovery discourse obscures important differences between medication versus non-medication using treatment models as well as the often-different reasons that lead people to choose either option. For example, the many people that use MMT as a way of managing harms associated with criminalization are erased by the Recovery discourse. Thus, by flattening distinctions between different kinds of treatment — and particularly the differences between medication versus non-medication using models — the utility of MMT as a pragmatic form of resistance to criminalization becomes invisible.

How is Addiction Conceptualized?

In line with constructing MMT as a means to achieve to Recovery, treatment providers maintained a view of addiction that focused almost entirely on the behavioral, psychological and spiritual. Although most stated that they saw addiction as a disease, they downplayed its material or biological aspects such as dependence and withdrawal in favor of a more value-based view that emphasized character flaws and moral shortcomings. Thus, patients were seen as both bad and sick (Fraser et al. 2017; Fomiatti et al. 2017; Tiger 2013). Treatment providers conceptualized treatment in a similar manner by stressing its ability to shape behavior seen as problematic rather than as providing a pharmacological substitute for illegal opioids. As one Clinic Director explained:

> We accept that there is a brain disease, but we're not intervening in the brain. We're intervening at the level of behaviors, of attitudes, of spirit. Of course, all of that's the brain, but… we discourage talk of neurotransmitters…. Really what you have to do is people, places, and things, and triggers to relapse, and anger management, and that kind of stuff (John, Clinic Director 2014).

Similarly, treatment providers avoided describing patients through their physiological dependence on opioids. They rarely mentioned the material role of methadone as a substitute for illegal opioids and often de-valued the notion that people use MMT for that reason. Patients were described instead using discourses of trauma and disorder that positioned them as a monolithic and universally damaged population (Fomiatti et al. 2017). For example, treatment providers stated:

> We're also looking to focus much more on trauma. It's no secret that most people that have an issue with addiction have experienced trauma of some sort in their lives, whether it be what led them to use or the trauma of the lifestyle of addiction… but I would say, with pretty clear confidence, that 99% of our clientele has experienced trauma of some sort or another (Michele, Clinic Administrator 2014).

> Recovery is going deeper into something that's beyond your narcissism, tapping into something. I say for folks that are kind of atheistic or not open to that I say 'We're your higher power'… It's investing in a community instead of your narcissistic drug taking behavior. If you can buy into that as a higher power, trust our rules and regulations, trust our staff, like being here or can tolerate being here, well maybe that's a higher power than the arrogance of your addiction (John, Clinic Director 2014).

By conceptualizing addiction as a whole-person sickness Recovery provided discursive support for the production of MMT as a comprehensive intervention that included treatment for behavioral, psychological, and spiritual maladies, all conceptualized as 'addiction'. Similarly, because Recovery situated patients within a more comprehensive and clearly articulated therapeutic relationship (than previous approaches to MMT), it restricted rather than promoted their agency. Clinicians were the experts on addiction and patients were advised to, as John states (above): 'trust our rules and regulations, trust our staff'. In some cases, this was framed in harsh and punitive language that positioned patients as requiring constant surveillance. For example, when asked about the need to monitor patients' behavior, Grace, another Clinic Director, argued: 'If you [addicts] can lie, you will lie. If you [addicts] can steal, you will steal… [But] as clinicians, we're trained to know what they're thinking'.

Moreover, by positioning treatment in this way, treatment providers were able to frame unpopular and restrictive clinic rules, therapeutically. For example, although clinic take-home policies – that force most people to come to the clinic everyday – are often criticized as overly restrictive and linked to high rates of patient dropout (Vocal-NY 2011; Pani et al. 1996), Marguerite, a Clinic Program Director, positions them as providing patients with a break from the presumed chaos of their daily lives. She states:

> [Patients] also [benefit from] the structure. You know, they come in, this is a professional environment and people treating them with respect, and their coming in and they have consistency. They're not living, wherever they're living, it's chaotic. They're coming in here and there's stability here (Marguerite, Clinic Program Director 2014).

Thus, treatment providers conceptualized addiction in a way that established a clear power dynamic between patients and treatment providers. Since it positioned patients as both bad and sick, any attempts by them to affect their treatment program would be interpreted through this lens, i.e. as a symptom of their addiction. Consequently, they had little power to affect their treatment program.

Treatment as Abstinence plus Self-reconstruction

Treatment providers also described Recovery-based treatment as a highly comprehensive intervention that required much more from people than abstaining from illegal drugs. Clinicians used narratives of Recovery to make judgements about virtually any aspect of their patients' lives including proper use of free time, community service, and even consumption of soft drinks. These activities were positioned by treatment providers as important indicators of Recovery that merited intervention. For example, treatment providers stated:

> It's [Recovery] not only being drug free. There is also behaviors and thoughts that have to follow… That's where a lot of our patients get caught out. A lot of them will be like (adopts mock whining tone) 'Well I've been maintaining abstinence for six months and I haven't gotten a schedule reduction'. Well ok, yeah you've been maintaining abstinence for six months but you're not doing anything productive in your free time. You still come in here with the same negative attitude. You're still having problems with your counselor. You're still keeping that 'stinking thinking… Yes we are an opioid treatment program but we're here to address all of your addiction[s] and I tell them [patients] 'if your addicted to Pepsi and you're a Diabetic and it's causing you health problems, we're gonna be addressing your Pepsi use' (Grace, Clinic Director 2014).

> I don't consider someone in recovery on the sole purpose that they're not using, because there's such a thing as a 'dry drunk', somebody who's not using but is engaged in all of the behaviors of addiction… I would call that, they're staying away from substances but that they have some steps in their recovery to focus on (Michele, Clinic Administrator 2014).

> Part of the recovery process is for you to become part of the community, [and] for you to become a part of the community, you can't just go and get your methadone, go back home and sit there. [So] how do we set you up to be a meaningful part of the community? That's a critical part of recovery (Sandy, OASAS 2014).

Thus, treatment providers rejected a view of MMT solely as a means of reducing or eliminating problematic drug use and emphasized the importance of patients' demonstrating a holistic change in their thoughts, behaviors, and attitude. Positioning the treatment in this way not only helps to justify Recovery's expanded jurisdiction and infrastructure, it also devalues low-threshold approaches to MMT. Such models prioritize harm reduction over abstinence and work to make methadone more easily accessible for people who use drugs oftentimes by eliminating the kinds of regulatory apparatus and oversight that characterize Recovery (Strike et al. 2013).

Treatment providers' descriptions of the clinic environment also aligned with their view of addiction as a whole-person ailment. Clinics were described as centralized locations for the treatment of a variety of behavioral, psychological, and metaphysical issues discursively linked by Recovery. Treatment providers referred to clinics as a 'more comprehensive model' and 'wrap-around service' that spoke to their wide-ranging view of addiction treatment and the diminished role of methadone the substance. Moreover, many of the programs focused specifically on

promoting the tenets of Recovery, such as on-site twelve-step meeting and 'Peer-Recovery Coaches', who were described as filling a similar role to that of mentor in twelve-step programs. As one Clinic Director explained:

> We have a wrap-around service that includes primary medical care in addition to counseling, psychological, psychiatric, vocational, and nutritional and social. So, we provide a large number of services in the view that in order for recovery to occur, you want to affect as many life environments, from health all the way to how people eat. In addition, we have a vocational person because obviously being employed is an important resilience factor for further use (Wilson, Program Director 2014).

The focus on clinics as whole-person treatment centers was also reflected in the changing language treatment providers used. For example, they often deemphasized the role of methadone by describing the treatment as an 'Opioid Treatment Program' or 'OTP' rather than the previous moniker of 'Methadone Maintenance Treatment' or 'MMT'. As Karen, an OASAS administrator, explained:

> We're moving now to saying Opioid Treatment Program, Opioid Treatment Services because we want to take away the 'Methadone' label. You call it 'Methadone Treatment' [and] it sounds like that's all that happens is that people drink their methadone. If we call it Opioid Treatment, they have medication, it could be Methadone, it could be Buprenorphine. But we [also] have a whole comprehensive array of services. One of our things is removing all of that 'MTP', 'MMTP', 'Methadone Maintenance', 'Methadone Treatment Program'. It's 'Opioid Treatment Program' or 'OTP' and the Feds have that too' (Karen, OASAS 20144).

Although the addition of new services is undoubtedly helpful to people who need them, they also greatly expand the clinics' ability to exert influence over parts of their patients' lives which had previously been unavailable to them. Treatment providers characterized the additional services as 'tools in a toolkit' rather than requirements, however, they were none-the-less positioned as important parts of the program, and whether or not patients utilized them, impacted their relationships with counselors and other clinic staff, which ultimately affected patient assessments and determined access to privileges. For example, although SAMHSA administrators stressed that patients would not be forced to adopt Recovery as their approach to treatment, they also noted that all patients are required to meet with their counselor every month, and that those 'patient assessments', are based on the tenets of Recovery. Thus, while there is no explicit mandate to adopt Recovery, it is built into the program structurally, ultimately meaning that those who are uninterested in community service, spirituality, or other aspects of Recovery may be viewed unfavorably.

Discussion

This article critically analyzed the institutional claim that Recovery represents a more patient-centric model that better enables people to structure treatment according to their own goals and values. Although treatment providers all stated that they saw Recovery in this way, their descriptions suggest that it is more proscriptive and restrictive than previous, less clearly articulated approaches to MMT. Since Recovery is based on the implicit desirability of abstinence and self-transformation, it functions as a barrier for the many people that use MMT for more pragmatic reasons such as avoiding overdose, withdrawal and arrest, or simply to escape the chaotic and risk-involved lifestyle associated with illegal drug use. Moreover, it will prevent those who would benefit from MMT but are not pursuing Recovery, from signing up, precisely when the risk of opioid-involved overdose is at its greatest.

That many individuals use and benefit from MMT for reasons outside of the Recovery model was particularly absent from how treatment providers conceptualized the program. Thus, Recovery can be read as an attempt to shore up the ontological and epistemological problems raised by MMT for government, who is interested in legitimizing MMT but within the current logics of prohibition. According to the narrative of prohibition, it is drugs and addiction, and not laws or policies, that cause the harms of drug use. Yet since methadone is an opioid, like heroin, its use as a maintenance medication problematizes this view. As sociologist Helen Keane explains, 'methadone in the context of maintenance therapy is produced as a paradoxical substance with a double identity, it is both 'not heroin and like heroin'; and it is both addictive and a treatment for addiction' (2013, 18).

Moreover, the ability of MMT to dramatically improve peoples' lives raises etiological questions about the treatment. Specifically, that people benefit by switching from highly criminalized opioids to a substance that is pharmacologically similar but available outside of the context of criminalization suggests that the problems people using drugs experience are more a product of drugs' illegality than from their pharmacological properties. In other words, MMT 'works' by decriminalizing peoples' opioid use. However, by incorporating MMT into the standard body of Recovery-oriented addiction treatment, and by re-framing it in a way that obscures its material basis as a pharmacological substitute for illegal opioids, Recovery works to paper over these cracks in the government's prohibitionist narrative.

In this case, the Recovery discourse seeks to construct addiction through an amaterialist lens that positions it primarily as a problem of personhood and individual values, unrelated to the physical characteristics of opioids such as tolerance and withdrawal, or the structural policies that govern their use. This position de-politicizes the role of treatment in the lives of people who use drugs by framing their choices as motivated solely by addiction and not as an attempt to escape from the effects of policy (Frank 2018). Yet, by incorporating a view of MMT that acknowledges the materiality of methadone as an opioid and MMT as a form of

substitution treatment, their decisions can be understood, at least in part, as a move from using illegal to legal opioids rather than from addiction to Recovery.

The findings of this study align with related scholarship that rejects the view of MMT as a stable and bounded entity governed by clearly identifiable causal relationships and sees it instead as dynamic and made through its interaction with politics, culture, institutions, and people (Fraser and Valentine 2008; Fraser et al. 2014). In particular, the emphasis on accounting for MMT's material characteristics is supported by Fraser and Valentine's call for analyses that incorporate 'both the social/cultural/discursive and the material' (2008, 21). It is similarly linked to deconstructive accounts of addiction narratives that demonstrate how the phenomenon of 'addiction' resists categorization through binaries like health/sick; normal/pathological; addict/recovered addict (Moore et al. 2017; Fomiatti et al. 2017; Pienaar et al. 2017). Such accounts were used by the treatment providers in this study, oftentimes to construct patients as disordered, and themselves as experts.

It is important to point out that this article's critique of Recovery is not about the lived experience of people in recovery or pursuing recovery-oriented goals. Recovery can be a meaningful and useful paradigm for some people to understand their drug use and treatment. Rather, it focuses on the discursive production and institutional use of Recovery, to demonstrate how such narratives — particularly when elevated from personal choice to the level of policy — can be used to restrict, control, and punish those with different aims for treatment.

In this article, I argue that MMT should be available for the full range of beneficiaries and not just those seeking Recovery as conceptualized by the discourse. Substantial research demonstrates that 'low threshold' approaches — which are used successfully in Canada and Europe — have higher retention rates, happier clients, and a reduced risk of overdose (Strike et al. 2013; Brugal et al. 2005). Moreover, the coercive structure that has long been a part of MMT, but that Recovery expands upon, should be dismantled in favor of non-punitive model that supports harm reduction. As Fraser and Valentine point out in *Substance & Substitution*, 'Other people are subject to rules as well, of course, but MMT operates in ways unthinkable in other treatment formats... Far from being active consumers or patients sharing treatment decisions and responsibility with their doctors, methadone clients are positioned within an apparently outmoded, paternalistic relationship of compliance' (2008, 86).

This is particularly important in the context of dramatically increased rates of opioid-involved overdose where access to treatment should take on an increased urgency. Potential changes could include abandoning the use of punishment for failed drug screens and/or liberalizing take-home polices. These policy shifts would push MMT in a direction that better reflected institutional rhetoric on promoting patient agency, and more importantly, would work towards reducing rates of opioid-involved overdose. As one of the harm reduction advocates I spoke

with pointed out: 'I totally respect anyone who considers themselves on a path to recovery, in recovery, whatever. I just don't think it should be required to participate in those activities to receive a lifesaving medication.'

Author Bio

David Frank recently graduated from the Graduate Center of the City University of New York in Sociology and is currently a Postdoctoral Research Fellow at New York University's Behavioral and Science Training program in substance use research. Dr. Frank uses primarily qualitative methods to study substance use and treatment issues. His work examines opioid use, overdose, and methadone maintenance, and focuses in particular on the role of structural factors like criminalization and the War on Drugs in behaviors thought to be caused by drug use or 'addiction'. He is currently interested in reducing barriers to methadone maintenance treatment as a means of reducing overdose.

Acknowledgements

The author was supported as a postdoctoral fellow in the Behavioral Science Training in Drug Abuse Research program sponsored by New York University Rory Meyers College of Nursing with funding from the National Institute of Drug Abuse (T32 DA007233B). Points of view, opinions, and conclusions in this article do not necessarily represent the official position of the U.S. government or New York University.

Competing Interests

The authors report no conflicts of interest. The author alone is responsible for the content and writing of this article.

References

Australian Injecting & Illicit Drug Users Union (AVIL). 2012. '"New recovery", harm reduction & drug use policy statement'.

Ball, John C., and Alan Ross. 2012. *The effectiveness of methadone maintenance treatment: patients, programs, services, and outcome*. Springer Science & Business Media.

Berger, Peter, and Peter Luckmann. 1971. *The Social Construction of Reality*. New York: Random House.

Best, David W. and Dan I. Lubman. 2012. 'The recovery paradigm: A model of hope and change for alcohol and drug addiction', *Australian family physician*, 41(8): 593.

Betty Ford Institute Consensus Panel. 2007. 'What is recovery? A working definition from the Betty Ford Institute', *Journal of Substance Abuse Treatment*, 33(3): 221–228. https://doi.org/10.1016/j.jsat.2007.06.001

Bourgois, Phillipe. 2000. 'Disciplining addictions: The bio-politics of methadone and heroin in the United States', *Culture, medicine and psychiatry*, 24(2): 165-195. https://doi.org/10.1023/A:1005574918294

Brugal, M. Teresa, Antonia Domingo-Salvany, R. Puig, Gregorio Barrio, Patricia Garcia de Olalla, and Luis De La Fuente. 2005. 'Evaluating the impact of methadone maintenance programs on mortality due to overdose and aids in a cohort of heroin users in Spain', *Addiction*, 100(7): 981-989. https://doi.org/10.1111/j.1360-0443.2005.01089.x

Callon, Cody, Evan Wood, David Marsh, Kathy Li, Julio Montaner, and Thomas Kerr. 2006. 'Barriers and facilitators to methadone maintenance therapy use among illicit opiate injection drug users in Vancouver', *Journal of Opioid Management*, 2 (1): 35-41. https://doi.org/10.5055/jom.2006.0006

Campbell, Nancy. 2011. 'From 'magic bullets' to medical maintenance: The Changing meanings of medical approaches to drug use in US drug policy', in *The drug effect: Health, crime, and society*, edited by Suzanne Fraser and David Moore, 122-136. Cambridge: Cambridge University Press.

Conrad, Peter, and Joseph W. Schneider. 2010. *Deviance and medicalization: From badness to sickness*. Philadelphia: Temple University Press.

Cousins, Graine, Conor Teljeur, Nicola Motterlini, Colin McCown, Borislav D. Dimitrov, and Thom Fahey. 2011. 'Risk of drug-related mortality during periods of transition in methadone maintenance treatment: a cohort study', *Journal of substance abuse treatment*, 41, 3: 252-260. https://doi.org/10.1016/j.jsat.2011.05.001

Drucker, Ernest, Peter Lurie, Alex Wodak, and Petal Alcabes. 1998. 'Measuring harm reduction: the effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV', *Aids-London-Current Science then Rapid Science Publishers then Lippincott Raven*, 12: S217-S230.

Duke, Karen. 2013. 'From crime to recovery: the reframing of British drugs policy?', *Journal of Drug Issues*, 43, 1: 39-55. https://doi.org/10.1177/0022042612466614

Earnshaw, Valerie, Laramie Smith, and Michael Copenhaver. 2013. 'Drug addiction stigma in the context of methadone maintenance therapy: an investigation into understudied sources of stigma', *International journal of mental health and addiction*, 11. 1: 110-122. https://doi.org/10.1007/s11469-012-9402-5

Fairclough, Norman. 2013. *Critical discourse analysis: The critical study of language*. London: Routledge. https://doi.org/10.4324/9781315834368

Fomiatti, Renae, David Moore, and Suzanne Fraser. 2017. 'Interpellating recovery: The politics of 'identity'in recovery-focused treatment', *International Journal of Drug Policy*, 44: 174-182. https://doi.org/10.1016/j.drugpo.2017.04.001

Foucault, Michel. 2003. *Madness and civilization*. London: Routledge. https://doi.org/10.4324/9780203164693

Frank, David. 2018. '"I Was Not Sick and I Didn't Need to Recover": Methadone Maintenance Treatment (MMT) as a Refuge from Criminalization', *Substance use & misuse*, 53, 2: 311-322. https://doi.org/10.1080/10826084.2017.1310247

Fraser, Suzanne, Kiran Pienaar, Ella O. Dilkes-Frayne, David Moore, Renata Kokanovic, Carla Treloar, and Adrian Dunlop. 2017. 'Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis', *International Journal of Drug Policy*, 44: 192-201. https://doi.org/10.1016/j.drugpo.2017.02.005

Fraser, Suzanne, David Moore, and Helen Keane. 2014. *Habits: remaking addiction.* Hampshire: Palgrave Macmillan https://doi.org/10.1057/9781137316776

Fraser, Suzanne, and Kylie Valentine. 2008. *Substance and substitution: Methadone subjects in liberal societies*. Basingstoke: Palgrave Macmillan https://doi.org/10.1057/9780230582569

Gryczynski, Jan, Jerome Jaffe, Robert Schwartz, Kristi Dušek, Nishan Gugsa, Cristin Monroe, Kevin O'Grady, Yngvild Olsen, and Shannon Mitchell. 2013. 'Patient perspectives on choosing buprenorphine over methadone in an urban, Equal-Access system', *The American journal on addictions*, 22(3): 285-291. https://doi.org/10.1111/j.1521-0391.2012.12004.x

Harris, Magdalena, and Tim Rhodes. 2013. 'Methadone diversion as a protective strategy: the harm reduction potential of "generous constraints"', *International Journal of Drug Policy*, 24(6): 43–50. https://doi.org/10.1016/j.drugpo.2012.10.003

Hunt, Dana, Douglas Lipton, Douglas Goldsmith, David Strug, and Barry Spunt. 1985. '"It takes your heart": The image of methadone maintenance in the addict world and its effect on recruitment into treatment', *International Journal of the Addictions*, 20(11-12): 1751-1771. https://doi.org/10.3109/10826088509047261

International Network of People who Use Drugs (INPUD). 2014. 'INPUD Position Statement on Language, Identity, Inclusivity and Discrimination; Draft version 2', Retrieved from: http://inpud.wordpress.com/position-papers/inpudposition-statement-on-language-identity-inclusivity-anddiscrimination/

Joseph, Herman, Sharon Stancliff, and Joseph Langrod. 2000. 'Methadone maintenance treatment (MMT): a review of historical and clinical issues', *The Mount Sinai Journal of Medicine*, New York 67(5-6): 347-364.

Keane, Helen. 2013. 'Categorizing methadone: Addiction and analgesia', *International Journal of Drug Policy*, 24(6): 18-24. https://doi.org/10.1016/j.drugpo.2013.05.007

Keane, Helen. 2002. *What's wrong with addiction?*, Melbourne University Publish.

Koester, Stephen, Kenneth Anderson, and Lee Hoffer. 1999. '"Active heroin injectors" perceptions and use of methadone maintenance treatment: Cynical performance or self-prescribed risk reduction', *Substance Use & Misuse*, 34(14): 2135–2153. https://doi.org/10.3109/10826089909039442

Langendam, Miranda W., Giehl H. van Brussel, Roel A. Coutinho, and Eric J. C. van Ameijden. 2001. 'The impact of harm-reduction-based methadone treatment on mortality among heroin users', *American journal of public health*, 91(5): 774. https://doi.org/10.2105/AJPH.91.5.774

Levine, Harry G. 1978. 'The discovery of addiction. Changing conceptions of habitual drunkenness in America', *Journal of studies on alcohol*, 39(1): 143-174. https://doi.org/10.15288/jsa.1978.39.143

Magura, Stephen, and Andrew Rosenblum. 2001. 'Leaving methadone treatment: lessons learned, lessons forgotten, lessons ignored', *The Mount Sinai Journal of Medicine*, 68(1): 62-74.

Mateu-Gelabert, Pedro, Milagros Sandoval, Peter Meylakhs, Travis Wendel, and Samuel R. Friedman. 2010. 'Strategies to avoid opiate withdrawal: Implications for HCV and HIV risks', *International Journal of Drug Policy*, 21(3): 179–185. https://doi.org/10.1016/j.drugpo.2009.08.007

McKeganey, Neil, Zoe Morris, Joanne Neale, and Michele Robertson. 2004. 'What are drug users looking for when they contact drug services: Abstinence or harm reduction?', *Drugs: education, prevention and policy*, 11(5): 423-435. https://doi.org/10.1080/09687630410001723229

Millson, Peggy, Laurel Challacombe, Paul J. Villeneuve, Carol Strike, Benedikt Fischer, Ted Myers, Ron Shore, and Shaun Hopkins. 2007. 'Reduction in

injection–related hiv risk after 6 months in a low-threshold methadone treatment program', *AIDS Education & Prevention*, 19(2): 124-136. https://doi.org/10.1521/aeap.2007.19.2.124

Moore, David, Kiran Pienaar, Ella Dilkes-Frayne, and Suzanne Fraser. 2017. 'Challenging the addiction/health binary with assemblage thinking: An analysis of consumer accounts', *International Journal of Drug Policy*, 44: 155-163. https://doi.org/10.1016/j.drugpo.2017.01.013

National Institute on Drug Abuse. 2018. 'Overdose death rates', Retrieved on November 7, 2018 from: https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

Neale, Joanne, Charlotte E. Tompkins, Carly Wheeler, Emily Finch, John Marsden, Luke Mitcheson, Diana Rose, Til Wykes, and John Strang. 2015. '"You're all going to hate the word 'recovery' by the end of this": Service users' views of measuring addiction recover', *Drugs: education, prevention and policy*, 22(1): 26-34. https://doi.org/10.3109/09687637.2014.947564

New York State Office of Alcoholism and Substance Abuse Services (OASAS). 2018. 'Building a Foundation for Recovery in New York State', Retrieved on August, 24, 2018 from: https://www.oasas.ny.gov/recovery/index.cfm

Nolan, Senoaid, Kanna Hayashi, M-J Milloy, Thomas Kerr, Huiru Dong, Vivianne Das Lima, Leslie Lappalainen, Julio Montaner, and Evan Wood. 2015. 'The impact of low-threshold methadone maintenance treatment on mortality in a Canadian setting', *Drug and alcohol dependence*, 156: 57-61. https://doi.org/10.1016/j.drugalcdep.2015.08.037

Pani, Pier Paolo, Roberto Pirastu, Antonia Ricci, Gian Luigi Gessa. 1996. 'Prohibition of take-home dosages: negative consequences on methadone maintenance treatment', *Drug and Alcohol Dependence*, 41(1): 81-84. https://doi.org/10.1016/0376-8716(96)01240-9

Parpouchi, Milad, Akm Moniruzzaman, Stefani Rezansoff, Angela Russolillo, and Julian Somers. 2017. 'Characteristics of adherence to methadone maintenance treatment over a 15-year period among homeless adults experiencing mental illness', *Addictive behaviors reports*, 6: 106-111. https://doi.org/10.1016/j.abrep.2017.09.001

Peterson, Alexis. 2016. 'Increases in fentanyl-related overdose deaths—Florida and Ohio, 2013–2015', *MMWR, Morbidity and mortality weekly report*, 65. https://doi.org/10.15585/mmwr.mm6533a3

Peterson, James. A., Robert P. Schwartz, Shannon G. Mitchell, Heather S. Reisinger, Sharon M. Kelly, Kevin O'Grady, Barry Brown, and Michael H.

Agar. 2010. 'Why don't out-of-treatment individuals enter methadone treatment programs?', *International Journal of Drug Policy*, 21(1): 36-42. https://doi.org/10.1016/j.drugpo.2008.07.004

Pienaar, Kiran, David Moore, Suzanne Fraser, Renate Kokanovic, Carla Treloar, and Ella Dilkes-Frayne. 2017. 'Diffracting addicting binaries: An analysis of personal accounts of alcohol and other drug 'addiction'', *Health* 21(5): 519-537. https://doi.org/10.1177/1363459316674062

Rudd, Rose A. 2016. 'Increases in drug and opioid-involved overdose deaths—United States, 2010–2015', *MMWR. Morbidity and mortality weekly report*, 65. https://doi.org/10.15585/mmwr.mm655051e1

Saloner Brendan, and Shankar Karthikeyan. 2015. 'Changes in substance abuse treatment use among individuals with opioid use disorders in the United States, 2004-2013', *Journal of the American Medical Association*, 314: 1515-1517. https://doi.org/10.1001/jama.2015.10345

Schwartz, Robert, Jan Gryczynski, Kevin E. O'grady, Joshua M. Sharfstein, Gregory Warren, Yngvild Olsen, Y., Shannon Mitchell, and Joseph Jaffe. 2013. 'Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995–2009', *American journal of public health*, 103 (5): 917-922. https://doi.org/10.2105/AJPH.2012.301049

Sordo, Luis, Gregorio Barrio, Maria J. Bravo, B. Iciar Indave, Louisa Degenhardt, Lucas Wiessing, Marica Ferri, and Roberto Pastor-Barriuso. 2017. 'Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies', *bmj*, 357: j1550. https://doi.org/10.1136/bmj.j1550

Strike, Carol, Margaret Millson, Shaun Hopkins, and Christopher Smith. 2013. 'What is low threshold methadone maintenance treatment?', *International Journal of Drug Policy*, 24(6): 51-56. https://doi.org/10.1016/j.drugpo.2013.05.005

Substance Abuse and Mental Health Service Administration. 2012. 'SAMHSA's working definition of recovery updated', Retrieved on November 6, 2018 from: http://store.pear-vt.org/wp-content/uploads/2015/08/SAMHSA_Working_Definition_Recovery.pdf

Substance Abuse and Mental Health Service Administration. 2014. 'Treatment Episode Data Set. 2014', Retrieved on November 1, 2018 from: https://www.samhsa.gov/data/sites/default/files/2014_TEDS_Discharge.pdf

Substance Abuse and Mental Health Service Administration. 2010. 'Recovery Oriented Systems of Care (ROSC) Resource Guide', Retrieved on Sept. 5,

2015 from: http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

Substance Abuse and Mental Health Service Administration. 2018. 'Recovery and Recovery Support', Retrieved on November 6, 2018 from: https://www.samhsa.gov/recovery

Tiger, Rebecca. 2013. *Judging addicts: Drug courts and coercion in the justice system*. New York: NYU Press.

Vocal-NY. 2011. *Beyond Methadone: Improving Health and Empowering Patients in Opioid Treatment Programs*, Retrieved on March 27, 2019 from: http://www.vocal-ny.org

Weiss, Gilbert, and Ruth Wodak. (Eds.). 2007. *Critical discourse analysis*. New York: NY: Palgrave Macmillan.

White, William L., John Kelly, and Jeffrey D. Roth. 2012. 'New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid', *Journal of Groups in Addiction & Recovery*, 7(2–4): 297–317. https://doi.org/10.1080/1556035X.2012.705719

White, William L., and Lisa Mojer-Torres. 2010. *Recovery-oriented methadone maintenance.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, William L. 2007. 'Addiction recovery: Its definition and conceptual boundaries', *Journal of substance abuse treatment*, 33(3): 229-241. https://doi.org/10.1016/j.jsat.2007.04.015

JOURNAL of EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 21-43 https://doi.org/10.5617.6720

Article

Gendered Triple Standard and Biomedical Management of Perinatal and Maternal Opioid Use Disorder in the United States

Investigating Bodily, Visceral, and Symbolic Violence

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Abstract

Despite trends towards treatment versus punitive-based approaches to addressing opioid use disorders (OUD) in the United States, pregnant and parenting women with OUD remain highly stigmatized, their maternal fitness routinely contested. Biomedical conceptions of OUD as a chronic, relapsing condition often run counter to the abstinence-based models enforced across the myriad institutions that manage OUD, particularly for women whose maternal status is contingent on treatment enrollment and adherence. Exposure to trauma is considered to be nearly universal among women with OUD; biomedical classifications of trauma primarily center on the interpersonal (i.e. adverse childhood [ACEs] and lifetime experiences). This work responds to a call to 'gender addiction' (Campbell and Ettorre 2011) and examine the 'epistemologies of ignorance' (Tuana 2006) around notions of 'risk' by advocating for a broadened definition of trauma that incorporates the institutional violence imbedded into policies and procedures specific to the biomedical management of OUD. Drawing on an 18-month ethnographic investigation of pregnant and parenting women with OUD living in the Northeastern United States, this article argues that the intertwined institutions (e.g. medical, legal, and social services) that manage OUD according to biomedical dictates enact a converging constellation of violence on women; this in turn becomes a form of embodied trauma, directly influencing perinatal and maternal opioid use trajectories. Key findings include: (1) civil commitment to treatment as a form of direct bodily violence, (2) loss of maternal status as visceral violence, and (3) institutional erasures (i.e. intergenerational family separation) as symbolic violence.

Keywords

opioids, maternal substance use, perinatal substance use, institutional violence, visceral violence

Introduction

Pregnant and parenting women who use opioids are a rapidly growing population in the United States (Centers for Disease Control and Prevention [CDC] 2019). Although there is a trend away from punitive towards treatment-based approaches to addressing opioid use in the U.S., pregnant and parenting women with opioid use disorders remain highly stigmatized, their maternal fitness routinely called into question. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma is an 'almost universal experience' (SAMHSA 2019, 2) shared by people with substance use disorders. Biomedical conceptualizations of trauma refer to adverse childhood and lifetime experiences, including direct and indirect exposure to physical, sexual, and emotional violence, as well as the traumas associated with war, combat, and natural disasters (SAMHSA, 2019). This article broadens current definitions of trauma to extend beyond the interpersonal and the structural (e.g. lack of transportation, income, or insurance coverage) and takes a pointed look at the role of the institutional violence imbedded into policies and procedures specific to the treatment and management of perinatal and maternal OUD in the U.S. This article argues that the intertwined institutions that manage OUD according to biomedical dictates enact a converging constellation of violence on pregnant and parenting women. In turn, this becomes a form of embodied trauma, directly influencing opioid use trajectories among this population.

Scope of Opioid Use in the U.S.

Opioid use and opioid-related fatalities in the United States have increased drastically. It is currently estimated that every day 130 Americans die from an opioid overdose. Between 1999-2017 over 400,000 people in the U.S. died from an opioid overdose. There are three notable spikes in opioid-related fatalities during that time. The first, from 1999-2009, wherein the bulk of overdoses were attributed to prescription opioids. The second, from 2010-2012, wherein most overdose deaths were attributed to heroin. And the third from 2013-2017 (and continuing beyond the time of this writing) where the bulk of opioid-related fatalities involve synthetic opioids, particularly illicitly manufactured fentanyl (CDC 2019).

Women in the U.S. with opioid use disorders are a rapidly growing and vulnerable population. Between 1999 and 2015, mortality rates from prescription opioid overdoses among women increased by 471% as compared to 218% for men; mortality rates for heroin overdoses among women during that same period were double that of men (U.S. Department of Health and Human Services [USDHHS] 2017). Concomitantly, rates of perinatal opioid use and neonatal opioid withdrawal syndrome more than quadrupled between 1999-2014 (CDC 2018). Women with opioid use disorders have higher rates of mental health comorbidities (e.g. depression, anxiety, post-traumatic stress disorder [PTSD]), poor self-concept, sexual trauma, intimate partner violence (IPV), and poverty as compared to men (Crandall et al. 2003; Kremer and Arora 2015).

Biomedical Conceptualization and Management of Opioid Use Disorder

Medical and public health discourse around opioid use primarily centers around the diagnosis of opioid use disorder (OUD). According to the most current Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-V), OUD refers to patterns of opioid use that interfere with multiple aspects of life, such as the ability to maintain employment and positive social relationships; it is classified as either mild, moderate, or severe (Substance Abuse and Mental Health Services Administration [SAMHSA] 2017). As defined by the National Institute on Drug Abuse (NIDA), OUD is a

> chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences. It is considered a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control, and those changes may last a long time after a person has stopped taking drugs (NIDA 2019).

This 'brain disease' biomedical model of addiction represents an important departure from a moral model of addiction, which points to notions of moral frailty as the true roots of addiction.

Some of the critiques harbored at the 'brain disease' biomedical model of addiction point to a silencing of structural factors that contribute to addiction, as well as minimizing concepts such as brain plasticity (i.e. capability of the brain's capacity to change and reorganize), existing evidence of people who 'age out' of problematic substance use patterns, and those individuals who use opioids but do not meet the criteria for diagnosis (Hall, Carter, and Forlini 2015). Guided by a biomedical model, current research goals in the U.S. specific to OUD primarily center on investigations related to neuroscience, epigenetics, pharmaceutical development, and prescription monitoring programs (NIDA 2018). With this focus the risk of somatic reductionism (Lock 2015) looms large, wherein the focus on biology and molecular processes overshadow the larger political-economic processes that shape 'the environment' and other 'risk factors' (Cadet 2014; Leatherman and Hoke 2016).

Under the biomedical model, OUD is categorized as a chronic health condition (commonly equated to other chronic illnesses, such as type two diabetes) that is best managed by sustained engagement with medications for opioid use disorder (MOUD), such as methadone, buprenorphine, naltrexone. Health experts largely view long-term treatment with medications as the 'gold standard of care' that improves health and psychosocial outcomes for people with OUD. However, approximately 90% of individuals living with OUD do not access MOUD; for those that do, treatment retention remains low. Furthermore, treatment rates are lower for women versus men (SAMHSA 2017).

In the field of maternal and child health, the perinatal period is often considered a 'window of opportunity' (Daley, Argeriou, and McCarty 1998, 240) for intervening in a multitude of health conditions among populations that might otherwise remain outside of the health care system, as is often the case with women who are active substance users. In pregnancy, women become a captive audience and routine prenatal visits present a unique opportunity to develop relationships with a clinic or hospital and health care providers, and to address health concerns. However, this notion is neither simple nor straightforward in the context of substance use. Interactions between care providers and women with OUD can be fraught with tension, judgement, and miscommunication, exacerbated by legitimate fears of punitive interventions that can divide mothers from their children and families (Holbrook 2015; Lupton 2012; Terplan, Kennedy-Hendricks, and Chisolm 2015). Additionally, while routine prenatal visits do indeed present an opportunity, the singular focus on this point in time remains mechanistic and shortsighted, evidenced by the reality that within six months of giving birth, treatment retention among mothers with OUD drops by over 50% and overdose rates spike dramatically (Wilder, Lewis, and Windhusen 2015).

The official position of the American College of Obstetricians and Gynecologists (ACOG) is that OUD is a chronic condition which requires routine care and maintenance, and women with OUD seeking prenatal care should not face criminal or civil penalties *including* loss of custody (ACOG 2016). In reality, however, stigmatizing public discourse inhibits care-seeking among this population. Complete withdrawal from opioids during pregnancy is not recommended; it can cause miscarriage, preterm birth, low birth weight, and stillbirth (ACOG 2016; Kremer and Aurora 2015). Yet, many women attempt detoxification before initiating prenatal care, and some avoid care altogether due to fears (often substantiated, and most definitely location dependent) of provider-stigma, mandatory reporting, social service involvement, and losing custody of children.

While considering OUD as a chronic condition has created space for a treatment versus punitive-based focus, this 'trope of chronicity' (Garcia 2010, 12) has reshaped moral notions of addiction by positioning MOUD as the sole option, particularly for women whose maternal status is contingent on treatment enrollment and adherence. Biomedical conceptions of addiction as a chronic, relapsing condition run counter to an abstinence-based model instituted across the myriad of managing institutions that mothers interact with, fear, or avoid on a daily basis, e.g. medical, legal, and social service entities (Holbrook 2015; Terplan, Kennedy-Hendricks, and Chisolm 2015). For example, as observed during the fieldwork for this project, many direct-care staff making decisions about a woman's maternal status remain aligned with a moral model of addiction and were strictly unforgiving of 'relapse'. And though the definition of 'abstinence' within some institutions increasingly includes the use of MOUD, failure to adhere to treatment protocols had multiple punitive implications, such as court-mandated stipulations for maintaining custody and accessing government-funded housing

Perinatal and Maternal OUD: Shifting Discourse and the Gendered Triple Standard

Current approaches to the management of OUD represent a departure from a War on Drugs approach from the 1970s that favored criminalization over treatment and drove the flagrant and dramatic rise of the incarceration of people of color in the U.S. (National Research Council 2014). As part of a series of legislation passed under the War on Drugs, the Comprehensive Drug Abuse and Prevention and Control Act of 1970 sought to lower rates of substance use and the violence associated with unregulated markets, allowing law enforcement to conduct 'no knock' searches, which primarily targeted low income communities of color. In response to the 'crack epidemic' of the 1980s, then President Reagan signed The Anti-Drug Abuse Prevention Act into law in 1986, creating funding for drug treatment, abstinence-based substance use education programs, *and* increased construction of prisons. Mandatory minimum sentencing for drug possession was central to The Anti-Drug Abuse Prevention Act, a policy that has been widely critiqued for promoting racial disparities in sentencing, and discriminant surveillance of low-income communities of color (Netherland and Hansen 2016). The majority of incarcerated individuals are men of color serving time for non-violent drug offences; females are the most rapidly increasing incarcerated population in the U.S. (National Research Council 2014).

Current policy efforts and public discourse around OUD have rapidly shifted from punitive-based legal interventions that focus on individual responsibility, to a call for compassionate treatment efforts that draws instead on a whitewashed narrative that depicts 'good kids' addicted because of the overprescription of legitimized medicine (Netherland and Hansen 2016). As a stark contrast to legislative efforts during the U.S. 'crack epidemic' the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act was passed in October 2018 with nearly unanimous, bipartisan support – a notable feat during the current combative political landscape in the U.S. In addition to providing funds for expanded access to MOUDs and lifting insurance restrictions, the SUPPORT Act specifically earmarks increased funds for the treatment of pregnant and postpartum women with OUD (Library of Congress 2018). It should come as no surprise then to read researchers Julie Netherland and Helena Hansen refer to the opioid 'crisis' as the 'war on drugs that wasn't' (Netherland and Hansen 2016, 664).

Building on what Sanders refers to as the 'gendered double standard' (Sanders 2014) faced by women with substance use disorders, I characterize the intersecting identities of female and pregnant/mother as a *triple* standard. Being held to this gendered triple standard intensifies the stigma faced by pregnant women and mothers with OUD as they navigate medical, social service, and legal institutions. Although there *is* a trend away from punitive towards humanistic approaches to OUD, pregnant and parenting women with OUD remain one of the most stigmatized groups in society, routinely judged as being unfit to parent and uncaring of their child(ren) (Terplan, Kennedy-Hendricks, and Chisolm 2015). Messaging and

discourse surrounding OUD in pregnancy shape conceptions of who is deserving of empathy and care, with pregnant women expected to adhere to 'reproductive asceticism' (Ettorre 2009, 246) by controlling and managing their bodies according to medical dictates, inscribing the notion of 'pregnancy as an ethical practice' (Lupton 2012, 4) and pregnant women as having a moral obligation to keep themselves and their growing child healthy. According to the collective discourse, pregnant and parenting women with OUD are not only harming themselves, but also their reproductive potential, threatening their socially prescribed 'purpose.'

Image taken less than 1 mile/km from a methadone clinic in Springfield, MA. September 2018, by author.

With a rising focus in the U.S. on addressing perinatal OUD and preventing neonatal opioid withdrawal syndrome, it is particularly important to consider the concept of a gendered triple standard as experienced by mothers with OUD who no longer fall into the perinatal and postpartum window. Although policies that address increasing rates of perinatal OUD and neonatal opioid withdrawal syndrome have importantly prioritized treatment access, in the first year postpartum many of these programs and supports taper. Mothers with OUD are most likely to die from a fatal opioid overdose during the '4th trimester' (i.e. the first year postpartum; Schiff et al., 2018). Because of parental substance use, the demand for foster care placements has spiked nationally (MADHHS 2018), disrupting families and contributing to intergenerational patterns and a negative feedback loop of substance misuse and trauma.

Theoretical Framework: Threads of Violence

This work responds to the call from Nancy Campbell and Elizabeth Ettore to 'gender addiction' (Campbell and Ettore 2011) by bringing a critical feminist lens to the fore to examine the 'epistemologies of ignorance' (Tuana 2006) around notions of 'risk' that remain 'resistant to acknowledging the… power differentials that structure the lives of drug-using women' (Campbell and Ettore 2011, 1). This article is informed by foundational ethnographic work that examines the threads of violence – structural, symbolic, and every-day (Bourgeois 2009; Farmer 1996; Scheper-Hughes 1993) – which are woven throughout the lives of women and mothers with opioid and other substances use disorders in the U.S. In particular, Angela Garcia's work, examining the violences of intergenerational material, cultural, and geographic dispossession in the context of indigenous heroin use in the Southwestern U.S. (Garcia 2010); Kelly Knights visceral depictions of structural vulnerabilities and violence inherent to the concurrent temporalities navigated by pregnant and addicted women living and working in low-rent hotels (Knight 2015); and Alison McKim's work highlighting structural violence as played out across private and public substance use treatment programs, and the racially discriminate policing of addicted women through the medical and criminal justice systems (McKim 2017). Building on this rich ethnographic work, this article takes a pointed look at the role of institutional violence imbedded into policies, programs, and procedures specific to the treatment and management of perinatal and maternal OUD. A notable contribution of this article is the concept of visceral violence, which remains underexplored in the violence literature, and yet is key when examining the intimacy of pregnancy and mothering.

Institutional violence is made possible by structural violence (Farmer 1996), and pointedly refers to institutional policies and practices that are considered part of a larger system that is perceived to be fixed (Curtin and Litke 1999; Foucault 2002). As with structural violence, it is the illegibility of institutional violence that is most problematic. The first example of institutional violence presented in this article is of direct bodily violence, an experience most aligned with exposure to interpersonal physical violence. The most pronounced example of bodily violence cited here is the use of physical restraints and withholding of MOUDs as part of standard procedures utilized in civil commitment of individuals into substance use treatment. Yet, unlike interpersonal acts of bodily violence such as intimate partner violence and childhood sexual abuse which social mores do not outwardly condone, interpersonal acts of bodily violence as standard institutional practices are accepted as 'business as usual' or even 'best practices.'

The second example of institutional violence presented here is of visceral violence. In one of two publications discussing visceral violence, Sarah de Leeuw examines the biopolitics of colonialism, and the visceral violence of being displaced from home and family for indigenous women and children in British Columbia (de Leeuw 2016). In the second, Clisby and Holdsworth explore the concept of visceral violence as relates to women's mental health over the lifecourse (Clisby and Holdsworth 2014). However, they conceptualize visceral violence as a syn-

onym for interpersonal experiences of gender-based violence, specifically the experiences of sexism and sexual violence for school-aged girls. While de Leeuw's conceptualization may be most closely aligned with the notion of visceral violence as set forth here, it draws on a decolonial perspective that, while critical and relevant to mental health and substance use among pregnant and parenting women, contains a specific set of biopolitical factors that are not universally applicable to all women with OUD.

The last example of institutional violence in this article is of symbolic violence. Drawing on Bourdieu (2001), symbolic violence refers to daily enacted 'gentle violence' that reinforces and internalizes socially patterned and hierarchical raced, classed, gendered, sexed, and othered ideologies that are 'exercised upon a social agent with his or her complicity' (Bourdieu and Wacquant 2002, 167). Symbolic violence is best identified via the silences or absences — of topics or people — woven throughout this project. As one example, nearly every woman interviewed for this project had been separated from their family and placed in a foster home for at least some length of time as children. Yet the role of intergenerational family separation was never discussed by women or clinicians or staff or administrators or policy makers as a potential risk factor for problematic substance use.

Methods

Situating the Project Locally

This project was conducted across the Northwestern region of Massachusetts (MA), an area with one of the highest rates of opioid-related fatalities and opioid exposed newborns in the U.S. MA stands out in the U.S. as a state that has instituted considerably progressive policies, such as expanding access to naloxone (an opioid overdose reversal drug), prioritizing treatment access for pregnant women, and developing systems and processes to prepare women for the inevitability of having a case opened with the Department of Children and Families (DCF) upon delivery. MA is one of the few states that has seen a reduction in fatal opioid overdoses from 2017-2018 (MA Department of Health and Human Services [MADHHS] 2018).

This research was carried out across two counties in Western Massachusetts. County X is rural and predominantly white (70,000 residents that are 91% non-Hispanic White, 4% Latinx, and 1.5% Black or African American). Approximately 10% of the population live below the poverty line. County Z is more urban and larger in size (estimated population in 2017 was 470,000) and is more racially diverse (approximately 63% non-Hispanic white, 25% Latinx, and 11% Black or African American); 25% of households speak a language other than English. Approximately 17% of the population in County Z live below the poverty line (U.S. Census Bureau, 2018), and it ranks in the top quartile of the most racially segregated metropolitan areas in the U.S (Baystate Medical Center 2016). Because of the stigma associated with OUD the decision not to name specific counties is a purposeful choice to protect the anonymity and privacy of project participants.

Data Collection and Analysis

While research around pregnant women and mothers with OUD is growing, the bulk of data on this marginalized population consists of population-level survey data. In contrast, findings presented here consist of an intersection of qualitative methods that center the voices and experiences of women themselves. Data were collected in clinical treatment spaces, community-based organizations, women-only residential recovery facilities, participants' homes, and coffee shops. A total of 30 in-depth interviews were conducted, including 20 life history interviews with mothers with OUD and 10 in-depth interviews with physicians, clinicians, social workers, and staff working directly with mothers with OUD. Ethnographic data were collected from March 2017 through September 2018 and include participant observation and field notes from: (a) two digital storytelling projects with mothers 'in recovery' from OUD (one with peer mentors that support women newly in recovery and the other with women who had children under 12 months); (b) local and regional public meetings, symposia, lectures, and conferences convened around perinatal OUD; and (c) in and around clinical, residential, and community treatment and support service settings for people with OUD. Data analysis was guided by constructivist grounded theory (Charmaz 2010) and assessed the ways in which each of these narratives speak to, resist, silence, and position themselves in relation to each other, and to what end.

All women interviewed had the lived experience of heroin and other substance use prior to, and during, pregnancy. All women self-identified as being 'in recovery' – a complex concept that does not have a standard clinical definition but is routinely used; a detailed discussion of the nuances inherent to this concept is beyond the scope of this article. For some women being 'in recovery' meant abstaining from heroin and other substances; for others it meant being maintained on an MOUD. Recovery can be considered as both a state of being (i.e. being abstinent or maintained on MOUDs) and key to belonging in the 'recovery community.' Women interviewed ranged from being 'in recovery' for five months to five years. All women had experienced 'relapse' at least once during and after pregnancy. The majority of women interviewed were unemployed; all but two estimated their household earnings at ≤$20,000 per year, and half either lived in a homeless shelter or a residential recovery home (colloquially referred to as a 'halfway house'). At the time of their interviews, thirteen of the twenty women did not have custody of at least one (of their) child(ren).

Liminal Complexities and the Biomedical Management of Maternal OUD

Rather than simply critiquing the biomedical management of perinatal and maternal OUD however, it is important to analyze the liminal complexities of how OUD is managed and navigated across multiple institutional settings. Wherein the use of the word liminal pushes us to consider states of being in spaces of ambiguity, the notion of *liminal complexities* asks us to take a step further and contemplate the ethical conundrums and complexities held in these spaces. For example, par-

ents who civilly commit their children to mandated treatment against their will often do so out of love and a true fear their child may fatally overdose. Yet this route to treatment often means being physically restrained with shackles, refused MOUDs, or being sequestered to a jail cell for 'safety' reasons. Additionally, while a 'brain disease' model of addiction leaves us to understand the brain to be 'hijacked' and incapable of autonomous thought or action among people with OUD, how do we interpret when women in recovery refer to the concept of 'readiness' as key to treatment engagement, particularly those with a long history of substance use? Does this signal autonomy and opposition to a 'brain disease' model of addiction, or an internalization of a moral model of addiction that remains imbedded in OUD programs and services? Furthermore, how does 'readiness' align with the notion of 'non-chaotic' opioid use, a concept referenced by two staff members that refers to individuals that use opioids intermittently, but would not be classified as addicted according to the biomedical definition of OUD?

Institutional Violence: Key Findings

Key findings from this project identify three forms of institutional violence as experienced by pregnant and parenting women with OUD, discussing the liminal complexities inherent to each form of violence: (1) civil commitment to treatment as a form of direct bodily violence, (2) loss of maternal status as visceral violence, and (3) institutional erasures as symbolic violence.

Civil Commitment to Treatment as A Form of Direct Bodily Violence

Civil commitment to a treatment facility is increasingly utilized in MA, driven largely by the dramatic rise in opioid-related fatalities. Colloquially referred to as 'sectioning' or 'being sectioned' (a reference to Section 35 of Chapter 123 of MA state legislation specific to Public Welfare, Title XVII) civil commitment to treatment results in up to 90 days of state-mandated detoxification and clinical support services. Access to MOUD as part of treatment is not standard. A person cannot 'section' themselves. The process must be formally initiated through the legal system by a spouse, blood relative, guardian, police officer, physician, or court official (Commonwealth of MA 2019). Once a petition is filed with the court, a warrant is issued and the person is then remanded to a holding cell and evaluated by a court appointed official prior to a court hearing. The decision to civilly commit an individual is based on the co-presence of an alcohol or substance use disorder *and* imminent 'likelihood of serious harm' to oneself or others due to their substance use. Recent updates to Section 35 require that the court report the person's name, social security number and date of birth to the state Department of Criminal Justice Information Services, barring access to firearms for up to five years and making their record of civil commitment publicly available, a process historically reserved for people convicted of a criminal offence (Commonwealth of MA 2019).

Although it is not standard for pregnant women in MA to be 'sectioned,' a life course approach (Hser, Longshore and Anglin 2007) asks us to consider how a lifetime of experiences influence health in the present moment; specifically, how the

experience of being 'sectioned' may influence a pregnant and/or parenting woman's decision to access OUD services. Nationally, women who are actively using when they get pregnant typically engage with the medical system only in the final trimester of pregnancy; this was the case for all women in this study who, like Aimee, were using heroin until close to their delivery date. The case of Aimee illustrates how the experience of being sectioned can be traumatic, resulting in fear and avoidance of institutions that can offer potential support. She tells me that being sectioned makes 'you feel like a criminal. You're thrown in handcuffs, put in a paddy wagon, and shackled with people who are getting dropped off at the jail on the way.' 'You're shackled' I ask? I'm incredulous. Aimee goes on: 'yeah, to each other. It's a nightmare. Hands and legs shackled. It's not fun.' Aimee describes the treatment facility as 'horrible,' recalling that there were '50 people in one room at a time, [and] four people in the bedroom.' It is not surprising then, when Aimee tells me how important it is for her to feel 'safe' in order to access clinical care.

I meet Aimee through Kathleen, a recovery coach who offers support to women and mothers with OUD. Aimee was 30 at the time we met. Her small and tidy apartment was in the back of a housing complex tucked off of a main road. Although her parents currently have custody of her nine-month old son, his presence was everywhere - toys stacked neatly under the TV for when her father would bring him to visit, a push-bike behind the couch, and a high chair pulled up to the kitchen table. The wall art was a combination of her son's drawings and framed inspirational quotes. At age 16 Aimee was prescribed benzodiazepines to manage her anxiety. Following an abortion at age 18 when she remembers being 'literally forced out of the car and told [by her mother she] had to do it,' Aimee described a 'spiraling moment' of substance use that lasted from ages 19 to 28. Starting with non-medical use of prescription opioids at age 24 then heroin at age 26, Aimee describes that period as a chaotic cycle of heroin use, voluntary treatment, civil commitment, and mixing heroin and MOUDs. At the time we spoke, Aimee had been stable on methadone for nearly one year.

MA state guidelines identify civil commitment as a 'last option,' yet in 2016 over 6000 people were civilly committed via Section 35 (Commonwealth of MA 2019). 'Sectioning' is indicative, in part, of the lack of available resources for loved ones who may feel like they have no other option, and for whom the potential of biomedical treatment through any means necessary offers hope. Prior to being 'sectioned' by her parents, Aimee had voluntarily entered into detoxification and 30-day treatment programs a few times yet was unable to abstain from heroin for any substantial length of time. We can imagine the desperation felt by her father when he finds her 'in the bathroom. By that point I had overdosed quite a few times… I think that kind of scared the shit out of him. [T]he next day I was sectioned.'

Women who had been sectioned were fundamentally opposed to it. When I ask if she thinks mandated treatment is effective, Aimee touches on the concept of readiness that was repeated throughout the project: 'I had literally just started us-

ing heroin at that time, so it was still new to me. I wasn't done experimenting. I knew I was gonna leave this place and literally use again. Like, that's just all I had in my mind for that whole time. I just wasn't ready.' Yet this notion of readiness comes into direct conflict with a brain disease model of addiction, which excludes notions of individual autonomy and points to 'physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavior control...[that] help explain the compulsive nature of addiction' (NIDA 2019). How, then, do we reconcile this definition with what Aimee tells me about her process of recovery after nine years of 'spiraling' and chaotic use: 'you have to like want it. If you're not at that point you're just gonna keep using, 'cause I know I did for years until I really wanted to stop.'

Loss of Maternal Status as Visceral Violence

In this article, visceral violence refers to acts of institutional violence that result in loss of custody, and are experienced by mothers as deep, physical emotions. The Merriam-Webster dictionary (2019) defines visceral as an adjective with three meanings: (1) as if in the internal organs of the body, (2) not intellectual, and dealing with crude or elemental emotions. Extending this definition to the sensory, we can imagine the complimentary definitions to be (1) deep, and below the surface; (2) of the heart, not the head; and (3) felt as anguish, perhaps expressed aurally through caterwauling or internalized; deep into the bones and gut.

A biomedical model of OUD recognizes relapse as part of its chronicity; as such, treatment 'success' typically requires multiple attempts (NIDA 2019; USDHHS 2016). However, in many of the institutions that mothers with OUD interact with routinely (e.g., medical, legal, social services), relapse often runs counter to expectations of maintaining or regaining child custody. In MA, substance use that impacts what DCF workers refer to as 'parental capacity to care' (MA Department of Children and Families 2018) is the primary reason that social service organizations remove children from their homes and place them into foster care (MADHHS 2018). However, the determination of who has the right to parent is highly subjective. Women talked regularly about how *hard* they work each day to prove their maternal fitness (Lupton 2012), tracked by checking off varying tasks from an ever-present, perpetually shifting, and seemingly insurmountable to-do list. Tanya describes

> literally walking hours, to take one bus to another bus, to take a bus for an hour here to go to IOP (intensive outpatient treatment), to go to my appointments, to come here to do whatever I needed to do to make my recovery work. Because I could not mess up. There was *no* way. If I did, I'd never see my kids again. I need them. I live and breathe for them. They're my life.

Marina, the regional substance abuse coordinator for the MA Department of Children and Families reinforces this sense of how hard women work: 'I don't know how we expect people with substance use disorders, and mental health, and

lack of resources, and a lack of support to get to 17 different appointments in one week every week for a period of time…. I don't know [if] I'd be able to do it.' Yet, she almost seems to catch herself, and quickly reverts to institutional speak when I ask about women's reports of the inconsistencies between workers who are charged with determining their 'parental capacity to care':

> what we say at [Department of Children and Families] is: 'we don't have substance use cases, we don't have intimate partner violence cases, we don't have mental health cases. We have impact cases.' So it's a case by case; there's no straight guidelines… [B]ut what it comes down to is decisions are made very differently in different area offices even within the same region.

It is these inconsistencies that reproduce inequalities along lines of race, place, and poverty, and require us to pay close attention to the intersectional layers of perinatal and maternal OUD. For example, women of color are more likely than white women to be reported to social service and legal authorities and subjected to punitive rather than supportive treatment approaches, dictating patterns of inequitable outcomes around determination of custody rights and access to support services (Holbrook 2015; Lyons and Rittner 1998; Netherland and Hansen 2016; Roberts 1995; Terplan, Kennedy-Hicks, and Chisholm 2015). During one afternoon at a community center that provides classes, resources, and childcare for low-income families of color in County Z, I meet Jamie, a recovery coach who has worked across the region for over five years. She illustrates these disparate experiences around the determination of 'parental capacity to care' when she tells me,

> a family that lives over on Belmont Ave (African American neighborhood in County Z) who smokes pot, you know, there's got to be a [child] removal. [But] a family in [primarily White town in County X] who for lack of a better term is shooting dope seven ways to Sunday, [the discussion is about trying] to figure out [if they] need a parent aid. Sometimes I think [the case workers] don't even realize they're doing it.

But they do.

Addiction treatment literature and discourse cites the importance of having a 'sense of purpose' as crucial to treatment success (Polcin, Mulia, and Jones 2012). Becoming pregnant and mothering were consistently identified by women in this project as that sense of purpose, and the reason for them to maintain recovery. Take Linda, who recalls that after the death of her nephew from sudden unexplained infant death syndrome during her pregnancy: 'I don't know what prevented me from using other than being pregnant with my son. Like for me that was enough to not pick up, cause I wanted to. I *really, really* wanted to.' And Sarah, who identifies that her main motivation for going into treatment was 'to be healthy and alive and safe for my daughter.' And Aimee, who tells me that the birth of her son

'just kept me at that point, like, I don't want to use anymore. I had something better, I had a point of living clean - living the good life.'

Yet, one of the first things mothers along the substance use continuum lose is their right to parent. As Tanya tells it, you can see how clearly the process of taking a child is deeply visceral:

> I was a mess, I was really not handling it well. They're taking my kids, you know? They told me I was acting inappropriate, and if I wanted to see my children again, I needed to act appropriately for their sake. [I] needed to pull myself together because I was acting outrageous. And I'm like, 'I'm crying because you're taking my kids!'

For Marguerite, losing custody is visceral and embodied. When I ask if depression and anxiety is something she had experienced, or been treated for before, she says yes, 'I have…. but it hit me hard when my kids were taken. It hit me really hard. I couldn't eat, couldn't sleep, all I do is lay around and look at the ceiling.'

The fear of losing custody drives women's choices to avoid treatment late into their pregnancies, largely due to state mandates that require medical institutions to automatically report maternal substance use to the Department of Children and Families (DCF). Amy tell me she was 'trying to use [buprenorphine] off the street 'cause I didn't want anybody to know. I didn't want to get in trouble yet… I knew DCF was coming no matter what.' Even when women do seek treatment and prenatal care, Emily, a nurse midwife, comments that 'the first question they ask when they come in is "are they [DCF] gonna take [my] baby?" And that's a real fear.'

It is here in this examination of mothering and the right to mother that we again bump up against the liminal complexities of maternal OUD. Although loss of custody and maternal status was perhaps *the* most prominent and pivotal experience that negatively influenced women's care seeking and substance using trajectories in this project, some mothers noted that having a break from the demands of parenting was critical to their early recovery and treatment success. And while leaving children at home when engaging in drug seeking is typically perceived as neglectful, some mothers identified leaving as a necessary act of care and protection that was far better than using and being high in front of their children. Furthermore, simultaneous to policy inconsistencies around custody determinations of 'parental capacity to care' is the reality that staff making these decisions are often new to the overall workforce, young, inexperienced, not parents themselves, underpaid, and likely to leave that position within their first year due to the emotional weight of the work. It is in examining these liminal spaces that we begin to know the complexities of how pregnant and parenting women with OUD navigate their many roles: as woman, as mother, as sister or daughter or partner, and not simply as 'addict.' In examining these complications, we may begin to reimagine how to best support women and families in humanizing ways.

Institutional Erasures as Symbolic Violence

In April 2018, the Trump administration enforced a highly controversial 'zero tolerance' policy at the Southwestern border of the U.S, forcibly separating children from parents as families were attempting to cross into the U.S. without documentation. There was an almost immediate proliferation of graphic imagery, protests and public outcry across multiple sectors critiquing the enforcement of the policy and the foot-dragging on the part of the administration to reunify families. In August of 2018 the American Public Health Association (APHA) released a public statement decrying the policy as 'inhumane' and setting the 'stage for a public health crisis.' The content of the statement is pivotal to my argument for the need of a critical interrogation of the field of public health, and bears repeating in its near entirety:

> As public health professionals we know that children living without their parents face immediate and long-term health consequences. Risks include the acute mental trauma of separation… and in the case of breastfeeding children, the significant loss of maternal child bonding essential for normal development. Parents' health would also be affected by this unjust separation. Furthermore, this practice places children at heightened risk of experiencing adverse childhood events and trauma, which research has definitively linked to some of society's most intractable health issues: alcoholism, substance misuse, depression, suicide (APHA 2018).

Of course, what is striking, is that this exact statement could be made about the separation of children and families that occurs on a routine basis in the U.S. via the intertwined institutions that manage perinatal and maternal OUD. And while the APHA does link family separation to heightened risk of future traumas and health issues such as harmful substance use, much of the public health literature fails to conceive of family separation as a form of violence and trauma in its own right. Exposure to parental substance use and sexual, emotional, or physical violence in the home are considered risk factors for intergenerational patterns of substance use and are primary reasons for foster care entry (NIDA 2019). However, the violence of family separation is predominantly absent from biomedical conceptualizations of risk. Nearly all the women in this project had spent some length of time in foster care in their youth, yet this was never discussed voluntarily in any of the biomedical spaces that I entered during this project. When I did pointedly ask about the impacts of family separation during interviews with clinicians and administrators specifically, the question largely appeared to be surprising.

Maeve is a young, single mother early 'in recovery.' When I asked her to describe herself from ages one to seven, she remembers herself as 'scared, um lonely, like, abandoned.' She is placed into her first foster home at age six, and by the age of 16 has lived in five foster homes. In addition to the trauma from being separated from parents and home, it is standard for siblings not to be fostered together -

largely due to availability of space, as well as the training and preferences of foster parents. When I ask Maeve if she and her brother are close, she tells me

> no. I [feel] really guilty [be]cause my brother's dad was in prison… I got to leave the foster home and go live with my dad, and my brother had to stay in the foster home because he had nowhere else to go. So sometimes I feel like my relationship with my brother is the way it is because he feels like, you know, I left him there.

Taking a step back from the lifelong impacts of the separation of Maeve's family of origin and speaking again to the liminal complexities of maternal OUD, removing children from an unsafe home and placing them in foster care can be a necessary decision. The deeper challenges come with the inconsistencies around which families get separated and which receive services, as well as the lack of appropriate support for children and parents to process an experience that has lifelong impacts. As Marina tells it:

> we're setting kids up for all sorts of problems. We're taking children from unhealthy environments where who knows what has happened thus far, and we're putting them in a different kind of unhealthy environment that doesn't necessarily support them healing or… moving forward.

When I ask Maeve to describe motherhood, she pauses for a full five seconds, sighs deeply, and tells me 'it's hard.' Although Maeve's mother and brother live within short distance, because of their separation their relationships are strained. Maeve has little tangible support. As I look around her apartment, I notice there are few personal items, minus a hand drawn sign that has the name David written in cursive letters. I realize as the interview progresses that David is the father of her child. As she talks about him with her head back and eyes closed, I look closer at the sign and see there are dates, realizing long before she gets to it that he has recently died from a heroin overdose. I count the months in my head as she talks. Only seven. And her daughter has just turned one. As I leave her apartment, I keep returning to her description of herself as a young child: scared, lonely, abandoned.

Conclusion

This article has presented findings on the lived experiences of pregnant and parenting women as they navigate the myriad institutions (medical, legal, and social services) that manage OUD in the Western region of Massachusetts (MA). The contribution of this article is to make legible the institutional violence enacted upon mothers with OUD, largely in the name of 'fetal victimhood' (Knight 2015) wherein 'reproductive asceticism' (Ettorre 2009) remains paramount. Returning to the notion of a gendered triple standard, more than other populations, pregnant

and parenting women with OUD have limited autonomy in the decision to engage with these systems. As such, exposure to institutional violence is nearly inescapable. The predominating approach to managing OUD that centers on 'fetal victimhood' continues to erase women with OUD as having needs that run concurrent to ensuring a healthy pregnancy and birth. This erasure is underscored for women whose maternal status may no longer be recognized by the biomedical institutions and policies that manage OUD: those that are no longer pregnant; whose children are no longer 'cute' babies; and those who may have lost custody of their child(ren), perhaps permanently.

It is important to note that MA is a state with considerably progressive policies around OUD. Although the passage of the SUPPORT Act in October 2018 does earmark funds for the treatment of pregnant and postpartum women with OUD, it does not overturn policies in 23 states and the District of Columbia (D.C.) that consider substance use in pregnancy to be child abuse. Nor does it call into question the three U.S. states that classify substance use in pregnancy as grounds for civil commitment to treatment (Guttmacher Institute 2019). We can imagine the experiences of institutional violence as identified in this article to be present, and likely magnified, in many of these states

While much of the addiction discourse is focused on the multiple forms of violence and trauma that contribute to disordered substance use, this article shifts that focus to make legible the violence interwoven into treatment itself. Each example of institutional violence discussed in this article – bodily, visceral, and symbolic – make the case that a robust critical public health agenda around perinatal and maternal OUD is crucial. Over the course of this project, conversations around structural violence (e.g. poverty, lack of housing and transportation) shifted to the fore. And although discussions did also touch on the impact of trauma on opioid use trajectories, the primary focus was interpersonal violence.

As part of a critical public health agenda I argue for the need to consider, envision, and categorize institutional violence as a distinct form of violence and trauma navigated and negotiated by pregnant and parenting women with OUD. The notion of visceral violence as explored here is an important contribution to the literature on forms of violence and is particularly relevant for any examination that considers the biopolitics of pregnancy and mothering. By erasing experiences of institutional violence, efforts to provide person-centered care, support families, and promote optimal health will remain incomplete and deficient. Lastly, the discussion around the liminal complexities inherent to the treatment and support of pregnant and parenting women with OUD is crucial to a broadened understanding of maternal OUD. Deep pondering of the quandaries held in these liminal spaces may then allow us to envision spaces of the 'otherwise' (Povinelli 2011) wherein the potential for intersectional notions of who has the right to mother and what constitutes humane approaches to the treatment of maternal OUD might simultaneously co-exist.

Author Bio

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References

American College of Obstetricians and Gynecologists (ACOG). 2016. "ACOG Statement on Opioid Use During Pregnancy." Accessed May 26, 2016. http://www.acog.org/About-ACOG/News-Room/Statements/2016/ACOG-Statement-on-Opioid-Use-During-Pregnancy

American Public Health Association (APHA). 2018. "Statement from the APHA and Trust for America's Health: Separating Parents and Children at U.S. Border is Inhumane and Sets the Stage for a Humanitarian Health Crisis." Accessed November 10, 2018 https://www.apha.org/news-and-media/news-releases/apha-news-releases/2018/parent-child-separation

Baystate Medical Center. 2016. "Community Health Needs Assessment, 2016." Accessed September 2017 https://www.baystatehealth.org/-/media/files/about-us/community-programs/community-benefits/bmc-chna.pdf?la=en

Bourdieu, Pierre. 2001. Masculine Domination. Stanford: Stanford University Press.

Bourdieu, Pierre and Loïc JD Wacquant. 2002. An Invitation to Reflexive Sociology. Chicago: University of Chicago Press.

Bourgeois, Philippe. 2009. "Recognizing Invisible Violence. A Thirty-Year Ethnographic Retrospective." In Global Health in Times of Violence, 18-40. Santa Fe, NM: School for Advanced Research Press.

Cadet, Jean Lud. 2016. "Epigenetics of Stress, Addition, and Resilience: Therapeutic Implications." Molecular Neurobiology, 53: 545-560 https://doi.org/10.1007/s12035-014-9040-y

Campbell, Nancy and Elizabeth Ettorre. 2011. Gendering Addiction: The Politics of Drug Treatment in a Neurochemical World. NY: Palgrave MacMillan.

Centers for Disease Control and Prevention [CDC]. 2017. "About Multiple Cause of Death: 1999-2017." Accessed November 2017 https://wonder.cdc.gov/mcd-icd10.html

CDC. 2018. "The U.S. Opioid Crisis: Addressing Maternal and Child Health." Accessed https://www.cdc.gov/reproductivehealth/opioid-use-disorder-pregnancy/index.html

CDC. 2019. "Understanding the Epidemic." Accessed January 19, 2019: https://www.cdc.gov/drugoverdose/epidemic/index.html

Charmaz, Kathy. 2010. Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis. Thousand Oaks, CA: Sage Publications.

Clisby, Suzanne and Julia Holdsworth. 2014. Gendering Women: Identity and Mental Wellbeing through the Lifecourse. Bristol: Policy Press. https://doi.org/10.1332/policypress/9781847426772.001.0001

Commonwealth of Massachusetts. 2019. "Section 35: The Process."Accessed December 2018 https://www.mass.gov/service-details/section-35-the-process

Crandall, Cynthia, Ross D. Crosby, and Gregory A. Carlson. 2004. "Does Pregnancy Affect Outcome of Methadone Maintenance Treatment?" Journal of Substance Abuse Treatment 26, 4: 295-303. https://doi.org/10.1016/j.jsat.2004.02.001

Curtin, Deane and Robert Litke. 1999. Institutional Violence. Leiden: Brill Rodopi.

Daley, M., Milton Argeriou., and Dennis McCarty. 1998. "Substance Abuse Treatment for Women: A Window of Opportunity?" Journal of Addictive Behaviors 23,2: 239-249. https://doi.org/10.1016/S0306-4603(97)00029-4

de Leeuw, Sarah. 2016. "Tender Grounds: Intimate Visceral Violence and British Columbia's Colonial Geographies," Political Geography 52: 14-23. https://doi.org/10.1016/j.polgeo.2015.11.010

Ettorre, Elizabeth. 2009. "Prenatal Genetic Technologies and the Social Control of Pregnant Women: A Review of the Key Issues." Marriage and Family Review 45(5):448-68. https://doi.org/10.1080/01494920903050680

Farmer, Paul. 1996. "On Suffering and Structural Violence: A View from Below." Daedalus 125(1): 261-283.

Foucault, Michel. 2002. The Birth of the Clinic. London: Routledge. https://doi.org/10.4324/9780203406373

Garcia, Angela. 2010. The Pastoral Clinic: Addiction and Dispossession Along the Rio Grande. Berkeley, CA: University of CA Press.

Guttmacher Institute. "Substance Use in Pregnancy, As of January 1, 2019." Accessed January 18, 2019: https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy

Hall, Wayne, Adrian Carter, and Cynthia Forlini. 2015. "The Brain Disease Model of Addiction: Is it Supported by the Evidence and Has it Delivered on its Promises?" Lancet Psychiatry 2: 105-110 https://doi.org/10.1016/S2215-0366(14)00126-6

Hser, Yih-Ing., Douglas Longshore, and M. Douglas Anglin. 2007. "The Life Course Perspective on Drug Use: A Conceptual Framework for Understanding Drug Use Trajectories." Evaluation Review 31(6): 515-547 https://doi.org/10.1177/0193841X07307316

Holbrook, Amber. 2015. "Methadone Versus Buprenorphine for the Treatment of Opioid Abuse in Pregnancy: Science and Stigma." The American Journal of Drug and Alcohol Abuse 41(5): 371-373 https://doi.org/10.3109/00952990.2015.1059625

Knight, Kelly. 2015. Addicted. Pregnant. Poor. Durham, NC: Duke University Press.

Kremer, Mallory and Kavita Shah Arora. 2015. "Clinical, Ethical, and Legal Considerations in Pregnant Women with Opioid Abuse." Obstetrics & Gynecology 126(3): 474-478 https://doi.org/10.1097/AOG.0000000000000991

Leatherman, Thomas and Morgan Hoke. 2016. "Critical Biocultural Anthropology: A Model for Anthropological Integration." In Routledge Companion to Contemporary Anthropology, edited by Simon Coleman, Susan B. Hyatt, and Ann E. Kingsolver, 1-40. New York: Taylor and Francis.

Library of Congress. 2018. "H.R.6.- SUPPORT for Patients and Communities Act, U.S. 115th Congress, 2017-2018." Accessed December 2018 https://www.congress.gov/bill/115th-congress/house-bill/6

Lock, Margaret, Wylie Burke, John Dupré, Hannah Landecker, Julie Livingston, Paul Martin, Maurizio Meloni et al. 2015. "Comprehending the Body in the Era of the Epigenome." Current Anthropology 56(2): 163-164. https://doi.org/10.1086/680350

Lupton, Deborah. 2012. "Configuring Maternal, Preborn and Infant Embodiment." Sydney Health & Society Group Working Paper, No. 2. Sydney: Sydney Health & Society Group. https://doi.org/10.2139/ssrn.2273416

Lyons, Peter and Barbara Rittner. 1998. "The Construction of the Crack Babies Phenomenon as a Social Problem." American Journal of Orthopsychiatry 68(2): 313-320. https://doi.org/10.1037/h0080340

MA Department of Children and Families. 2018. "Massachusetts Department of Children and Families." Accessed October 2018 https://www.mass.gov/orgs/massachusetts-department-of-children-families

MA Department of Health and Human Services [MDHHS]. 2018. "Massachusetts Responds to the Opioid Epidemic." Accessed November 2018. https://www.mass.gov/massachusetts-responds-to-the-opioid-epidemic

Martin, Peter and AJ Reid Finlayson. 2015. "Opioid Use Disorder During Pregnancy in Tennessee: Expediency vs. Science." The American Journal of Drug and Alcohol Abuse 41(5): 367-370. https://doi.org/10.3109/00952990.2015.1047502

McKim, Alison. 2017. Addicted to Rehab: Race, Gender, and Drugs in the Era of Mass Incarceration. New Jersey: Rutgers University Press. https://doi.org/10.2307/j.ctt1pwtdfw

Mendenhall, Emily. 2014. "Syndemic Suffering in Soweto: Violence and Inequality at the Nexus of Health Transition in South Africa." Annals of Anthropology Practice: 300-312. https://doi.org/10.1111/napa.12058

National Institute on Drug Abuse (NIDA). 2019. "Advancing Addiction Science." Accessed January 2019 https://www.drugabuse.gov/

National Research Council. 2014. The Growth of Incarceration in the United States: Exploring Causes and Consequences. Committee on Causes and Consequences of High Rates of Incarceration, J. Travis, B. Western, and S. Redburn, Editors. Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

Netherland, Julie and Helena Hansen. 2016. "The War on Drugs that Wasn't: Wasted Whiteness, 'Dirty Doctors,' and Race in Media Coverage of Prescription Opioid Misuse." Culture, Medicine, and Psychiatry 40: 664-686. https://doi.org/10.1007/s11013-016-9496-5

Peterson, Jefferey, Aline Gubrium, and Alice Fiddian-Green. 2018. "Meth Mouth, White Trash, and the Pseudo-Racialization of Methamphetamine Use in the U.S." Health Communication. Advance online publication: doi: 10.1080/10410236.2018.1471333. https://doi.org/10.1080/10410236.2018.1471333

Polcin, Douglas, Nina Mulia, and Laura Jones. 2012. "Substance Users' Perspectives on Helpful and Unhelpful Confrontation: Implications for Recovery." Journal of Psychoactive Drugs 44: 144-152 https://doi.org/10.1080/02791072.2012.684626

Povinelli, Elizabeth. 2011. Economies of Abandonment. Durham, NC: Duke University Press. https://doi.org/10.1215/9780822394570

Roberts, Dorothy. 1995. "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Rights of Privacy." In Critical Race Theory: The Key Writings that Formed the Movement, Edited by K. Crenshaw, N. Gotanda, G. Peller, and K. Thomas, 384-425. New York, NY: The New Press.

Sanders, Jolene. 2014. Women in Narcotics Anonymous: Overcoming Stigma and Shame. New York, NY: Palgrave MacMillan. https://doi.org/10.1057/9781137430496_3

Scheper-Hughes, Nancy. 1993. Death without Weeping: The Violence of Everyday Life in Brazil. Berkley, CA: Univ of California Press.

Schiff, Davida M., Timothy Nielsen, Mishka Terplan, Malena Hood, Dana Bernson, Hafsatou Diop, Monica Bharel et al. 2018. "Fatal and nonfatal overdose among pregnant and postpartum women in Massachusetts." Obstetrics & Gynecology 132(2): 466-474. https://doi.org/10.1097/AOG.0000000000002734

Singer, Merrill. 2009. Introduction to Syndemics: A Critical Systems Approach to Public and Community Health. Thousand Oaks, CA: Jossey-Bass.

Substance Abuse and Mental Health Services Administration. 2019. "SAMHSA's Concept of Trauma and guidance for a trauma-informed approach." Ac-

cessed January 2019 https://store.samhsa.gov/system/files/sma14-4884.pdf

Substance Abuse and Mental Health Services Administration. 2017. "Substance Use Disorders." Accessed October 2017 https://www.samhsa.gov/disorders/substance-use

Terplan, Mishka, Alene Kennedy-Hicks, and Margaret S. Chisholm. 2015. "Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness." Substance Abuse: Research and Treatment 9(S2): 1-4 doi:10.4137/SART.S23328. https://doi.org/10.4137/SART.S23328

Tuana, Nancy. 2006. "The Speculum of Ignorance: The Women's Health Movement and Epistemologies of Ignorance" Hypatia 21(3):1-19 https://doi.org/10.1111/j.1527-2001.2006.tb01110.x

U.S. Census Bureau. 2018. "Quick Facts" by County. Accessed December 2018 https://www.census.gov/quickfacts/franklincountymassachusetts

U.S. Department of Health and Human Services (USDHHS), Office of Women's Health. 2017. "Final Report: Opioid Use, Misuse, and Overdose in Women." Accessed January 2017 https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf

Wilder, Christine, Daniel Lewis, and Theresa Windhusen. 2015. "Medication Assisted Treatment Discontinuation in Pregnant and Postpartum Women with Opioid Use Disorder." Drug and Alcohol Dependence 149: 225-231. https://doi.org/10.1016/j.drugalcdep.2015.02.012

Worthman, Carol M. and Brandon Kohrt. 2005. "Receding Horizons of Health: Biocultural Approaches to Public Health Paradoxes." Social Science and Medicine 61: 861-878. https://doi.org/10.1016/j.socscimed.2004.08.052

JOURNAL of EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 44-71 https://doi.org/10.5617.7015

Article

Totalistic Programs for Youth

A Thematic Analysis of Retrospective Accounts

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Abstract

Recent annual estimates suggest that in the United States, approximately 57,000 young people are placed by their parents into some type of residential treatment program. Parent-pay programs are exempt from federal safety standards and some states provide little or no regulatory oversight. Federal investigations revealed a nationwide pattern of institutional abuse across multiple facilities, and some professionals have noted 'cruel and dangerous uses of thought reform techniques' within such programs (U.S. House of Representatives 2007, 76). This article summarizes qualitative research based on interviews with 30 adults who lived for an average of 20 months within a 'highly totalistic' youth program. The concept of totalistic treatment was operationalized and measured with seven key identifiers found in the literature. Twenty-five different programs of four general types were represented: therapeutic boarding schools, residential treatment centers, wilderness/outdoor programs, and intensive outpatient programs. To organize qualitative findings, three themes explaining the experiences, immediate effects, and long-term impacts of treatment help to reveal implicit meanings woven throughout the interviews. By understanding a wider range of experiences associated with totalistic programs, efforts to improve quality of care and strategies to prevent harm may be improved. Harm prevention efforts would benefit from the analytical perspectives found in theories of coercive persuasion and thought reform.

Keywords

qualitative, evidence-based practices, totalism, residential treatment, youth programming, coercive persuasion, therapeutic boarding schools, thought reform

Introduction

According to the U.S. Census Bureau's most recent annual estimates for 2018, approximately 137,000 children and adolescents under the age of 18 were placed within some type of group home, residential treatment center, boot camp, or correctional facility in the United States (U.S. Census 2018). By subtracting the num-

ber of young people who were court-ordered or placed in treatment by foster care authorities we can deduce that approximately 57,000 were placed by their parents into one of these 24-hour-a-day settings (Sickmund et al. 2017; U.S. DHHS 2018a). The legal authority behind youth placements is a key distinction because in the United States, federal safety standards do not apply to parent-pay programs and some states provide no protective oversight or regulation of these teen treatment programs (Federal Trade Commission 2019; U.S. GAO 2008b).

Young people living within these facilities are protected by a variable 'patchwork' of state policies and regional agencies (U.S. House of Representatives 2008, 51). The most recent estimates report that in 2016, there were 1,500 cases of institutional abuse documented and confirmed in the United States, but this number reflects only the official cases, and further, 11 states did not provide data (U.S. DHHS 2018b). Federal investigations by the United States Government Accountability Office (GAO) documented numerous confirmed and reported cases of abuse and deaths within private-pay treatment settings (U.S. GAO 2008a; U.S. GAO 2008b; U.S. GAO 2008c). Some professionals have noted 'cruel and dangerous uses of thought reform techniques' within these programs (U.S. House of Representatives 2007, 76).

The concept of thought reform was developed by the psychiatrist, Robert Jay Lifton, in the classic text, *Thought Reform and the Psychology of Totalism: A Study of 'Brainwashing' in China* (1989), first published in 1961. In that study, he identified eight key features associated with thought reform methods that were used in totalitarian prisons to change the identity, beliefs, and attitudes of prisoners, bringing them into harmony with the prosocial ideals that were valued by authorities during the Maoist revolution. Lifton was among the first to mention a comparison of totalistic treatment methods in the United States and methods of ideological totalism in China. In academic literature, this comparison was addressed also by scholars such as Edgar Schein, in *Coercive Persuasion* (1961), Jerome Frank, in *Persuasion and Healing* (1974), and Barbara Frankel, in *Transforming Identities* (1989). They concluded that for adults, the difference between treatment and thought reform lies not in any essential set of methods, but in the individual's freedom to exit the milieu. This perspective raises ethical questions and concerns about totalistic milieus where young people are unable to refuse treatment.

Early experimenters who developed intensive group reform methods for youth in the 1960s, such as LaMar Empey and Jerome Rabow (1962), openly compared their approach to treatment to methods of 'brainwashing' in totalitarian thought reform programs. In response to fears about the immorality of this new 'Communist' method of reeducation, they and Edgar Schein (1961 and 1962) argued that such methods were morally neutral and could be applied toward benevolent or malevolent purposes. Concerns that such methods were antithetical to American values of self-determination were countered by Schein, who explained that these were *American* treatment methods: 'It could just as well be argued that the Communists are using some of our own best methods of influence' (1961, 269).

In order to call attention to the potential for harm in youth programs, drug policy experts such as Barry L. Beyerstein (1992) and Bruce K. Alexander (1990) applied classic models of thought reform to the study of teen treatment settings. Beyerstein's book chapter is a rare example of scholarship devoted to this topic. Despite the similarities between thought reform and youth treatment programs, and despite the potential for psychological harm in coercive reform methods, few empirical studies on youth treatment measure or explore key variables identified in classic theories of coercion. The American sociologist, Benjamin Zablocki (1997) argued that scholarly discussions about thought reform were lacking in objectivity and were constrained by emotional polemics. He explained how social scientists had effectively blacklisted the concept, preventing meaningful discourse.

Theories of coercive persuasion and thought reform may provide important variables to consider when studying totalistic treatment settings. These conceptual lenses could help to explain dynamics of personal change. This is an area of academic neglect, noted by many scholars who point to the need for theory explaining why and how intensive program methods act upon individuals (De Leon 2000; Edelen et al. 2007; Harder and Knorth 2015; Harper 2010; Neville, Miller, and Fritzon 2007; Whitaker, del Valle, and Holmes 2015). While the current state of the literature suffers from a lack of strong theory, residential treatment providers face increasing pressures to demonstrate the effectiveness of their methods as increasing numbers of critics argue that some group care settings are inherently inappropriate to healthy youth development (Dozier et al. 2014; Reamer and Siegel 2008; Walker, Bumbarger, and Phillippi 2015). This combination of underdeveloped theory and intensifying pressure to demonstrate results may partially explain why so many studies have focused on a narrow set of outcome variables while privileging the analytical perspectives of those who deliver treatment.

The dominant trend in research literature examines residential teen treatment from the perspective of the adults who provide care (Polvere 2011). Only a handful of studies examine first-hand accounts of the lived experiences of youths in residential settings. Mary Elizabeth Rauktis (2016) explores how young people perceive behavior management status-level systems within various types of residential settings. Samson Chama and Octavio Ramirez (2014) present a retrospective study describing program atmosphere, interactions with staff, and punishment practices, noting a general lack of research exploring the subjective experience of residential programming. Alexandra Cox (2017) presents one of the most elaborate institutional ethnographies using a phenomenological approach to feature lived experiences within juvenile justice programs. These works shed light onto the way young people construct meaning, adapt to highly controlled environments, and struggle to access psychosocial resources. Ethnographic research among adult recipients provides additional perspectives on the variety of lived experiences within high-intensity treatment settings (Garcia 2015; Gowan and Whetstone, 2012; Kaye 2012; Stevens 2012).

The present study summarizes a qualitative research project titled, *Adult Perspectives on Totalistic Teen Treatment* (Chatfield 2018). This research explores the experiences, immediate effects, and long-term impacts of treatment by analyzing interviews with 30 adults who lived for an average of 20 months within a variety of 'highly totalistic' youth programs. In their retrospective accounts, they provided first-hand descriptions of life within twenty-five different programs in the United States and one American owned program in Mexico. Five were court-ordered into a program, and twenty-five were placed in treatment by their parents due to a combination of family problems, personal behavior, academic performance, and substance abuse. Four general types of programs are represented: therapeutic boarding schools, residential treatment centers, wilderness/outdoor programs, and intensive outpatient programs.

The concept of 'totalistic' teen treatment was operationalized and measured quantitatively using sampling frame data that was collected in an online questionnaire. An index variable created for the study identified seven items reflecting key totalistic program characteristics (TPC): 1) strict controls of communication; 2) peer surveillance and policing; 3) a philosophy based on the need to change the whole person; 4) a series of prescribed stages or phases of progress and privileges; 5) frequent participation in formal or informal group sessions involving confrontation, confession rituals, or prolonged interpersonal encounter methods; 6) a strict system of rules and inflexible punishments; and 7) a central authority structure that governs all aspects of life.

The sections that follow provide key theoretical foundations informing the research design and analytical perspectives. A detailed methods section reviews the sampling and screening processes that ensured breadth in the range of experiences represented. To organize findings, three main themes help to explain some of the implicit meanings woven throughout the interviews. These findings are applied to a discussion of harm in teen program settings and the prevention of institutional child abuse.

Theoretical Perspectives

Important theoretical perspectives shaped key aspects of the study. George De Leon's (2000) descriptions of autocratic therapeutic communities helped to identify some of the essential features of totalistic programs (De Leon and Melnick 1993). Frank K. Salter's (1998) perspective on the limited variability of institutionalized persuasion shaped the decision to include multiple types of programs by identifying the features they had in common. The research questions, interview questions, and interpretation of findings were informed by Kurt Lewin's (1947) three phases of personal change. These phases were described in his theory of group dynamics and then expanded by Edgar Schein's (1961) adaptation to the study of coercive persuasion. George De Leon's theoretical descriptions of the autocratic therapeutic community model provide a list of features that characterize multiple types of totalistic youth programs (De Leon and Melnick 1993). De Leon

(2000) mentions Erving Goffman's (1961) concept of the total institution but the term, 'totalistic treatment,' goes beyond Goffman's typology of total institutions to include some of the more intrusive features described by George De Leon and Frank Salter. It was the potential for harm in this set of features that was so alarming to Beyerstein, Alexander, and to critics of Empey and Rabow.

According to Australian ethologist and political scientist, Frank K. Salter, despite differences in cultural content, institutionalized persuasion is applied with a limited number of methods that are found globally in settings of acute indoctrination. His work emphasizes the 'limited variability' of this narrow set of methods (422). Across multiple cultures, prosocial and destructive methods of indoctrination rely on a similar set of features. This perspective informed the decision to consider multiple types of youth programs within the same study by identifying a set of key program characteristics. Adding an important dimension to the discourse on treatment and coercive persuasion, Salter described six essential differences between traditional initiation rituals and methods associated with thought reform in modern organizations. Specifically, numerous features were shared, such as control of milieu, isolation from information, severance of interpersonal bonds, intense peer pressure, threats, and prestige testimonials. However, traditional milieus did not include modern methods such as routine obedience, interrogation, accusation, mild degradation with self-revelation, intense degradation with confession/apology, and punishment/reward systems (Salter 1998, 444). These traditional and modern methods are applied with varying degrees of intensity within totalistic treatment programs and totalitarian thought reform programs (De Leon 1995 and 2000; Dye et al. 2009; Lifton 1989; Ofshe and Singer 1986; Singer and Ofshe 1990).

One of the foundational models linking totalistic treatment to coercive persuasion is Kurt Lewin's theory of group dynamics (1947), which explains how and why group processes can influence individual change. Lewin's three phases of change model (*Unfreeze, Change*, and *Freeze*) was developed during WWII when worker productivity, enhanced teamwork, and popular morale were important for national defense, making them a high priority for research. Lewin believed that the capacity to predict and change social behavior might 'prove to be as revolutionary as the atom bomb' (Lewin 1947, 5). George De Leon (2000) alluded to the usefulness of Lewin's theory to explain personal change processes but it was Edgar Schein who adapted and expanded Lewin's work to explain coercive persuasion in thought reform environments. As military innovations in guided group interaction and the 'total psychotherapeutic push method' were adapted for use among American civilians, Schein argued that his theory of coercive persuasion could improve treatment methods for adult prisoners and juvenile delinquents in the United States (Knapp and Weitzen 1945; Schein 1961 and 1962).

The theoretical perspectives informing the present study are some of the foundational works that shaped the development of group dynamic approaches to treatment during the twentieth century. The program features associated with these

approaches were relatively new in the 1960s, but they are widespread today and found in multiple types of intensive youth treatment programs. Because group dynamic approaches to treatment can be labeled with a variety of names and applied with varying degrees of intensity, foundational theories are crucial for identifying and analyzing the design features that multiple types of programs share in common.

Sampling Methods

This IRB-approved research was completed in 2018 at the University of Florida in the Department of Family, Youth and Community Sciences. In the first stage of the research, participant responses to an online questionnaire (N=235) were collected for quantitative analysis to create a sampling frame of potential interview participants. Two index variables were developed for the questionnaire. A quality of experience (QOE) index variable was created for this study by calculating each participant's mean score on 15 key indicator items found in the literature. Participants were asked to rate six items measuring how helpful, safe, fair, and reasonable the program felt to them. They were also asked how equally the staff treated residents and how easy it was to adjust to life after the program. They were asked to rate nine items measuring how strongly they agreed or disagreed with statements such as how much they trusted the staff, how well their basic needs were met, and the positive long-term impact of the program. Each participant was ranked according to their mean per item score on a five-point scale, producing a combined index variable representing their overall perceived QOE. To measure participants' perceptions about the design of their respective programs, an index variable asked them to rate 'how totalistic' their program was. These seven items reflected the totalistic program characteristics (TPC) listed in the introduction.

Invitations to participate in research described the nature of the study and provided a link to the online questionnaire. It was shared with numerous professional organizations, individual experts, clinicians, academicians, and authors. A total of 223 adult participants, who were 11 to 17 years old at intake, passed the first screen. The second stage of the study began with the creation of a sampling frame of potential interview participants who rated their program as 'highly totalistic.' Measured on a five – point scale, those with a mean TPC index score below 4.00 were screened out to ensure that qualitative data was collected only from those who had experienced a highly totalistic teen treatment program, defined as a TPC score of 4.00 to 5.00. A total of 212 participants rated their program as highly totalistic and these were included in the sampling frame.

Two subgroups were created based on participants' ranked index scores for overall quality of experience (QOE). The lower scoring group included 15 participants randomly sampled from those who scored QOE below 2.00 (n=154). But for higher QOE scoring participants (n=36), because so few were represented in the study, a random subgroup sampling approach was not possible. Therefore, the higher scoring group consisted of the 15 highest ranking participants who were

willing to be interviewed; their QOE scores ranged from 4.60 to 2.60 on a five – point scale. To help ensure that the two subgroups were distinct, those scoring QOE between 2.00 and 2.60 were identified as a middle scoring group (n=22) and were screened out of the interview sampling frame. The screening and sampling processes are shown in Figure 1 and a descriptive summary of 'Group H' and 'Group L' are provided in Tables 1 and 2.

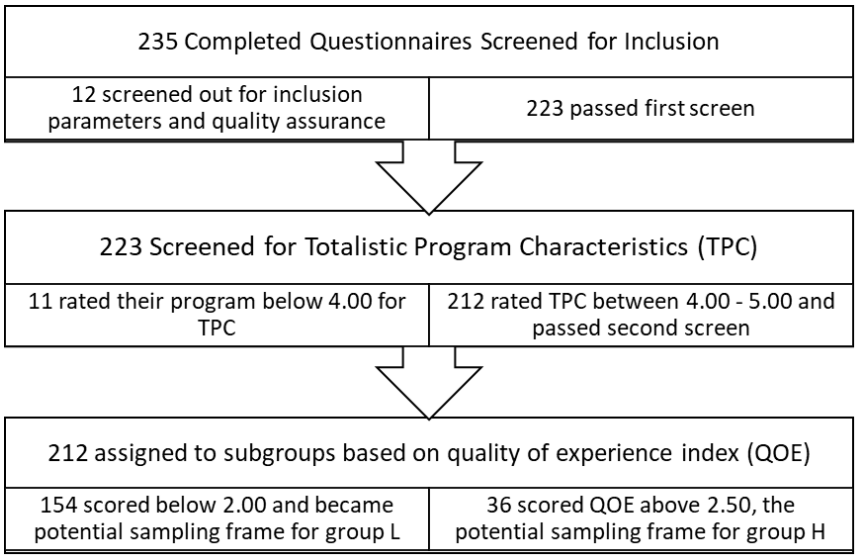

Table 1. Higher Scoring Group of Interview Participants Descriptive Data (Group H)

Alias	*Gender*	*Age*	*Intake Year*	*Program Type*	*State*	*Grad.*	*TPC*	*QOE*	*Intake Age*	*Months In*
Lawrence	M	31	2002	Wilderness: ID	ID	Y	4.86	4.60	16	3
Ann	F	38	1995	RTC/Outdoor	TN	Y	4.86	4.00	16	12
Greg	M	48	1985	RTC/TBS	ME	N	4.86	3.93	16	18
Cee Cee	F	44	1985	TBS	TN	N	5.00	3.93	12	72
Frank	M	23	2009	TBS	MT	Y	4.71	3.67	15	24
Howard	M	51	1982	Intensive Outpatient	OH	Y	5.00	3.60	17	18
Yvonne	NG	19	2012	RTC	UT	Y	4.71	3.60	14	7
Barry	M	29	2004	TBS	MT	Y	4.86	3.20	15	22
Xander	M	48	1985	Intensive Outpatient	FL	Y	4.00	3.20	16	12
Uriah	M	36	1995	Outdoor/JJ	FL	Y	4.29	3.13	14	14
Valorie	O	28	2004	TBS	MT	N	4.43	2.80	14	26
Nathan	M	29	2003	RTC/TBS	UT	N	5.00	2.73	16	14
Iris	F	42	1991	TBS	ID	Y	4.86	2.67	16	28
Wilma	F	20	2011	TBS	IA	Y	4.71	2.67	14	30
Aaron	M	53	1982	TBS	ME	Y	4.86	2.60	17	16

Note. NG=Nongendered; O=Some Other Gender Identity; RTC = Residential Treatment Center; TBS = Therapeutic Boarding School; JJ = Juvenile Justice. Grad.=Graduated or Completed Program; Months in = # of months in the program.

Table 2. Lower Scoring Group of Interview Participants Descriptive Data (Group L)

Alias	*Gender*	*Age*	*Intake Year*	*Program Type*	*State*	*Grad.*	*TPC*	*QOE*	*Intake Age*	*Months In*
Carmen	F	41	1989	Intensive Outpatient	TX	N	4.71	1.80	15	36
Tony	M	42	1991	RTC/TBS/Outdoor	OR	Y	5.00	1.73	16	24
Mary	F	21	2010	Wilderness/Outdoor	OR	Y	4.14	1.73	14	3
Dee Dee	F	27	2004	RTC/TBS	UT	Y	5.00	1.60	13	37
Elsa	F	31	2004	TBS	MX	N	5.00	1.60	17	12
Bobbi	F	39	1994	RTC/TBS/Outdoor	AL	N	5.00	1.53	16	22
Pat	F	30	2001	RTC/TBS	UT	Y	5.00	1.53	14	27
Kam	F	31	2003	TBS	MT	Y	5.00	1.40	17	20
Joan	F	19	2016	TBS	MT	Y	5.00	1.40	17	18
Sebrina	F	27	2006	RTC	UT	Y	4.86	1.33	16	10
Quill	F	22	2009	TBS	MT	Y	4.86	1.27	14	24
Ozzie	F	24	2010	RTC	PA	Y	4.14	1.27	15	11
Ziggy	F	39	1994	Intensive Outpatient	FL	N	5.00	1.20	15	16
Donnie	O	19	2012	RTC/TBS	IA	Y	5.00	1.00	13	21
Rudi	F	44	1989	Wilderness	UT	Y	4.71	1.00	15	3

Note. O=Some Other Gender Identity; RTC = Residential Treatment Center; TBS = Therapeutic Boarding School; MX=Mexico; Grad.= Graduated or Completed Program; Months in = # of months in the program.

The Qualitative Approach

The design of this study was shaped by the pragmatic qualitative research principles described by Jamie Harding (2013) and Robert Yin (2016). Semi-structured interviews were conducted nationally by phone with 30 participants and each was recorded. Each interview was loosely structured around the same twelve open-ended questions, but participants were encouraged also to speak to what was most important to them. All interviews were fully transcribed and coded line by line for analysis. The interviews were developed to collect data that would be useful in answering three research questions. How are totalistic teen treatment methods experienced? How do participants describe the immediate effects of the program? How do participants describe the long – term impacts of the program?

Thematic Findings

This summary presents three themes that were developed to answer the research questions. The full report explains how these themes are grounded in qualitative data and distilled from topical, categorical, and comparative analyses. The participant names provided below are aliases.

Induction/Abduction

The theme of *induction/abduction* expresses a 'toward and away' motion of placement into the program and removal from the outside world. This theme is revealed in the way interview participants described being transported and introduced to the program. Rudi described a literal abduction: 'I was kidnapped to be taken out there, my parents hired a transporter that came into my room and like, woke me up and searched me and took me away.' Pat linked the abduction experience to a shocking intake procedure: 'I was terrified when I went because they grabbed me out of my bed in the middle of the night.'

For Mary, after being tricked into the program, her *induction/abduction* was overwhelming and disorienting. 'From the very beginning of the program – when I said one of the biggest emotions for me was pure confusion, fear and confusion, well, I was tricked into going, my parents told me we were having brunch with a family member out of town.' When she was 14, after her parents caught her smoking marijuana, they took her to a strange house in the woods. There she learned that she would be spending several weeks on a hike with strangers, walking all day, every day, in silence. First, she was taken to the basement and strip searched. 'They took one of us at a time into the back room and did a strip search, which at the time I had no idea what was happening, I didn't know who these people were, where my parents were, anything.' Then she was put into a windowless van and forbidden to speak or ask questions on the drive through the night.

> They didn't explain much. One of the things that they said over and over and over was 'no questions, no questions,' so obviously a lot of us were asking a lot of questions, were trying to. I wasn't necessarily, I was just kind of stunned.

The van stopped around 4:00 A.M. and she was assigned a backpack so heavy she could not lift it by herself. At the time, she weighed 105 pounds and for the next three weeks, her treatment consisted of walking in silence with a 65 – pound backpack strapped to her shoulders. During this time, she was allowed to eat only beans and rice, and allowed to drink only small amounts of collected water, which was sometimes muddy and always treated with iodine. At the time of her interview she still experienced physical pain where the backpack straps cut into her shoulders during her initiatory hike.

In all program types, as initiates struggled to get their bearings, they were threatened with harsh punishments that could be given without explanation or warning. Iris was punished for breaking rules and 'agreements' she knew nothing about.

> They tell you there's only three rules here, 'no sex, no violence, and no drugs,' so those are the only rules, everything else is called an 'agreement' and they don't tell you that you're out of agreement until you break the agreement, so the first few months are just kind of like, you know, you feel like a puppy waiting to get your nose smacked.

Protesting unfair punishments or questioning the program's logic could invite even more restrictions. As the structure's power was induced, the outside world, old habits, and the old self, became farther away. A few participants described the *induction/abduction* experience in positive terms. To Lawrence, being led away from the past and his old friends was a good thing. 'The whole point of the program is to take you away from your support system and all the things that completely take your mind off of what's important in real life.' In sharp contrast with Mary's experience, Lawrence's induction was facilitated by helpful staff members.

Photo 1. by Mandy Carlisle, 2012, Milford, Ohio. *Front entrance*.[1]

> There was no rulebook, there were staff members who were explaining it as best as they could and walking you through and getting you changed, getting you out of your civilian clothes, and getting you prepared with all your physical stuff you're going to need for the program you know. There was a lot of explanation going on there and they were always willing to answer questions and stuff like that at appropriate times.

The singular motion of this theme, being led away from the past and led toward a future self, describes the simultaneous 'tearing down of the old selves and the building of new ones' (Adams 1995, 101). Participants referred to the induction/abduction process as an experience that taught them there was one choice: resist and suffer indefinitely or comply and rise up through the levels of the program toward release.

[1] Photos 1-5 were taken between 1982 and 2008, the facility shown housed three different teen treatment programs: Straight, Incorporated, Kids Helping Kids, and Kids Helping Kids, A Pathway Family Center. More information about the site is available here: http://survivingstraightinc.com/kids_helping_kids_-_straight_renamed

Photo 2 by Mandy Carlisle, 2012, Milford, Ohio. *Hallway to intake rooms*.

Containment/Release

The theme of *containment/release* reflects the short-term desire for internal relief and the long-term goal of actual release from the containment structure of the program. Interactions within the program environment create a milieu of transformation where youth actively participate in their own containment and the contain-

ment of others. This theme reveals a circular logic based on participant descriptions of four interlocking conditions: 1) the only way out is to work up through the program levels, 2) resistance, lack of compliance, or complaints are seen as a symptom of a personal disorder, never indicative of some larger systemic problem, 3) the more resistant or disordered you are, the more treatment you need, and 4) progress and graduation are only possible for those who establish a genuine emotional bond with other residents and staff that demonstrates their commitment and gratitude for the program.

Ann's description of her 'big internal change' helps to demonstrate how *containment* and *release* are intertwined. One of the most important moments in her treatment was the sudden flash of insight triggered by a staff member who pointed out that Ann's mother could choose to abandon her, refusing to let her come home after the program. Rather than feeling threatened, Ann remembers opening up, realizing she was deeply connected with all the people in her life. Rather than feeling coerced, she described this as a process of becoming more authentic, enabling her to embrace the program with more depth. She emphasized that this transformation only occurred after many months of adhering to the program's strict regimen.

> I talked about all the hard stuff with my stepdad and I talked about all that, but I think that ultimately the big change hadn't happened within me. Like, I've done all the external stuff you know, but see, I had started going to therapy when I was seven years old, so at that point I knew all the words to say, I knew how to participate, I knew how to not get in trouble, I knew how to do the stuff, but the big internal change hadn't really happened as far as being myself for who I am I guess, and so, I think that that's just a long process.

She reported a long process leading up to the big change, but the moment of change was a sudden flash of insight that taught her humility.

> Somehow, I learned humility and that was my big lesson, that was my biggest lesson from my whole experience there…it was a huge turning point. And I think that if it all hadn't happened exactly the way it did, if I hadn't been isolated for a month…I mean this packet they gave us to do, the fourth step [of Alcoholics Anonymous] was so in – depth…if all of those things hadn't happened exactly the way they had I don't know that I would've had such an experience.

This month – long period of isolation for her fourth step was an unexpected punishment that set the stage for her moment of internal change. She had been in the program for 10 months by then and was progressing along quite well when the staff decided she needed a demotion.

Photo 3. by Phillip Laurette, 2012. Milford, Ohio. *Rap room*.

I'd been there for about 10 months and I thought that I was progressing really well through the program, and then at the last minute, right as I was about to move up to the new level in the program, they turned around and took it away from me and actually put me on kind of like, this isolated thing. It was a really

> wild kind of moment because they actually decided that the way that I'd been interacting with my mother and the way that I'd been interacting with the rest of the group was really controlling, and you know, that I was just kind of like skating through and that it wouldn't really be right for me to move up. And so, here I thought that I was about to get to move up to the next level and actually they drop me down to like, below the first level.

Photo 4. by Kathy Moya, 2017, Milford, Ohio. *Time out room*.

This setback meant she lost privileges and would have to spend each day in isolation, called 'blackout.'

> When the whole group was all eating together, I was sitting over in the corner, if they were all standing around, I was off to the side facing the wall. I didn't have to participate in chores, I didn't have to participate in work. If everybody else was chopping wood, I was sitting over next to a tree facing the tree all day.

Rather than framing her punishment as an arbitrary setback or an unwarranted seclusion, she remembers learning humility. It was after this month in blackout when Ann's therapist reminded her that her mother could refuse to take her back.

> So I was really kind of confronted with that possibility and then the next day I did my fifth step which is where you kind of, in recovery you don't necessarily read your fourth step to the person but you kind of talk about what you found out about your-

> self in your fourth step, and that was really illuminating for me and that was really the big turning point, that weekend.

Photo 5. by Mandy Carlisle, 2012, Milford, Ohio. Slogans.

Across the interviews, participants described how the program structure provided rigid boundaries against the outside world while softening or violating interpersonal boundaries within the milieu. Even those who praised the program's effects described the constant pressures as a general sense of dread, a fear of unpredictable confrontations, an exhausting schedule, and a constant threat of punishment. For the majority, these pressures were described as stressful or traumatic, but at the time of her interview, Ann saw these as positive experiences and opportunities. 'The phrase that the program director would say all the time was "everything we do is therapeutic," and so you know, there was always – they're always finding new ways to poke at you so that you could explore your issues.' Unlike Ann, who embraced the unexpected, Nathan described the threat of unpredictable punishments as constant pressure: 'It felt like all the moments that I was happy there were a reprieve from the constant, like, oppression.' He explained that his favorite time of day was when he was finally allowed to go to sleep, and his least favorite time of day was waking up in the morning.

Others made no attempt to frame the experience in positive terms. In one understated sentence, Kam revealed a potentially harmful aspect of *containment/release*

that many spoke to: 'It could be hours that you are getting screamed at, and the best way to avoid a heavy confrontation was to confront other people about things that you saw them do.' By deflecting attention onto others in cathartic confrontations, frustrated emotional pressures may be released. And when such deflections demonstrated compliance with staff expectations, that temporary relief was coupled with rewards of status and progress toward actual release as graduation.

Photo 6. by Lillian Speerbrecker, 2015, Lucedale, Mississippi. Facility grounds.[2]

Ironically, the only way to earn *release* from the container was to become an integral part of the container. Rudi mentioned the most basic expression of this theme when describing the social environment: 'The program encouraged us…to punish people who didn't hike fast enough, or you know, fall in with the group.' Joan explained that there were consequences for not becoming part of the container: 'I was responsible for making sure these other people get their stuff done, otherwise I would get in trouble.'

[2] The facility shown at photos 6-8 housed a succession of different programs that apparently operated from the 1970s until 2011 or 2012, when the most recent program, Gulf Coast Academy, ceased operations there. More information about this site is available here: http://www.heal-online.org/noeagles.htm and here: http://www.secretprisonsforteens.dk/fornitswiki/index.php/Gulf_Coast_Academy

Release came through performing officially sanctioned responses. Whether the performance accompanied therapeutic changes or not, they were designed to increase the power of the program. In one even – handed statement, Frank explained the logic and power expressed in the theme of *containment/release*: 'While I appreciate things I gained from that experience, I think there was a level of brainwashing that happened in that space. Like, your life becomes this bubble, and your life becomes "how do I get out?" and you start kind of like, performing for the system.'

Trajectory and Perspective

The theme of *trajectory and perspective* helps to conceptualize the way the totalistic teen treatment experience relates to the arc of life after exiting and the way that arc is viewed. This theme is perhaps most vivid when exploring attitudes toward harm that is associated with the treatment experience. At the time of his interview, Lawrence was a PhD student with the goal of working as the director of a wilderness therapy program. In his view, reports of harm are to be expected, and sometimes, those who claim to be victims may bear some of the blame. His concern about the portrayal of harm was linked to his interest in being interviewed.

> The thing that people don't talk about when it comes to these programs is yeah, there are a lot of kids that go out there and have a really bad time, don't listen to directions, get hurt or whatever it is, and that's just kind of the nature of the beast. So anyway, I just wanted to have an opportunity to speak my part. I think it's way more beneficial than not… I'm on a couple of different groups on the internet and you know, it's about 50/50 – 50% of people say that they have PTSD and stuff like that from it, and other people say it was awesome, so it's just a mixed bag. Just like any therapeutic model, it doesn't work for everybody.

Like Lawrence, Mary was also interested in working with young people, but her experiences of harm gave her a different perspective. At the time of her interview, painful physical injuries sustained in the program were interfering with her secondary education.

> I have such a great interest in working with teens in similar situations so that's really what I've done with my life, until recently, is work towards that. And I believe that going through something like that really helps you develop a great sympathy and empathy for others. And I've used that trait of mine in deciding what career I want to choose for myself. But it's also, obviously the chronic pain is something that affects every aspect of my life so that's been something huge that I would say came from this program.

Those who experienced psychological trauma described a long process of coming to terms with harm in their engagement with healing. In Elsa's perspective, after exiting the program, her life was impaired by trauma responses for many years.

> I really didn't have any coping mechanisms to kind of deal with the things that had affected me and I kind of shut down in a lot of ways … I was just kind of in this overall numb state of life in general. It was really bad especially the first couple years after I got out. I started doing therapy about a year ago and did some trauma therapy … I mean that's like 12 years that, I would honestly say that's probably about how long it took for me to really come out of it in a real impactful way.

Photo 7. by Lillian Speerbrecker, 2015, Lucedale, Mississippi. Dorm room.

Nathan's perspective was informed by the experience of serious harm as well as personal growth he attributed to friendships made in the program. While he valued the help he received, he was sceptical of recent graduates and their zealous praise for treatment.

> I've seen people [online] who've done different years say they had a great experience. Kind of like, "You have that post [program] glow. Give it another five months and come back to us,

> we'll see what you're gonna say once, you know, that kind of brainwashing wears off and your perspective changes and you really start thinking about everything you went through."

Whether or not they perceived help, harm, or a complicated mix of both, the degree to which they were transformed or traumatized, and the resources available to them after *release*, all reflect the theme of *trajectory and perspective*.

Photo 8. by Lillian Speerbrecker, 2015, Lucedale, Mississippi. Pews.

Discussion

The findings in this study highlight the importance of understanding the subjective experience of harm in teen treatment settings. Twelve participants (80%) in the lower QOE scoring group and four (27%) in the higher QOE scoring group named symptoms associated with traumatic stress as some of the most impactful aspects of treatment. Participants explicitly linked program features to negative outcomes such as: panic attacks, debilitating anxiety, flashbacks, triggering reminders, nightmares, mistrust of clinical professionals, difficulties in relationships, social isolation, lost sense of selfhood, and a lingering sense of violation. These participants attributed harm to unethical staff behavior, medical neglect, and interpersonal abuse, but they emphasized also that the totalistic design features of their respective programs were a primary cause of psychological injury.

The subjective nature of program effects is perhaps more complicated when the experience of institutional abuse is framed in beneficial terms. Five participants in the higher QOE scoring group attributed beneficial responses to practices many professionals might judge as unethical, including: staff ridicule, arbitrary setbacks, public humiliation, extreme restrictions on communication, prolonged social isolation techniques, and unreasonable punishments. These participants indicated that they realized others in their cohorts experienced harm from some of the same program features they found helpful. Some simply referred to themselves as 'one of the lucky ones,' but others struggled to reconcile the discrepancy.

Many in the lower QOE scoring group indicated that their perspective on treatment changed drastically over the course of many years. Some reported a disillusionment process similar to what Nathan described; as recent graduates they believed they had been saved, but as time wore on, they realized that what they once thought of as treatment was actually institutional abuse. For some, the ethos instilled in treatment trained them to take responsibility for their role in negative life events. Failing to hold themselves accountable by criticizing the program would have signaled a backsliding. In their view, the treatment itself prevented their ability to recognize, critique, and heal from negative program effects. For others, their parents were trained to watch for complaints as a sign that they may not be ready for life outside the program, effectively linking criticism to the threat of readmission. A few reported that the program improved their family relationships but most described broken trust and impairment to parental relationships as current challenges or something the program worsened.

The thirty people who were interviewed in this study received treatment between 1982 and 2017. Some of the most extreme forms of institutional maltreatment were reported by participants with relatively recent intake dates. Compared to past decades, there may be fewer overtly brutal treatment programs in the United States now, but the prevalence of institutionalized abuse is a current topic that warrants research.

One of the strengths of this study is that it begins to portray the complex 'totality of conditions' that combine to shape personal experiences of harm (Leach 2016). If the prevention of harm in treatment settings requires the ability to identify and measure problematic design features that combine to produce unacceptable levels of risk, then treatment providers, regulatory agencies, and researchers will need to distinguish between acceptable and unacceptable risks and injuries.

Limitations

This study offers a rare glimpse into what many scholars refer to as 'the black box' of residential treatment (Harder and Knorth 2015). Although the study's focus on totalistic programming makes an important contribution to the literature by providing a wide range of research variables related to treatment quality and the prevention of harm, this focus is also a weakness because it limits the ability to ex-

plain how critical factors such as race and class may interact to shape experiences, immediate effects, and long-term impacts. Almost all of the people who responded to the invitation to participate in research had been placed in a private-pay program by their parents and identified as white. In a larger study that could recruit participants from the general population, a focus on race and class might help to increase the relevance and generalizability of any findings.

In data collection and analysis, the topic of gender was not placed in a central position. This weakness reflects the pragmatic constraints that made an expanded scope impossible. Gendered differences were perhaps most apparent in reported reasons for placement, but by chance of the random draw, the lack of males in the lower QOE scoring group limited the ability to develop a gendered analysis. The unique nature of harm experienced by females who reported 'slut shaming' and staff interest in sexually explicit disclosures seems to indicate that power over female residents may have been leveraged more often in ways related to sexuality.

The concept of totalistic teen treatment is a new way to evaluate treatment environments and the study is limited by its exploratory nature. The two index variables demonstrated strong internal validity, with each item contributing to the discriminatory power of their respective sets. But the qualitative findings indicate that new QOE index items are needed to measure experiences of medical neglect, abandonment and betrayal, torture, or witnessing a death in the program.

Any weaknesses associated with retrospective studies should be weighed against the dynamics present within youth programs that equate ingratitude with personal failure. Interviewing youth who are currently in treatment can place them in jeopardy if their complaints are punishable or likely to be diagnosed as a failure to respond to treatment. Considering the restrictions against free communication and the risk of placing youth in jeopardy, retrospective interviews might be the most ethical and accurate way to conduct research on this topic.

Conclusion

In this summary article, three themes help to describe the experiences, immediate effects, and long-term impacts of totalistic teen treatment. Thirty interview participants provided candid windows into the way they remember and understand the meanings and values associated with their respective programs. In the sampling frame, a total of 71 different program facilities located within 25 different states were rated 'highly totalistic,' defined as a score of 4.00 to 5.00 on a five-point scale. The number of current programs that might be rated this way by former residents is unknown. If federal legislation were passed, creating uniform safety standards and a centralized data collection system in the United States, population sizes and program typologies might become clearer. Currently, due to a 'glaring lack of information,' even some of the most basic questions about residential programs go unanswered (Friedman et al. 2006, 295).

This study found that a majority of interview participants who participated in highly totalistic programs described treatment methods that fit professional definitions of institutionalized abuse (Harrell and Orem 1980). To predict and prevent harm in teen treatment settings it is necessary to understand the problematic features associated with experiences of coercive persuasion and thought reform in youth programs. This study identifies a set of features that are found together in multiple types of youth treatment programs where the experience of harm may be common. If it were possible to measure the presence of problematic program characteristics, efforts to prevent institutionalized abuse might be improved.

Acknowledgements

This study was possible because of the many people who completed the questionnaire and the 30 people who participated in an interview. Thank you for your time and candor. David Diehl, Jodi Lane, Suzanna Smith, Sebastian Galindo, and Tracy Johns advised me with the thesis project that is summarized in this article. Their expertise and mentorship enhanced the quality and rigor of the research. This manuscript was improved greatly by Cindy Coalter and the anonymous expert reviewers who provided generous comments and suggestions

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References

Adams, David W. 1995. Education for Extinction: American Indians and the Boarding

School Experience, 1875 - 1928. Lawrence: University Press of Kansas.

Alexander, Bruce K. 1990. Peaceful Measures: Canada's Way Out of the 'War on Drugs.' Toronto: University of Toronto Press.

Beyerstein, Barry L. 1992. "Treatment, thought reform, and the road to hell." In Strategies for Change: New directions in Drug Policy, edited by Arnold S. Trebach and Kevin B. Zeese, 245 - 251. Washington, D.C.: Drug Policy Foundation.

Chama, Samson, and Octavio Ramirez. 2014. Young People's Perceptions of a Group Home's Efficacy: A Retrospective Study. Residential Treatment for Children & Youth, 31(2),120 - 134. https://doi.org/10.1080/0886571X.2014.918442

Chatfield, M. M. 2018. "Adult Perspectives on Totalistic Teen Treatment: Experiences andImpact." Master's thesis. University of Florida. Digital Collections Institutional Repository. http://ufdc.ufl.edu/UFE0052745/00001

Cox, Alexandra. 2017. Trapped in a Vice: The Consequences of Confinement for Young People. New Brunswick: Rutgers University Press. https://doi.org/10.2307/j.ctt2050wn2

De Leon, George. 1995. "Therapeutic Communities for Addictions: A Theoretical Framework." International Journal of Addictions, 30(12), 1603 - 1645. https://doi.org/10.3109/10826089509104418

De Leon, George. 2000. Therapeutic Community: Theory, Model, and Method. New York: Springer Publishing Company.

De Leon, George and Gerald Melnick. 1993. "Therapeutic Community Survey of Essential Elements Questionnaire (SEEQ), Short Form." New York: Community Studies Institute. http://www.ndri.org/manuals-instruments/seeqshor.doc

Dozier, Mary, Joan Kaufman, Roger Kobak, Thomas G. O'Connor, Abraham Sagi - Schwartz, Stephen Scott, Carole Shauffer, Judith Smetana, Marinus H. van IJzendoorn, and Charles H. Zeanah. 2014. "Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association." American Journal of Orthopsychiatry, 84(3), 219 - 225. https://doi.org/10.1037/ort0000005

Dye, Meredith Huey, Lori J. Ducharme, J. Aaron Johnson, Hannah K. Knudsen, and Paul M. Roman. 2009. "Modified Therapeutic Communities and Adherence to Traditional Elements." Journal of Psychoactive Drugs, 41(3), 275 - 283. https://doi.org/10.1080/02791072.2009.10400538

Edelen, Maria O., Joan S. Tucker, Suzanne L. Wenzel, Susan M. Paddock, Patricia A. Ebener, Jim Dahl, and Wallace Mandell. 2007. "Treatment Process in the Therapeutic Community: Associations with Retention and Outcomes Among Adolescent Residential Clients." Journal of Substance Abuse Treatment, 32(4), 415 - 421. https://doi.org/10.1016/j.jsat.2006.10.006

Empey, LaMar and Jerome Rabow. 1962. "Communist Rectification Programs and Delinquency Rehabilitation Programs: A Parallel?" American Sociological Review, 27(2), 256 - 258.

Frank, Jerome. 1974. Persuasion and Healing (Revised Edition). New York: Schocken Books.

Frankel, Barbara. 1989. Transforming Identities: Context, Power and Ideology in a Therapeutic Community. New York: Peter Lang.

Friedman, Robert M., Allison Pinto, Lenore Behar, Nicki Bush, Amberly Chirolla, Monica Epstein, Amy Green, Pamela Hawkins, Barbara Huff, Charles Huffine, Wanda Mohr, Tammy Seltzer, Christine Vaughn, Kathryn Whitehead, and Christina Kloker Young. Alliance for the Safe, Therapeutic and Appropriate use of Residential Treatment. 2006. "Unlicensed Residential Programs: The Next Challenge in Protecting Youth." American Journal of Orthopsychiatry, 76(3), 295 - 303. https://doi.org/10.1037/0002-9432.76.3.295

Federal Trade Commission. 2019. "Residential Treatment Programs for Teens." https://www.consumer.ftc.gov/articles/0185-residential-treatment-programs-teens

Garcia, Angela. 2015. "Serenity: Violence, Inequality, and Recovery on the Edge of Mexico City." Medical Anthropology Quarterly, 29(4), 455 - 472. https://doi.org/10.1111/maq.12208

Goffman, Erving. 1961. Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. New York: Anchor Books.

Gowan, Teresa and Sarah Whetstone. 2012. "Making the Criminal Addict: Subjectivity and Social Control in a Strong-Arm Rehab." Punishment & Society, 14(1), 69 - 93. https://doi.org/10.1177/1462474511424684

Harder, Annemiek T. and Erik J. Knorth. 2015. "Uncovering What is Inside the 'Black Box' of Effective Therapeutic Residential Youth Care." In Therapeutic Residential Care for Children and Youth: Developing Evidence - Based International Practice, edited by James K. Whittaker, Jorge F. del Valle, and Lisa Holmes, 217 - 230. Philadelphia: Jessica Kingsley Publishers.

Harding, Jamie. 2013. Qualitative Data Analysis from Start to Finish. Los Angeles: SAGE.

Harper, Nevin J. 2010. "Future Paradigm or False Idol: A Cautionary Tale of Evidence - Based Practice for Adventure Education and Therapy." Journal of Experiential Education, 33(1), 38 - 55. https://doi.org/10.5193/JEE.33.1.38

Harrell, Sharon A. and Reginald C. Orem. 1980. Preventing Child Abuse and Neglect: A Guide for Staff in Residential Institutions. Washington, D.C.: U.S. Department of Health and Human Services, Office of Human Development Services.

Kaye, Kerwin. 2013. "Rehabilitating the 'Drugs Lifestyle': Criminal Justice, Social Control, and the Cultivation of Agency." Ethnography, 14(2), 207 - 232. https://doi.org/10.1177/1466138112457311

Knapp, Joseph L. and Frederick Weitzen, F. 1945. "A Total Psychotherapeutic Push Method as Practiced in the Fifth Service Command Rehabilitation Center, Fort Knox, Kentucky." The American Journal of Psychiatry, 102(3), 362-366. https://doi.org/10.1176/ajp.102.3.362

Leach, John. 2016. "Psychological factors in exceptional, extreme and torturous environments." Extreme Physiology & Medicine, 5(1), 7. https://doi.org/10.1186/s13728-016-0048-y

Lewin, Kurt. 1947. "Frontiers in Group Dynamics: Concept, Method and Reality in Social Science; Social Equilibria and Social Change." Human Relations, 1(1), 5 - 41. https://doi.org/10.1177/001872674700100103

Lifton, Robert J. 1989. Thought Reform and the Psychology of Totalism: A Study of 'Brainwashing' in China. Chapel Hill: University of North Carolina Press.

Neville, Lucy, Sarah Miller, and Katarina Fritzon. 2007. "Understanding Change in a Therapeutic Community: An Action Systems Approach." Journal of Forensic Psychiatry & Psychology, 18(2), 181 - 203. https://doi.org/10.1080/14789940601108439

Ofshe, Richard and Margaret T. Singer. 1986. "Attacks on Peripheral Versus Central Elements of Self and the Impact of Thought - Reforming Techniques." Cultic Studies Journal, 3(1), 3 - 24.

Polvere, Lauren. 2011. "Youth Perspectives on Restrictive Mental Health Placement: Unearthing a Counter Narrative." Journal of Adolescent Research,

26(3), 318-343.
https://doi.org/10.1177/0743558410391257

Rauktis, Mary Elizabeth. 2016. "'When You First Get There, You Wear Red': Youth Perceptions of Point and Level Systems in Group Home Care." Child and Adolescent Social Work Journal, 33(1), 91-102. https://doi.org/10.1007/s10560-015-0406-4

Reamer, Frederic G. and Deborah R. Siegel. 2008. Teens in Crisis: How the Industry Serving Struggling Teens Helps and Hurts Our Kids. New York: Columbia University Press.
https://doi.org/10.7312/ream14462

Salter, Frank K. 1998. "Indoctrination and Institutionalized Persuasion: Its Limited Variability and Cross - Cultural Evolution." In Ethnic Conflict and Indoctrination: Altruism and Identity in Evolutionary Perspective, edited by Irenäus Eibl - Eibsfeldt, and Frank K. Salter, 421 - 452. New York: Berghahn Books.

Schein, Edgar. 1962. "Man Against Man: Brainwashing." Corrective Psychiatry and Journal of Social Therapy, 8(1-4), 90 - 97.

Schein, Edgar with Inge Schneier and Curtis Barker. 1961. Coercive Persuasion: A Socio-psychological Analysis of the 'Brainwashing' of American Civilian Prisoners by the Chinese Communists. New York: Norton.

Sickmund, Melissa, T. J. Sladky, W. Kang, and C. Puzzanchera. 2017. "Easy Access to the Census of Juveniles in Residential Placement." http://www.ojjdp.gov/ojstatbb/ezacjrp/

Singer, Margaret T. and Richard Ofshe. 1990. "Thought Reform Programs and the Production of Psychiatric Casualties." Psychiatric Annals, 20(4), 188 - 193.
https://doi.org/10.3928/0048-5713-19900401-06

Stevens, Alisa. 2012. "'I Am the Person Now I was Always Meant to Be': Identity Reconstruction and Narrative Reframing in Therapeutic Community Prisons." Criminology & Criminal Justice, 12(5), 527-547. https://doi.org/10.1177/1748895811432958

U.S. Census. 2018. "Characteristics of the Group Quarters Population in the United States 2017 American Community Survey 1 - Year Estimates." https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S2601A&prodType=table

U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2018a. "A National Look at the Use of Congregate Care in Child Welfare." https://www.acf.hhs.gov/sites/default/files/cb/cbcongregate-care_brief.pdf

U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018b). "Child Maltreatment 2016." https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment

U.S. Government Accountability Office. 2008a. "GAO - 08 - 146T: Residential Treatment Programs: Concerns Regarding Abuse and Deaths in Certain Programs for Troubled Youth." United States Government Accountability Office Testimony Before the Committee on Labor and Education: House of Representatives. 2008. https://www.gao.gov/new.items/d08146t.pdf

U.S. Government Accountability Office. 2008b. "GAO - 08 - 346: Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well - Being of Youth with Behavioral and Emotional Challenges." https://www.gao.gov/new.items/d08346.pdf

U.S. Government Accountability Office. 2008c. "GAO - 08 - 713T: Residential Programs: Selected Cases of Death, Abuse, and Deceptive Marketing." https://www.gao.gov/assets/120/119828.pdf

U.S. House of Representatives, 110th Congress. 2007. "Cases of Child Neglect and Abuse at Private Residential Treatment Facilities: Hearing Before the Committee on Education and Labor." https://www.govinfo.gov/content/pkg/CHRG-110hhrg38055/pdf/CHRG-110hhrg38055.pdf

U.S. House of Representatives, 110th Congress. 2008. "Child Abuse and Deceptive Marketing by Residential Programs for Teens: Serial No. 110 - 89." https://www.govinfo.gov/content/pkg/CHRG-110hhrg41839/html/CHRG-110hhrg41839.htm

Walker, Sarah Cusworth, Brian K. Bumbarger, and Steven W. Phillippi. 2015. "Achieving Successful Evidence - Based Practice Implementation in Juvenile Justice: The Importance of Diagnostic and Evaluative Capacity." Evaluation and Program Planning, 52, 189 - 197. https://doi.org/10.1016/j.evalprogplan.2015.05.001

Whittaker, James K., Jorge F. del Valle, and Lisa Holmes. 2015. "Introduction: The current landscape of therapeutic residential care." In Therapeutic Residential Care for Children and Youth: Developing Evidence - Based International Practice, edited by James K. Whittaker, Jorge F. del Valle,

and Lisa Holmes, 23 - 33. London & Philadelphia: Jessica Kingsley Publishers.
https://doi.org/10.1080/0886571X.2016.1215755

Yin, Robert. 2016. Qualitative research from start to finish (Second Edition). New York: Guilford Press.

Zablocki, Benjamin. 1997. "The Blacklisting of a Concept: The Strange History of the Brainwashing Conjecture in the Sociology of Religion." Nova Religio: The Journal of Alternative and Emergent Religions, 1(1), 96 - 121. https://doi.org/10.1525/nr.1997.1.1.96

JOURNAL of EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 72-93 https://doi.org/10.5617.7054

Article

Experimental Trajectories of Young Users of Psycho-active Prescription Drugs in Urban Indonesia

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Abstract

In Indonesia, a country with stringent drug laws, psycho-active prescription drugs (PPDs) have become popular among urban youth as they are seen to be safe – both medically and in terms of the risks of being arrested. During the ChemicalYouth project, which involved a multi-sited ethnography in urban centers in South Sulawesi (Makassar, Gowa, and Maros) and in Yogyakarta, we found that young people encourage each other to try out different kinds of PPDs to determine which (combinations) work best for them. Sharing their experiences, they jointly build up knowledge that guides their 'experimental trajectories' (Raikhel and Garriott 2013). The experimental trajectories of youths are enabled by pharmacies, where young people can buy PPDs, and private sector doctors who sell and prescribe PPD prescriptions. When certain PPDs become harder to get, young people will try out new substances in their search for happiness, highs, and the confidence and stamina needed to perform precarious informal sector jobs such as sex work, street singing, and helping people park their cars. Across the sites, the researchers encountered young people realizing that they had become addicted to PPDs. Simultaneously, health workers lack instruments to prevent harm related to PPD use as they work in public sector harm reduction programs designed narrowly to address illicit heroin addiction. We argue that educational interventions need to address the desires and aspirations for good enough lives that are reflected in young people's creative poly-drug use practices, and the iatrogenic effects of unregulated pharmaceutical markets that enable medicalization of precarious lives.

Keywords

PPD, youth, Indonesia, harm reduction, addiction, experimental trajectories

Introduction

Like many other Southeast Asian countries, Indonesia is known for its draconian laws on drug use and trafficking. Upon his election in 2014, President Jokowi re-introduced the death penalty for drug traffickers. Shortly thereafter, the Dutch citizen Ang Kiem Soei and four others faced a firing squad for their alleged involvement in producing ecstasy; other highly publicized executions of drug traffickers soon followed. Indonesia has a long history of drug use and trafficking, with opium having roots in the precolonial and Dutch colonial era. In more recent decades, Indonesia has become a major producer of methamphetamines (locally known as *shabu*), the use of which is today more pervasive than the use of heroin. Media regularly report on raids on meth laboratories and seizures by the police (UNODC 2018). While the crackdown has made *shabu* more expensive and difficult to access, one unintended – but perhaps predictable – consequence is that young people, in large numbers, are turning to legal psychoactive prescription drugs to get high.

The non-medical use of psychoactive prescription drugs (PPDs) is a growing world-wide problem that affects individual well-being and creates costly problems for societies. According to the United Nation's 2018 *World Drug Report*, the non-medical use of prescription drugs has become a major threat to global health, with prescription opioids causing the most harm and accounting for 76% of drug-related deaths. A 2018 global health survey among 130,000 young people (aged between 18 and 35) found that 2.3% had used the prescription painkiller Tramadol for non-medical reasons over the past year (Winstock et al. 2018). In Indonesia, the national child protection agency recently reported that 5.9 million children (below the age of 18) out of a total of 87 million (a staggering 6.7%) are using drugs, prominent among them the psychoactive painkiller Tramadol and cough syrups that if ingested in large enough quantities can induce highs (Rakhmat and Tarahita 2018).

Under Indonesian Law No. 35/2009, the list of the country's controlled substances is divided into three groups based on the substances' risk for addiction and potential therapeutic value. Group 1 drugs include heroin, cocaine, marijuana, MDMA (ecstasy), and methamphetamine, which are viewed by the Indonesian government as therapeutically useless and with a high potential for addiction. Possession of group 1 drugs can lead to life imprisonment and the death penalty for convicted drug traffickers. Group 2 drugs include morphine, methadone and oxycodone. They are seen to have some therapeutic value but are perceived as dangerous because of their potential for addiction; their trafficking and possession can result in imprisonment. Group 3 drugs include PPDs with therapeutic value (codeine and buprenorphine), and penalties are not very clear. In the local language, drugs in group 1 and 2 tend to be referred to as *narkoba* (narcotics), while PPDs are referred to as *obat resep* (prescription drugs).

The prevention strategy of Badan Narkotika Nasional's (BNN, *Indonesian National Narcotics Agency*) mobilizes fear to emphasize the addiction risks of illicit (group 1) drugs. It runs rehabilitation programs for their users, who are committed to rehab centers and forced to go cold turkey for several months while receiving counselling. A different approach is followed by the National Commission on AIDS. As injecting drugs remains a key transmission route for HIV, it runs harm reduction programs that offer heroin users the injecting of methadone as a substitution. Although BNN has recently begun to acknowledge the widespread use of PPDs, including those in group 3, its educational efforts clearly lie elsewhere. In the absence of effective regulation, young people access PPDs through pharmacies that sell the drugs over the counter without prescription, and through street dealers.

The off-label use of PPDs by young people is part of a worldwide trend (Coveney, Gabe and Williams 2011; Dumit 2012; Jenkins 2010; Rose 2007; Quintero and Nichter 2011). Lin and Zhang (2014) for example describe how the young users of PPDs whom they interviewed in a Shanghai detention center emphasized the emotional, social and psychological benefits of 'skating ice' (sniffing methamphetamine) and taking ecstasy, ketamine and other synthetic drugs. Drug taking for them had been a means to achieve socially acceptable goals; businessmen, for example, used synthetic drugs to cultivate connections. Green and Moore (2009) likewise describe how middle-class youth in Western Australia use 'dexies' (prescription drugs containing dexamphetamine) to 'drink like a trooper while maintaining bodily control' and to 'enjoy socializing for longer periods without getting too messy' (Green and Moore 2009: 408). Compared to getting drunk, female informants also reported feeling safer and more in control when using dexies.

The ChemicalYouth project was designed to elicit interpretative understandings of why young people turn to 'chemicals' – illicit drugs, off-label prescription pharmaceuticals, enhancement products of various kinds – to achieve their everyday goals. Working with a team of youth ethnographers, we conducted multi-sited ethnography (Hannerz 2003) in Indonesia, the Philippines, France and the Netherlands, examining patterns of drug use in different settings. Across the sites, we inquired about *what* youth want to achieve by using drugs; *how* they use drugs to achieve their desired mental and bodily states; and how local policymakers, harm reduction initiatives, and health workers view and respond to these emerging trends. This article presents an analysis of the use of PPDs to enhance mental well-being in four ChemicalYouth sites in Indonesia.

Instead of focusing on a handful of 'problem drugs', the focused ethnographies examine what Indonesian youth want to achieve by using PPDs. Our premise is that if we want to minimize the harms of PPD use, we need to first understand both how and why young people turn to these drugs – their concrete practices of drug use and the aims they wish to attain. We also present the views and experiences of policymakers and health workers, who seek to reduce drug-related harm in the field sites.

Methods

Settings

The study was carried out in urban centers in South Sulawesi (Makassar, Gowa, and Maros) and in Yogyakarta. Makassar is the metropolitan capital city of South Sulawesi; Gowa and Maros are smaller towns near Makassar. Yogyakarta on the island of Java is a renowned center of education; it hosts a large student population and numerous schools and universities. Both Makassar and Yogyakarta have methadone replacement programs, while persons addicted to illicit heroin from Gowa and Maros are referred to Makassar. Makassar has one public hospital and five public health centers (*Puskesmas*) offering methadone replacement treatment; Yogyakarta has two hospitals and three *Puskesmas* offering this service. Policies differ slightly between the sites. For example, those who want to enter the methadone program in Makassar must have been using heroin for at least one year, as shown in laboratory blood tests. In Yogyakarta, the period is six months.

Informants and Recruitment

We conducted ethnographic interviews with regular users of PPDs and other illicit drugs. In Makassar, we interviewed 20 young people (11 students, 6 unemployed youths living with their families, 2 working for their families, and 1 working in a car repair shop). In Gowa, our 20 informants included 10 high school students, recruited through an acquaintance of one of our junior researchers. In Maros, our 17 informants, all male youth, included the owner of a printing business, 2 workshop employees, a mechanic, 2 unemployed persons, 1 school dropout, and 7 students. In South Sulawesi, we encountered difficulties obtaining consent for interviews from women using drugs as their drug use is more covert than that of their male peers. All of our informants in South Sulawesi were therefore men. In Yogyakarta, we were able to interview 4 female and 7 male users of PPDs.[1] In addition, we interviewed police officers, (assistant) pharmacists, outreach workers, and staff at community health centers and at the BNN both in Makassar and Yogyakarta.

For recruitment, we worked with harm reduction NGOs: the *Makassar Harm Reduction Community* and our colleagues from the University of Gadjah Mada in Yogyakarta who introduced us to *Persaudaraan Korban Napza di Yogyakarta* (Narcotics and Addictive Substance Victim Brotherhood of Yogyakarta). In Gowa and Maros, there are no harm reduction NGOs, so we recruited informants were through snowball sampling.

Data Collection

To gather data on the young people's experiences with PPDs, we asked the informants to fill in a self-administered four-day chemical recall, which included items on the kinds of drugs used, the dosages involved, and for what purposes. After the recall, usually in the same session, we held an in-depth individual interview on the

[1] A 2010 survey conducted by BNN and the Center for Health Research, University of Indonesia, found male drug users outnumbering their female counterparts five to one (BNN and Puslitkes-UI 2011).

positive and negative effects of each drug reported in the recall, on what factors influenced informants' use of specific drugs, and how they learnt about and acquired them.

The results of the recalls and interviews were discussed in three focus groups in Makassar, involving nine, six and eight participants respectively, and a focus group in Yogyakarta with nine participants. In the focus groups, we placed samples of products mentioned in the individual interviews on the table to elicit group discussion. We asked participants to rank the drugs on the basis of which most individually suited them or had the best effects. We also delved further into themes and issues that emerged in the interviews and four-day recalls. The focus groups allowed us to validate our observations and probe more in-depth into specific themes.

Interviews and focus groups were conducted and recorded only after we received consent. They took place in venues where our informants felt secure discussing drug use. Most interviews across the three sites took place in NGO offices, as did the focus groups in Makassar. In Gowa and Maros, the focus groups were held in a house where our informants frequently gathered. In Yogyakarta, the focus group took place in our fieldwork homestay. Throughout the research, we emphasized that we were interested in our informants' perceptions and experiences. We strove to listen carefully to their stories and not to be judgmental. We found our informants to be eager to share their experiences with us; many appreciated the reflexive space that emerged in the individual and group interviews.

Analysis

We recorded and transcribed all individual interviews and group discussions and entered them in a digital database, using NVivo 10. We began by identifying themes that emerged from the transcripts, such as *coba-coba* (trying out), *cocok* (compatibility), *campur* (mixing), *enak* or *bagus* (feeling good), *heppi/senang* (happy), *mabuk* (high), *pede* (confident) and *sakaw* (withdrawal) – the usual first step in ethnographic analysis (Fetterman 2010). These terms were then included in a coding scheme used by our assistants to analyze the data. Subsequent queries identified further themes, advancing the focused and iterative analysis of data. Youth ethnographers participated in the analysis of data and used their subsets of data to write chapters for the Indonesian-language edited volume *Bukan Narkoba, Bisa Berbahaya* (*Not Narcotics, Can Be Dangerous*) (Idrus and Kutanegara 2018).

Ethical approval was obtained from the University of Amsterdam, which stipulated that interview transcripts be anonymized, and verbal consent procedures be followed. We further obtained official research permits from the provincial as well as city/regency authorities to conduct research in their respective areas. We scraped interview transcripts of all information that could disclose our informants' identities. All names in this article are pseudonyms.

Experimental Trajectories

In a setting where the war on drugs criminalizes illicit drug use, we found a limited list of fairly cheap and easily accessible PPDs used in all of our field sites, with only minimal variation. An important segment of the PPDs we encountered were heroin-replacement drugs such as methadone and Subutex (buprenorphine), which are appreciated for the quality of the highs they induce. Our informants told us that PDDs are cheaper and easier to obtain than *putaw* and *shabu* (heroin and methamphetamine). They also considered using PPDs – which are not considered *narkoba* (narcotics) – to be safer as they are legal and sold in pharmacies. Many emphasized that with the ratcheting up of the war on drugs, it had become dangerous to possess *narkoba*; they feared being arrested. Some had experience with injecting drugs; others did not. Some told us that their drug use trajectories had begun with *shabu*; others, with *putaw* or prescription drugs. Some were already involved in methadone substitution programs, although most were now using methadone as another way to get high for free.

Fajar from Makassar, who had just graduated from high school, told us:

> I already smoked in my teens. I learnt about *putaw* from observing my uncle injecting every day, so I asked him if I could try it out. I had no idea about the effect, until I experienced withdrawal when the high effect went away. I am HIV-positive due to my needle sharing habit, am co-infected with TB, and have been hospitalized a number of times.… I also use various prescription drugs like Somadril, Tramadol, Calmlet. I also got involved in the methadone program.

Upik from Yogyakarta, a *shabu* user, observed her husband taking *putaw* every day, tried it, and became addicted. Kamil from Makassar, a university student, substituted *putaw* with Subutex but when it was not available, tried Suboxone. Now, Calmlet, Subutex and Suboxone (whichever are available) have become his daily drugs of choice to feel better and to 'unblock' his brain. He also takes *Inex* (ecstasy) once in a while, usually when he goes clubbing. '*Inex* is good for tripping, it feels like flying', he told us.

Most of our informants used PPDs on a daily basis. Our four-day recalls and probing of chemical products in the focus groups revealed the popularity of a limited number of narcotic substances and PPDs, along with shared insights on their pros and cons. Table 1 shows the most popular illicit and prescription drugs and their beneficial as well as adverse effects as experienced by our informants.

Table 1. Commonly used illicit drugs and PPDs and their experienced effects

	Content	Desired effects	Adverse effects
Group 1 Drugs			
Putaw	Heroin	Getting high; working and thinking well; feeling creative, calm, good	Short lasting (commonly 3 hours), feel lazy, isolated, easily get sick, weight loss
Shabu	Methamphetamine	Getting high, calm, agile, creative, feeling good, talkative, confident	Difficult to sleep, not feeling hungry, paranoid, becoming thin, hallucinations, easily get sick, lazy
Inex / Ecstacy / Triple-X	MDMA	Flying	Dry throat
Ganja / marijuana	Cannabis	Happy, good appetite	Starving, sleepy, limp, looking stupid
PPDs			
Methadone	Methadone	Strong high, long lasting	Strong withdrawal, lazy, un-communicative
Subutex	Buprenorphine	Flying	Vomiting
Suboxone	Buprenorphine with naloxone	Flying	Vomiting
Alprazolam	Alprazolam	Confident, brave	Sleepy
Calmlet	Alprazolam	Confident, creative, talkative, sleeping well, thinking well, brave, calm, feeling good	Convulsion, forgetful, easily get sick, unconscious, sleepy, black eyes, shaky
Dextromethorphan (Dextro)	Dextromethorphan	Confident, stamina, euphoria, cheap, feeling high, happy, not tired	Itchy, dry throat, blurry eyes, dizzy, oblivious, nausea, confused, vomiting, hallucination, indifferent, looking crazy
Kode-15	Dextromethorphan	Fast effect, long lasting, not tired	Itchy, cough, flu

Trihexyphenidyl (Trihex / Tehad / THD)	Trihexyphenidyl	Confident, flying, calm, happy, long lasting	Dry throat, itchy, headache, forgetting, blurred vision, sweating, stomach ache, nausea, paranoid, talking alone, dry throat, red eyes, feeling hot, vomiting, limp
Tramadol	Tramadol	Long lasting, calm, happy, flying	Itchy, sleepy, stomachache, nausea, vomiting, losing weight, blurred vision
Somadril (Somad)	Carisoprodol	Flying, confident, less shy, immediate effect, enhanced libido, stamina	Headache, itchy, looking stupid, no appetite, limp, emotional, sleepy, nausea
LL	Unknown	Flying	Dizzy
Riklona	Clonazepam	Flying	Insomnia
Esepuluh	paracetamol, caffeine, ephedrine	Flying	Insomnia
Codeine	codeine	Sleep well	Itchy throat, not feeling well

Most of the drugs listed in the above table were used in both Yogjakarta and in our urban field sites in South Sulawesi. Somadril, the PPD which the Indonesian Food and Drug Authority has taken off the market, remained popular among our informants in South Sulawesi. The PPDs Riklona, Codeine and Kode-15, popular among our informants in Yogyakarta, were not used by our informants in Makassar.

Balancing Acts

Much of the discussion in the individual interviews and focus groups revolved around enhancing the beneficial effects and avoiding the adverse effects of PPDs. These balancing acts differed depending on what was at stake in their everyday lives. For example, young women engaging in sex work sought to avoid 'flying' as this could make them more vulnerable to sexual violence (Hardon and Ihsan 2016). Students adjusted dosages in order to be alert enough to go to school and do their homework.

Our informants further observed that effects differ from one person to the other and emphasized the need to find out whether specific drugs are *cocok* (compatible)

with their bodies. The concept of *cocok* is not simply about suitability of a single substance, but about mixing the drug with drinks and food, and about getting the dosage right. One of our informants in Gowa, Broken (17), described how he initially took the painkiller Tramadol to get high and feel more confident. But after trying Somadril, it became his drug of choice; he consumed this psychoactive painkiller on weekdays and Saturday nights as it made him feel high, confident and courageous, while it also increased his appetite. He observed that Somadril's effects appear sooner when he eats spicy food, especially handy when jamming on Saturday nights. But when combined with alcohol, Somadril's effects are less pronounced and short-lived. He thus drinks alcohol when the effects of Somadril have subsided after two to three hours.

Finding one's *cocok* involves trying out and combining drugs for different purposes. Dirham (23), a parking attendant in Yogyakarta, began experimenting with ecstasy to feel *kuat kerja* (strong for work). But he gave it up because of its dry throat effect; he now takes Riklona and/or Calmlet for work and combines marijuana with beer to make him feel happy after work. Yayan (18) a Yogyakarta street singer who previously favored marijuana and heroin, subsequently tried out two different brands of cough tablets, taking up to 50 tablets of Dextromethorpan and 40 tablets of Kode-15 at a time to speed up and prolong their effects. Once he combined 20 tablets of Kode-15 and 10 tablets of Trihexyphenidyl, which made him sleepy. On other occasions, he mixed Tramadol, Calmlet and a local traditional drink (*ciu*), which caused him to vomit and cough up blood.

PPDs have different, sometimes contradictory, effects on individuals. Tramadol makes Zaky sleepy, causes Amir to stay up longer, and Mamat to experience itchiness, swelling, and ulcers. Drugs are considered cocok when the high is strong and they have no significant adverse effects, or when these adverse effects (e.g. nausea, vomiting) can be tolerated or managed. In Maros, Romo (14) reported his favorite PPDs to be Somad and Tramadol. The former on its own can produce a strong effect, so Romo does not combine Somadril with other drugs. But as Tramadol has a more pleasant toning effect, Romo combines two tablets of Tramadol with three tablets of a drug called LL (which on its own, makes his throat feel dry and his head dizzy). The choice to combine Tramadol and LL not only has to do with the sensation, but to neutralize LL's side effects.

Adjusting Dosages

Fine-tuning PPD use also involves finding the right dosage, which varies from one person to the next. Yani from Yogyakarta, a junior high school graduate, began with 15 tablets of Dextromethorphan twice a day before doubling the dosage to get high faster. With Kode-15, Yani takes between 20 and 30 tablets twice a day. These drugs make her fly, happy, indifferent to risks, and keep her from feeling tired. She finds these PPDs not only *cocok* for her individual body, but for her work as a street singer. Amir (24) commonly takes a strip (ten pills) of Tramadol or So-

madril each day. Yayan (18) takes 50 tablets of Dextromethorphan or 40 tablets of Kode-15, often falling unconscious as a result. Others complained that the dosages of Dextromethorphan required to get high (15-50 tablets) was too much and 'not tasty' (*enak*).

Table 2. Dosage ranges reported for selected PPDs

Drug	Dosage (tablets)
Suboxone	1/4-2
Subutex	1-2
Calmlet	2-5
Riklona	2-5
Tramadol	2-40
Somadril	2-30
Codeine	10-15
Trihexipenidyl	2-20
Kode-15	2-40
Dextro-Plus	30-40
Dextrometorphan	15-50

Somadril was the PPD of choice in our sites in South Sulawesi. In our focused ethnography on the use of Somadril by sex workers in Makassar (Hardon and Ihsan 2014), we observed them taking larger and larger doses over time. While the prescription painkiller bolsters sex workers' confidence to approach prospective clients, it became increasingly unclear to us whether they were taking Somadril to work or working to take Somadril. The lion's share of their income went to feeding their habit. The three male and three female sex workers who filled out 4-day recalls reported using between 6 and 24 pills a day, far above the recommended daily maximum. They craved Somadril, suffering all kinds of aches and pains, anxiety, and insomnia when they could not get it.

Informant	Pills per day	Reported beneficial effects	Reported adverse effects	Reported withdrawal effects
Mira female, 24	3–10, average 7	Confidence, increased sexual desire	Dizziness, falls asleep with too many pills, headache	Neck and shoulder pain
Naimah female, 22	3–10, average 5	Feels comforted, less shy, more happy, less resistance to sex with clients	None reported	Throbbing eyes, crying, bad mood, insomnia
Rina female, 20	8–16, average 10	Confident, less shy, happy, stays awake and flies high	Dizziness	None reported
Hasan male, 22	7–23, average 16	Confident, more talkative, can stay up late; fly high; feels less stress, enjoys himself more and has more sex; weight loss	Nausea, makes you stupid, thinking too much, hard to move; insomnia or sleepy (depending on dose)	Headache and bad mood
Udin male, 24	5–10, average 8	Confident, less shy, happy, stronger	Feels sick and hungry, vomiting. If too much: angry, delirious, cannot walk, stomach problems	Sleepy, anxious, sad, crying
Rudi male, 23	21–31, average 24	Confident, calm, sleepy	Diarrhea, trembling	Headache, thinks a lot

Table 3. Somadril daily dosages and reported effects among sex workers

In Gowa, we encountered intense PPD use by high school students on Saturday nights. They gathered on the 'compulsory nights of drunkenness' to drink and pop extreme dosages of PPDs to get high and feel courageous during motorbike races and to make mischief, disturbing other motorists, bumping into sidewalks or other vehicles. Zaky (17) told us that he usually takes up to ten Tramadol tablets per day but increases his dosage to 40 tablets on Saturday nights. Mamat (16) told us he usually takes 15 tablets each weekday. For him Tramadol is a 'life encouragement', without which he would feel sluggish. To prepare for Saturday night, he consumes 7 tablets of Tramadol in the morning, 15 tablets in the afternoon, and 7 tablets or more in the evening, dosing gradually until he reaches his desired high. Harianto (16) told us of the time he combined ten Tramadol tablets with five bottles of Topee Rioja beer. He raced around the city of Makassar with his friends until he hit a food vendor on the roadside.[2]

Dosages also depended on young people's financial resources. Depending on whether one bought it in the pharmacy or from a street dealer, Tramadol, the cheapest of the PPDs, costs around Rp 2000-3000 per tablet; Xanax, Calmlet and Somadril cost much more. Swan, a student from Makassar, explained:

> Sanax and Calmlet are a bit expensive. Sanax is Rp 6,000 per tablet, that's 1 mg. … Alprasolam is available in 0.5 and 1 mg doses, the 1 mg one is sold for Rp 5,000 per tablet, for Calmlet the price is Rp 8,000 for 2 mg … but it is cheaper nowadays, because alprasolam is generic, yes, generic drugs are easier to get. If I take alprasolam, at most I take 6 mg a day, 6 mg is already a lot ... if I want it and have money, I can do it every day, but if I don't have money, I don't take the drug at all. Sometimes I was only able to get more after several weeks, after getting money, it depends on whether I have money or not.

[2] See also Fauzan (2018), a focused ethnography of these high school students in Gowa.

Figure 1. Youth enjoying time together, Yogjakarta. Picture taken bij Sari Damar Ratri (November 2016).

Jono (13) told us he had been using PPDs since the first year of high school. A year later he became a dealer, using the profits to buy school supplies, snacks, clothes, and more drugs:

> Sharing with friends, then my friend or I will go buy Tramadol (for Rp 1,500-2,000 per tablet). We then sell them for Rp 3,000 to 5,000 per tablet. So, the money earned is shared, and is used to buy drugs again.

Across the sites, we encountered young people realizing that they had become addicted to PPDs, in the sense that the need PPDs daily to stay well. Addiction was a common theme in our discussions with students in Maros and Makassar. Jack, a 21-year-old student in Makassar, told us that he had been taking Tramadol since high school:

> Initially it was because of my friends… later on I got hooked and addicted… it's difficult to kick the habit, just like cigarettes…. It depends, usually I take one strip a day, but if I am really upset, I could take five strips…

In Maros, Aco told us he initially tried PPDs only to be accepted into his peer group, but over time it became as necessary as food. Similarly, Romo told us:

> It's hard, it's very difficult to stop, even if I were paid any amount I would not stop, I just have a different feeling if I don't take the drugs. If the drug is no longer available, I would maybe make it myself.

Some of our informants did manage to kick their habits, especially when they were caught by their parents. Nur recalls how his parents grounded him and he lost contact with his friends. According to him, if he uses again, he will become addicted. Amin was caught using PPDs while in middle school. His parents went as far as sending him to Papua to keep him away from friends who were considered a bad influence.

The Response of Health Workers and Policy Makers

The health workers we interviewed in Makassar and Yogyakarta were concerned about youth experimentation with PPDs and the high dosages used but reported that they lacked instruments to confront the problem. One of our key informants, a BNN employee in Yogyakarta, pointed out that in addition to laws on illegal narcotics (UU No. 35/2009), there is an administrative order on psychotropic drugs (UU No. 25/2007). But the latter does not provide any instruments to discipline the 'naughty doctors' who prescribe and pharmacists who sell the PPDs. He also pointed out that young people can easily purchase the drugs online (e.g. www.jualriklona.blogspot.com).

The Indonesian Food and Drug Authority (Badan POM) is responsible for monitoring medicine provision and use,[3] and is aware of the misuse of PPDs. One senior policy advisor told us that efforts have focused on stopping the production of commonly abused PPDs. This has happened for Carisoprodol (the active ingredient of the painkiller Somadril).

Badan POM adopted a regulation (HK.04.1.35.06.13.3534/2013) that allows cancelling licenses for medicines that contain Dextromethorphan single dosage. Based on this regulation, 130 kinds of drugs that contain Dextromethorphan were removed from the market, starting from 24 June 2013. But these actions do not appear to have had much impact. Single dosage dextromethorphan is still on the market as cough tablets, while Somadril (probably a counterfeit version) remains on the market in Makassar.

[3] Presidential Decree Number 166/2000 (Article 73) states: 'BPOM has the task of carrying out government duties in the field of supervision of drugs and foods in accordance with the provisions of applicable laws and regulations.'

According to other key informants, Badan POM carries out inspections of pharmacies that sell large quantities of PPDs. But often, news of the inspection leaks out beforehand; officials therefore rarely unearth irregularities in the field. Moreover, if pharmacies are found to be selling drugs without prescriptions, Badan POM cannot take direct action against the pharmacy as its authority is limited to the supervision of products. If there is a violation, Badan POM can only send a warning letter to the Health Office.

In both Makassar and Yogyakarta, we were told that psychiatrists provide easy access to prescriptions for PPDs. In Yogyakarta, we encountered a Riklona and Calmlet boom as they were being prescribed by a psychiatrist, 90 tablets at a time. One Yogyakarta pharmacy was found to have sold 17,000 Riklona and Calmlet tablets per month; another pharmacy belonged to a psychiatrist who has 'queuing patients' each night. In Makassar, our informants told us that they could buy prescriptions at the clinics of psychiatrists without seeing a doctor. The cost for each prescription ranged between Rp 15,000 and Rp 30,000 (approximately US$1.50 to $3), depending on the requested quantity of pills.

In Yogyakarta, the growing abuse of PPDs has led the local government to sign a Memorandum of Understanding with the Badan POM, the municipal Health Department, pharmacies, and the police to restrict prescribing. Prescribing is now monitored. A prescription can be for no more than 30 tablets per week and is based on the philosophy of 'one doctor, one pharmacy', with only psychiatrists able to prescribe PPDs. This means that a patient can only get the drugs from the pharmacy referenced for the psychiatrist. One psychiatrist responded to the strict control of Riklona and Calmlet by announcing on the outer wall of his clinic: 'no prescription for Riklona and Calmlet'.

In Makassar, we found that when certain drugs became difficult to obtain and/or were no longer available due to control by the authorities, other drugs emerged. Our informants repeatedly stated: 'mati satu, tumbuh seribu' (one disappears, thousands will emerge). The trends are fluid as new popular drugs appear and others disappear. Early on in our fieldwork in Makassar, Somadril was the most popular prescription drug; Tramadol was only used when Somadril was unavailable. A year later, Tramadol had become the new drug of choice. Somadril, although not completely absent from the market, had become difficult to obtain, although a new version of loosely packaged Somadril had emerged, most likely an imitation produced by the local cottage industry.

NGO outreach workers in Makassar have tried to confront private sector psychiatrists who overprescribe PPDs. They told us that the psychiatrists respond that they 'know what they are doing', claiming that their patients suffer from withdrawal symptoms and need treatment. While they were often genuinely trying to help young people with addiction problems, psychiatrists noted that they lacked time for individual screening and careful diagnosis. According to the workers, the psy-

chiatrists chose to just write prescriptions, sometimes even without seeing the patients. In addition, as Brown and colleagues (2012: 81) found, physician often prefer to prescribe what patients demand than risk arguments. Our informants told us about patients threatening psychiatrists with guns and swords, although no such cases had been reported to the police.

While control over prescription drugs was stricter in Yogyakarta (a number of pharmacies had been closed for selling PPDs without prescriptions), in Makassar, a well-known drug store selling PPDs without prescriptions to 'regular customers' was located close to the police office and had never been raided. A policeman in Makassar pointed out that youth who use PPDs are not engaging in illegal activity and thus cannot be charged; they are released after being 'advised' not to abuse PPDs in the future. Overall, the police are more interested in arresting dealers and users of group 1 – *narkoba*, as acting on illicit drug use is considered heroic in the currently intensified war on drugs, giving promotion points and offering opportunities to demand bribes from offenders, who fear that they will be imprisoned if they do not pay the bribe.

Discussion

We observed across our urban sites in Indonesia how young people experimentally combine PPDs with illicit substances and heroin substitution drugs. Our fieldwork further suggested that prescription drugs have become more popular than illicit drugs as they are seen to be safe ways of enhancing mental well-being, while at the same time avoiding being arrested for the possession of drugs. We observed youth encouraging each other to try out different, affordable psychoactive substances to find out which (combinations) work best for them. Sharing their experiences with each other, they jointly built up knowledge that guides their 'experimental trajectories' – a concept Raikhel and Garriott use to draw attention to the ways in which people who uses drugs 'throw… [themselves] into a series of personal experiments' (Raikhel and Garriott 2013: 27).

PPD use in Indonesia is facilitated by processes of 'pharmaceutical leakage', a term Lovell (2006: 146) uses to refer to the circulation of buprenorphine outside of therapeutic settings. Such leakage occurs in many settings in the Global South where drug regulations are weak and/or not fully implemented (Ecks and Basu 2009). The experimental trajectories of our informants suggest that over time, PPD use escalates along with the desire for stronger highs. To achieve these stronger highs, young people mix different PPDs, PPDs with alcohol, PPDs with hot food/drinks, and experiment with diverse ways of administering drugs (oral, injection, injection of crushed oral tablets). Along these experimental trajectories, they seek to avoid adverse effects such as being too high to work, feeling sleepy and vomiting. They consider a drug use regime to be *cocok* (compatible with their body) when there are no adverse effects or when the adverse effects are balanced by strong highs. They improvise when their drug of choice is unavailable or too ex-

pensive. The high-enhancing practices of mixing drugs with Sprite and hot food can be seen as a strategy to make the most out of the drugs given their scarce resources.

The drug use practices of our informants need to be situated in the precarious urban environments in which they seek to fulfill their aspirations fueled by a sea of media images that often sharpen the sense of exclusion and marginality for those who cannot afford the desired goods and lifestyles (Comaroff Comaroff 2000; Cole and Durham 2007). Many were struggling to make a living with limited educational achievements. Needing to work in the informal sector, they turn to drugs to induce confidence and stamina, selecting combinations that do not make them too disoriented. On other occasions, they seek to escape from the stresses of daily life by taking extreme dosages that make them 'fly'.

Making sense of the experimental trajectories of our informants requires a biocultural understanding of how PPDs work. The escalating trends of drug use that we observed suggest that some of our informants are experiencing dependence and withdrawal symptoms, which they only seem to recognize as such for heroin and its substitutes. Many of the PPDs we encountered are known pharmacologically to lead to dependence when used regularly. This is the case for benzodiazepines as well as for potent painkillers such as Tramadol and Somadril. We suggest that the sex workers we studied in Makassar have become addicted to Somadril, craving the painkiller when they do not use it. Some students in our field sites use PPDs intermittently at parties and during periods of academic stress, as their peers do in urban areas in the USA and Australia (e. g. DeSantis and Hane 2010; Green and Moore 2009). However, other informants in our field sites used PPDs on a daily basis to enhance their mental well-being. Ready access to PPDs, unawareness of their full risks, and the belief that pharmaceuticals bought over the counter in pharmacies must be relatively safe have facilitated dependence and addiction.

Poly-drug use furthermore is common in our field sites. Most of our informants use several different kinds of PPDs regularly, at times substituting preferred drugs with other PPDs which are more accessible at the time, or cheaper. They also often mix PPDs with food and alcohol to enhance efficacies. They refer to the concept of *cocok* to indicate which substances and combinations make them feel good. *Cocok* is not simply about suitability of a single substance, but about mixing the drug with drinks and food, and about getting the dosage right.

The experimental trajectories of youths are enabled by private sector psychiatrists who easily prescribe and even sell prescriptions, while pharmacies often provide easy access to PPDs. Aware of the growing abuse of prescription drugs, Puskesmas staff are frustrated by these practices. Nevertheless, they lack the instruments to prevent harms related to poly-drug use as they work in public sector harm reduction programs. Emerging in the wake of the AIDS epidemic, these programs are

designed narrowly to address illicit heroin addiction and are ill-adapted to the experimental drug use cultures and the creative poly-drug practices that we observed, which now include the drugs meant to substitute heroin.

Harm-reduction programs in Indonesia, thus fail to acknowledge that young people also are at risk of becoming addicted to PPDs, including pain killers such as tramadol and carisoprodol and a range of benzodiazepines. They also fail to inform young people of the adverse effects of PPDs, when taken in large quantities for recreational purposes, when mixed with food and drinks to enhance effects, or when used to self-medicate withdrawal effects. Local level health and drug policy makers respond to the emerging PPD problems by limiting access to PPDs, but our ethnography suggests that young people can always find pharmacies or street dealers who are willing to sell them the drugs, or psychiatrists who are willing to prescribe them.

Experimenting with New kinds of Harm Reduction

Aware of the seriousness of the PPD epidemic and the risks that young people run without anticipating that prescription drugs can be as harmful as illicit drugs, we experimented with several novel harm reduction strategies. The first was to conduct feedback sessions with our informants, where we gathered the most commonly used PPDs and invited a pharmacologist to explain their pharmacological effects (through diverse administration routes). The pharmacologist's approach was dialogical, asking users about their preferred drugs and appealing to their experiential knowledge, followed by an explanation of the various ways in which the drugs enter and are metabolized in the body. His questions included whether participants had friends who had died recently. When the response was positive, he conducted a verbal autopsy, for instance, explaining that the victim's yellow skin pointed to liver failure. The young participants were keen to learn, revealing the latent need for education on the pharmacological effects of PPDs.

To generate greater awareness of the PPD problem, the first author – who is also a columnist for a local Makassar newspaper – reported on our findings in the local newspaper. She also gave talks at high schools on the use of PPDs to inform parents. We further co-created a three-minute YouTube video with the Jakarta-based youth communications collective Pamphlet, in which the core message was that prescription drugs are not necessarily safe, see Figure 2 for stills from this video.[4] The first author also published the Indonesian-language volume *Bukan Narkoba, Bisa Berbahaya* (*Not Narcotics, Can Be Dangerous*) which included chapters on a variety of chemicals including PPDs used by young people in their everyday lives (Idrus and Kutanegara 2018).

[4] See https://www.youtube.com/watch?v=TsLpt1bWzs8&t=124s

When we were pursuing these outreach activities at the end of our project, a new presidential initiative (No. 3 of 2017) was announced: The National Action on the Eradication of Drug Abuse, with the slogan 'Reject the Misuse of Drugs'. The joint commitment of the National Action on the Eradication of Drug Abuse was signed by 11 parties representing the government and all elements of society, including the Minister of Health, the Head of Badan POM, the Chief of Police Crime Section, the Indonesian Doctors Association, the Chair of the Indonesian Pharmacists Association, the Chair of the Young Generation Pharmacy students, and members of a popular band. Through this program, the BNN now commands more resources for education, an opportunity to scale up efforts for youth-friendly drug education. However, implementing youth-friendly harm reduction programs is easier said than done given the history of criminalizing users or approaching them as addicts in need of rehab. To be effective, the National Action Plan needs to address the lack of regulatory control that enables easy access to PPDs through pharmacies, the malpractices of psychiatrists who over-prescribe psychoactive drugs, and the economic interests that fuel these practices.

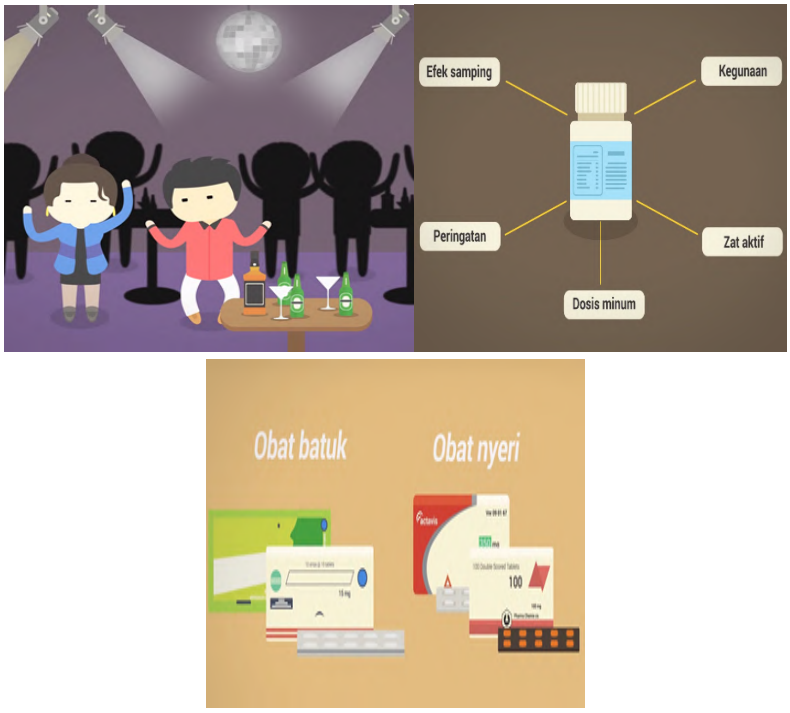

Figure 2. Three images from the Kok Bisa/Pamflet YouTube video Apakah Minum Obat Bisa Membahayakan Kesehatan Kita? (Can taking medicines cause harm?). The middle image refers to cough (batuk) medicine and paind (nyeri) medicine, and the right image calls on users to read the product information, including that on side-effects (efek samping).

Educational strategies need to speak to the dynamic experimental drug use trajectories of young people in Indonesia. When certain PPDs become harder to get, in

a situation fueled by the prevailing war on drugs, young people will try out new substances in their search for happiness, highs, and the confidence and stamina needed to perform precarious informal sector jobs such as sex work, street singing, and helping people park their cars. To address the experimental drug use trajectories of youth, harm reduction efforts need to go beyond addiction paradigms that see persons who use drugs as victims of potent substances. Instead, they need to address the desires and aspirations for good enough lives that are reflected in their drug use practices, and the iatrogenic effects of unregulated pharmaceutical markets that facilitate a medicalization of precarious lives.

Acknowledgments

We thank our interlocutors for their patience each time we visited them with more questions on the role of drugs and PPDs in their lives We hope that our analysis will improve harm reduction programs in such a way that young people are more aware of the risks of PPDs in the future. We are indebted to Takeo David Hymans who did the substantive editing of this manuscript. Our two anonymous peer reviewers gave very helpful comments and suggestions. The empirical research phase of this project was funded through the Global Health Research Priority Program of the University of Amsterdam. Analysis of the findings was funded by the European Research Council Advanced grant 'ERC-2012-AdG – 323646-ChemicalYouth', awarded to Anita Hardon. Nurul Ilmi Idrus was the Indonesia senior research fellow on the project.

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References

BNN dan Puslitkes-UI. 2011. Ringkasan eksekutif: survei penyalahgunaan narkoba di Indonesia, studi kerugian ekonomi dan sosial akibat narkoba. Jakarta: Puslitkes-UI.

Brown, Martha, William Swiggart, Charlene Dewey and Marine Ghulyan. 2012. Searching for answers: proper prescribing of controlled prescription drugs. Journal of Psychoactive Drugs 44, no. 1: 79-85. https://doi.org/10.1080/02791072.2012.662081

Comaroff, Jean, and John L. Comaroff. 2000. Millennial capitalism: First thoughts on a second coming. Public Culture 12, no. 2: 291–343. https://doi.org/10.1215/08992363-12-2-291

Comaroff, Jean, and John L. Comaroff (eds). 2000. Millennial capitalism and the culture of neoliberalism, Public Culture 12, no. 2: 291-34. https://doi.org/10.1215/08992363-12-2-291

Coveney, Catherine, Jonathan, Gabe and Simon Williams. 2011. The sociology of cognitive enhancement: medicalisation and beyond. Health Sociology Review 20, no. 4: 381-393. https://doi.org/10.5172/hesr.2011.20.4.381

DeSantis, Alan, and Audrey Hane. 2010. Adderall is definitely not a drug: justifications for the illegal use of ADHD stimulants. Substance Use & Misuse 45, no. 1-2: 31-46. https://doi.org/10.3109/10826080902858334

Cole, Jennifer, and Deborah Durham. 2007. Generations and globalization: Youth, age, and family in the new world economy. Bloomington: Indiana University Press.

Dumit, Joe. 2012. Drugs for life: How pharmaceutical companies define our health. durham: Duke University Press. https://doi.org/10.1215/9780822393481

Ecks, Stefan, and Soumita Basu. 2009. The unlicensed lives of antidepressants in India: generic drugs, unqualified practitioners and floating prescriptions. Transcultural Psychiatry 46, no. 1: 86-106. https://doi.org/10.1177/1363461509102289

Fetterman, David. 2010. Ethnography: Step-by-Step. Thousand Oaks: Sage.

Green, Rachael and David Moore. 2009. 'Kiddie drugs' and controlled pleasure: recreational use of dexamphetamine in a social network of young Australians. International Journal of Drug Policy 20, no. 5: 402-407. https://doi.org/10.1016/j.drugpo.2008.12.002

Hannerz, Ulf. 2003. Being there… and there… and there…: reflections on multi-site ethnography. Ethnography 4: 201-16. https://doi.org/10.1177/14661381030042003

Hardon, Anita, and Amelia Ihsan. 2014 Somadril and edgework in South Sulawesi. International Journal of Drug Policy 25, no. 4: 755-761. https://doi.org/10.1016/j.drugpo.2014.05.012

Idrus, Nurul Ilmi, and Pande Made Kutanegara. 2018. Bukan Narkoba - Bisa Berbahaya. Yogyakarta: Pustaka Pelajar.

Jenkins, Janis. 2010. Introduction. In Janis Jenkins (ed.) The pharmaceutical self: The global shaping of experience in an age of psychopharmacology (pp. 3-16). Santa Fe: School for Advanced Research Press.

Lin, Shaozhen, and Yong-an Zhang. 2014. Risk control and rational recreation: a qualitative analysis of synthetic drug use among young urbanites in China. International Journal of Drug Policy 25, no. 5: 769-775. https://doi.org/10.1016/j.drugpo.2014.06.008

Lovell, Anne. 2006. Addiction markets: the case of high-dose buprenorphine in France. In Adriana Petryna, Andrew Lakoff, and Arthur Kleinma (eds) Global pharmaceuticals: Ethics, markets, practices (pp. 136-171). Durham: Duke University Press. https://doi.org/10.1215/9780822387916-006

Quintero, Gilbert, and Mark Nichter. 2011. Generation RX: Anthropological research on pharmaceutical enhancement, lifestyle regulation, self-medication and recreational drug use. In Meryl Singer and Pameela Erickson (eds) A Companion to medical anthropology (pp. 339-357). Oxford: Wiley-Blackwell. https://doi.org/10.1002/9781444395303.ch17

Raikhel, Eugene, and William Garriott. 2013. Introduction: tracing new paths in the anthropology of addition. In Eugene Raikhel, and William Garriott (eds) Addiction Trajectories (pp.5-36). Durham: Duke University Press. https://doi.org/10.1215/9780822395874

Rakhmat, Muhammad Zulfikar, and Dikanaya Tarahita. 2018. Drug use among Indonesian children is pervasive. International Policy Digest, November 8. https://intpolicydigest.org/2018/11/08/drug-use-among-indonesian-children-is-pervasive/

Rose, Nicholas. 2007. The politics of life itself: Biomedicine, power and subjectivity in the twenty-first century. Princeton: Princeton University Press. https://doi.org/10.1515/9781400827503

UNODC (United Nations Office on Drugs and Crime). 2018. World drug report 2018. Vienna: UNODC.

Winstock, Adam, et al. 2018. Global drug survey 2018: Key findings. London.

JOURNAL of EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 94-115 https://doi.org/10.5617.7046

Article

Alienation and Lack of Trust

Barriers to Seeking Substance Use Disorder Treatment Among Men Who Struggle to Cease Anabolic-Androgenic Steroid Use

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Abstract

Anabolic-androgenic steroid (AAS) use became illegal when the Norwegian Drug Act was amended in 2013, and AAS and other image- and performance-enhancing drugs were included in the politics and treatment of substance use. Few individuals with AAS-related health problems seek substance use disorder (SUD) treatment. This article aims to explore understandings of AAS dependence, barriers to treatment-seeking, and experiences of entering SUD treatment among a sample of men with AAS-related health problems struggling to cease AAS use. Seeking treatment for AAS-related health problems within SUD treatment services was described as alienating. First, because the participants experienced their struggle to quit using AAS to be different from being dependent upon psychoactive substances. They linked their struggles to symptoms of hormonal disturbance, need for a certain body size, and/or the sense of wellbeing provided by AAS and which enable them to function socially. Second, they experienced alienation because of their healthy identities, bodies and lifestyles, as opposed to how they viewed individuals with severe SUDs and emaciated bodies. A major barrier to treatment-seeking was participants' lack of trust that SUD treatment providers had the knowledge and the means to provide treatment of their AAS-related health problems and struggle to quit AAS use. Experienced barriers towards seeking SUD treatment should be taken into account when planning, organizing and implementing health services for individuals with AAS-related health problems.

Keywords

Anabolic androgenic steroids, performance and image enhancing drugs, dependence, addiction, substance use disorder treatment, health service, 'broscience', qualitative study

Introduction

Non-prescribed anabolic-androgenic steroids (AAS) include testosterone and substances with similar structure and effect (Kicman 2008). Use of AAS to increase muscle mass, performance and image enhancement is not a new phenomenon. AAS were mostly used by elite athletes until the 1970s, when individuals in competitive bodybuilding subcultures used them to cultivate 'previously unseen muscular male bodies' (Andreasson and Johansson 2019). During the 1980s and 1990s, a moderately muscular body ideal motivated usage of AAS among some gym users and recreational athletes (Kanayama and Pope 2018; Pope, Khalsa, and Bhasin 2017). Lifetime AAS use is higher among men than among women and is reported to be widespread across the globe (Sagoe et al. 2014). In Norway, lifetime use is estimated to be 1-3% among men (Bilgrei and Sandøy 2015; Sagoe et al. 2015), but is found to be many times higher among inmates (Lundholm et al. 2010) and patients in substance use disorder (SUD) treatment (Dodge and Hoagland 2011, Kanayama et al. 2003, Nøkleby and Skårderud 2013, Havnes et al. 2019).

It is common to combine different types of AAS, either as cycles with breaks between, or continuously with varied or constant dosages (Pope et al. 2013, van de Ven et al. 2019). Long-term AAS use is associated with increased risk of developing a wide range of mental and physical health problems (Baggish et al. 2017; Bjørnebekk et al. 2017; Hauger et al. 2019; Piacento et al. 2015; Pope et al. 2013; Rasmussen et al. 2016; Rasmussen et al. 2018). An estimated 20-50% of users seem to develop some form of AAS dependence (Brower et al. 1991; Bjørnebekk et al., 2017; Copeland, Peters and Dillon, 2000; Kanayama et al. 2009), and use higher doses and shorter breaks than planned, or use continuously, despite adverse effects. Mechanisms behind this dependence are argued to include 1) a psychological need to have increased muscle volume and body size, 2) activation of the reward system during use, and 3) mental and physical health problems as symptoms of hypogonadism[1] that are difficult to endure after discontinuation (Kanayama et al. 2009).

Persons who struggle to stop using AAS may restart use to relieve symptoms of androgen deficiency, or they may try to avoid or treat the symptoms with non-prescribed 'Post Cycle Therapy' (PCT) to restore endogenous testosterone production (Griffiths et al. 2017). Making use of what Bilgrei (2017) terms 'broscience'[2] is always an option – either by seeking personal advice from perceived knowledgeable and trustworthy person(s) in the gym environment (Christiansen, Vinther, and Li-

[1] When using many times higher amounts of AAS than the testosterone produced in the body, a negative feedback mechanism will reduce or stop endogenous testosterone production. Therefore, when AAS use is ceased, within a few weeks' time the user may enter a state with low levels of or absent endogenous testosterone, and may experience symptoms of hypogonadism such as depression, anxiety, sleep disorder, fatigue and sexual dysfunction. This state may last from months up to years, or permanently (Rahnema et al. 2014; Rasmussen et al. 2016).

[2] '…personally grounded drug experiences form the basis of experiential learning, sometimes referred to as "broscience", a portmanteau of "brother" and "science", which concerns the user-generated knowledge that is maintained, contested and passed on through online communication' (Bilgrei 2017)

okaftos 2017; Zahnow et al. 2018), or by using querying online forums on how to avoid and handle side effects following AAS use and cessation. Such communities create online trust (Bilgrei 2017) and tend to base information about the harms associated with AAS use and how to avoid these harms on personal experiences and selected scientific literature supporting their opinions. However, when forum members lack information of harms related to AAS, they 'recommend seeking information from medical professionals' (Tighe et al. 2017). Few studies have explored experiences of AAS dependence, but Griffiths (2017) describes how AAS users used PCT to minimize health harms when coming off cycle. The participants explained that it was more difficult to access PCT than anabolic steroids, and they understood that cessation gave rise to mental health symptoms. Therefore, a lack of access to PCT could result in long-term or permanent AAS use.

There is a gap in the literature about barriers to seeking SUD treatment among AAS users. The main reason is likely that very few countries have implemented treatment of AAS-related health problems in the SUD treatment system. It is important to note that few users seek any health services (Pope, Khalsa, and Bhasin 2017; Zahnow et al. 2017), despite being concerned for their health (Zahnow et al. 2017). Barriers include fear of stigmatization (Dunn, Henshaw and Mc Kay 2016; Yu, Hildebrandt, and Lanzieri 2015), unknowledgeable staff (Jørstad, Skogheim, and Bergsund 2018; Pope et al. 2004), sanctions (Havnes, Jørstad and Wisløff 2019), belief that the treatment provider cannot/will not help, or belief that the health problem is not serious enough (Zahnow et al. 2017). Yet, among a sample of Norwegian AAS users where mental health problems were the most common motivation for AAS cessation and treatment seeking, three out of four desired SUD treatment after receiving information tailored to AAS users about side effects, treatment options and potential outcomes (Havnes, Jørstad and Wisløff). Furthermore, a qualitative study from a Swedish addiction treatment facility stated that 'AAS users often experience a range of highly desirable effects from the drugs and only seek treatment as an alternative when the negative effects outweigh the positive effects' (Skårberg, Nyberg, and Engström 2008). The negative effects described as motivation to seeking SUD treatment were mental health problems related to AAS use: depression, excess jealousy, aggression, body dysmorphia, and concurrent use of psychoactive drugs. In the UK, experienced AAS users advised younger users to attend harm reduction services to reduce harms related to AAS use (Kimergård and McVeigh 2014).

Norway's context is particular, as use and possession of AAS and other doping agents became illegal when the Norwegian Drug Act was amended in 2013, and AAS and other doping agents were included in the politics and treatment of substance use in 2012. Persons with previous or current AAS use and AAS-related health problems have the right to outpatient SUD treatment and National SUD treatment guidelines states that examination of mental health symptoms during withdrawal, access to psychotherapy and treatment of mental health and other symptoms should be provided. SUD treatment in Norway is publicly funded, widely available, and individuals with SUDs have treatment rights as patients

(Nesvaag and Lie, 2010). Nevertheless, relatively few AAS users with health problems seek SUD treatment. Therefore, this article aims to explore understandings of AAS dependence, barriers to seeking, and experiences of entering SUD treatment among a sample of men with AAS-related health problems struggling to cease their AAS use.

Methods

This article forms part of an exploratory qualitative study focusing on experiences with AAS use, health problems, and health services, and in particular SUD treatment. A subset of data from this study has been published in a mixed methods paper (Havnes, Jørstad and Wisløff 2019) describing how use of an information service may facilitate SUD treatment-seeking.

Sampling and Recruitment

Inclusion criteria in the current study were that participants were above legal age, had used AAS and had experienced health problems with or without seeking health services. The participants were recruited through social media adverts, posters, snowball sampling, e-mails to managers and treatment providers in various SUD treatment clinics in southeastern Norway, and through information to participants in ongoing research projects in our research groups. Seventeen men were included; one participant was interviewed twice, whereas the others were interviewed once, making the total of 18 individual interviews. Ages ranged from 22 to 51 years of age at the time of the interview, ages at AAS initiation varied from 15 to 32 years, and length of AAS use ranged from two to 27 years. Most of the participants were working and had ceased AAS use at time of the interview.

Interview Guide and Data Collection

The interview guide was developed together with a panel of five individuals who all had previous experiences with AAS use and AAS-related health problems. Several also had experience with SUD treatment for health problems related to AAS use, and for psychoactive substances. Among the topics in the interview guide were the positive and negative experiences of AAS use, health problems with or without treatment experiences, reasons for not seeking help, methods to avoid or handle side effects, views on health services, what a desired treatment system would be like, and understandings of legal matters related to AAS use. The semi-structured interviews that lasted approximately one hour were audio-recorded and transcribed verbatim. Thea Steen Skogheim conducted the majority of the interviews.

Analysis

A biopsychosocial model that elaborates on neuroscience, environmental and social factors of addiction of drugs and behaviors forms the theoretical framework for the study (Griffiths 2005). An inductive form of thematic analysis was an ongoing process that started during the data collection. This made it possible to include some findings from previous interviews in the interview guide. This flexible design opened up for inter-subjective comparison of experiences. During the analytical

process, both authors read and reread the transcripts to get an overview of the data. The transcripts were handled in NVIVO 10 and Thea Steen Skogheim conducted the initial coding. The initial codes were regularly discussed by both authors and a third researcher, regrouped in themes, and compared to ensure that there was little overlap of the themes. The authors regularly discussed emerging themes. The findings presented in this article underwent the final two steps of thematic analysis: reviewing themes and producing the report with representative quotes. The data set was reread again to ensure the validity of the themes in each interview as a whole by Ingrid Amalia Havnes (Braun and Clarke 2006, Pope, Ziebland, and Mays 2000). The concept of trust between the participants and potential and actual SUD treatment providers, as seen from the view of the participants, became a central emerging theme in this study. Therefore, we let the work by the philosopher Grimen (2009) inspire the last stage of the analysis of what trust may be in a potential patient/treatment provider relationship: if a person with a health problem trusts a health professional, the person expects that the treatment provider a) will not do something that harms the person's interests, b) is competent, and c) has the necessary means to take appropriate care of the health problem.

Terms and Words: Addiction, Dependence and Substance Use Disorder

This article subscribes to the neurobiological model of addiction, which defines addiction as a chronic, relapsing brain disease with development of a physical and psychological dependence on substances or a behavior (Volkow et al, 2016). The fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) released by the American Psychiatric Association (2013) replaced the term addiction with substance use disorder (SUD). In the fourth version of the manual, the word 'abuse' was used as a mild form of addiction, and 'dependence' was used for moderate or severe forms of addiction. Although the standard DSM-IV substance dependence criteria were projected for intoxicating substances, the term AAS dependence was adapted to the DSM-IV version (Pope et al 2010) and accepted in DSM-V (Piacento et al 2015). The term AAS-dependence is therefore used throughout the paper. Also, the 11th edition of the International Classification of Diseases (World Health Organization 2019) uses the term substance dependence as a 'disorder of regulation of use of a specified substance arising from repeated or continuous use of the specified substance.'Both the words 'dependence' and 'addiction' can be translated into the Norwegian word *avhengighet* that was used by the participants for explaining physical and/or psychological needs to use AAS and their struggles to quit using. The word *avhengighet* is translated into 'dependence' in the Findings section.

The participants used the word *rus* (getting high or intoxicated) about use of illicit psychoactive substances. The word *rus* is included in the name of most Norwegian treatment units: *rus og avhengighetsbehandling* that means a unit/department providing treatment for intoxicating substances and addictive disorders. However, the official translation treatment in Norway is: SUD treatment, and this is used

throughout the paper for the Norwegian context. It should however be noted that including *rus* in the name of treatment centers was found alienating in itself for most of the participants.

Ethics

The study was assessed by the Regional Committee for Medical and Health Research Ethics (2016/1480) as not requiring ethical approval from the Committee. As some of the participants were recruited from SUD treatment at Oslo University Hospital (OUH) and the project is organized at OUH, the data protection officer at OUH assessed and approved the study (2016/12244). All participants provided voluntary and written informed consent. In addition to the formal requirements, emphasis was placed on ensuring anonymity throughout the publication process. All participants were offered informal meeting with health professionals and referral to treatment if they desired to seek treatment.

Findings

This exploratory study generated rich empirical material on phenomena related to use of anabolic-androgenic steroids. In this article, we focus on the participants' experiences and understandings of AAS dependence or why it is difficult to stop using AAS, and the ways to cease AAS use, while placing treatment of AAS-related health problems within the addiction/SUD treatment field.

Understandings and experiences of AAS dependence

Almost all participants perceived dependence of AAS and psychoactive substances as two different forms of dependence, even though continuation of use, despite wanting to cease, was central for both. They explained the differences and how psychoactive substances give an immediate 'high' and fast withdrawal symptoms, whereas AAS give a longer lasting sense of wellbeing. The withdrawal symptoms were mostly reported to be linked to symptoms of androgen deficiency some weeks after cessation. Restarting AAS use was most often motivated by a desire to alleviate these withdrawal symptoms, but also to maintain this sense of wellbeing and muscle volume.

Some participants explained that they found it difficult to stop using AAS due to the desired effects of the substance: a strong sense of wellbeing and a desire to have big muscles and feel strong. Fredrik said clearly that he felt dependent on using AAS. When he was asked what effect the steroids had on him that made it difficult to cease use, he responded:

> For my part, I think it had to do with me becoming myself. I felt I became myself. I felt I became how I wanted to be in a way: I was simply extroverted and much happier, so I think that was the reason to continue using it. For me, even if I have stopped using steroids, I will always be eager to be big and strong and have muscles. I will always want that, I think.

He managed to quit after nearly ten years of continuous AAS use. To him, it was mostly the strong sense of wellbeing that gave him a new identity and the social behavior that he missed when not using AAS. Another participant, Emil, explained that the desire to be strong was replaced with a positive, long-lasting and almost euphoric effect of AAS use, which he compared to using central stimulants:

> In the beginning I wanted to become big and strong, like the older guys were. You know what I mean. Then it changed, I don't know what happened, but I started to feel great, mentally, … and strong. It was just like taking cocaine, kind of. You are kind of Superman constantly, for months, but cocaine only last a night.

Another example showing various motivations behind AAS use is presented by Tobias, who had been a victim of violence in several contexts. His main motivation for starting to use AAS was to protect himself. To him, being dependent on being big and strong had another meaning than having a nice appearance; it meant that he was able to protect himself physically. When asked whether he felt dependent on AAS, he explained:

> No, I didn't really feel…yes, I felt it in a way because to work out without [AAS] was not an option. And it wasn't nice to think about it [ceasing AAS], because then I would become small and a wimp again.

Harald initiated AAS use as a teenager. After some years, he started to use AAS continuously and also competed in bodybuilding. He explained how vital the muscle volume was to him and that the psychological desire to be so big was the form of dependence he experienced:

> You get completely obsessed; you never get satisfied. You needed even more muscles, [to be] even more defined. If I didn't get serious health problems, I probably would have continued. Because you get so dependent on that stuff!

Ways to Cease AAS Use

Despite health problems, some participants did not want to quit using AAS, as they found the positive effects to outweigh the negative ones. Several were ambivalent and had not yet decided whether they wanted to cease use or not. Bill provides an example of the latter. He had been offered AAS at the gym for many years, but first started using it a few years prior to the interview when he had experienced stagnation in his training. He sought advice about how and what to use to get the desired effects, and how to avoid unwanted effects. He mainly used the advice he got from trusted and experienced friends at the gym, as they had used AAS for up to two decades. In addition, they were also in touch with medical professionals who could give advice when they themselves did not have all the answers to

his questions. Furthermore, as a harm reduction initiative, he paid for blood tests at a private laboratory and had the results sent to his home. He also participated in a somatic research project exploring cardiovascular status among long term users of AAS and an examination concluded that he had an enlarged heart as well as other pathological findings. He explained how this finding made him feel like a failure, as he believed he had done everything correctly, and followed all suggestions from the people at the gym, whom he trusted, and thought were knowledgeable:

> Now I have experimented enough with [AAS] and gotten my heart harmed, so I kind of only want to cry over it all, as I've put so much effort into this by working out, healthy exercise and healthy eating and getting to bed at the right time every day. When I got the test results I thought: 'Shit, what have I been doing?' In addition – early brain aging is something I never thought about [..] there's speculation that steroids can give Alzheimer's diagnose, so I've gotten scared, it's as easy as that. […] This was such a feeling of failure when you think you've done a good job… and you've taken moderate amounts and had the breaks you should have, and kind of thought it was OK, but it wasn't OK.

Nevertheless, he admitted that he has about 3000 euros' worth of AAS and other substances at home; enough for the next one to two years. He knows that he will not be able to sell the substances, so all the money will be lost if he ceases AAS. He explains that he would rather use AAS himself than throw it away, and refrain from buying more when his stockpile runs out, and perhaps cease use at that point in time. In addition, he fears getting caught by the police, which may lead to serious problems at his workplace. Altogether, he is considering obtaining a referral to SUD treatment to be able to quit AAS but has not yet decided what to do.

The participants offered several descriptions of how to quit AAS use: abruptly, tapering, and not starting again after a planned break between cycles. Erik had used AAS for a decade and felt good about it until he began having legal and employment problems. But it was an incident with family members when he felt depressed and vulnerable that made him want to quit, or not start using anything after a break between cycles:

> …when I decided [to quit], I was already on an off-cycle. So, I struggled with [health] problems, and I always stopped the off-cycles quite fast. I did. Or I guess, I self- medicated myself in between cycles, everything from using small doses of steroids, what you call micro-doses, although way higher than the endogenous production, but still called micro-doses. To things like happy pills [antidepressants] that I could get from a friend, so I could take it [problems during the off-cycle], kind of. To potency

> pills and everything that in a way could help you [testosterone production] get started again.

Harald had used steroids for nearly ten years when he noticed signs of serious cardiovascular problems. He saw this as a 'first warning' but blamed it on stress and continued to use AAS and other image and performance enhancing drugs in high doses. Some years later, he experienced several cardiovascular episodes and his first heart attack was severe and undoubtedly linked to AAS use. He then decided to quit AAS abruptly:

> It had to be sudden! If not, then I wouldn't be here today. There were so many clogged vessels so…I was in and out of the hospital, several heart attacks. They blocked my arteries and…cardiac arrest. [..]…But when I had been off [AAS] for one, two, three years, and my body kind of changed, so…so that was no fun! But luckily then I had started to focus on my health.

It took some time before his body became less muscular and gained more fat. Harald found it difficult to cope with this psychologically. To him, being able to focus on his health was an ongoing process that took several years after he ceased AAS.

Kristoffer had used AAS for almost two decades, and in the second decade, used continuously in very high doses. He had experienced mental health problems related to his use, before he entered outpatient SUD treatment and ceased use. When asked whether he tapered or quit abruptly, he responded:

> I tapered. I had never managed to quit abruptly, even if I wanted to. I'm a person who, if I decide to do something – it's like *[clapping]*: 'bang – bang'! So, when I came and met the treatment provider, I said I wanted to stop using steroids and cannabis, right away. And then he said no. 'Huh, what are you talking about?' I said [laughing]. 'You need to taper,' he said. 'Yes, that's OK,' I said.

He realized that his impulsive wish to quit everything, both cannabis and steroids at the same time, could be difficult. The treatment provider advised tapering as he had used very high doses of both AAS and cannabis. Kristoffer had to buy illicit steroids to follow the advice from his treatment provider. He managed to quit with strong support from family and the treatment provider, in addition to psychoactive medications during the withdrawal phase. Alexander had used AAS for a year, but he did not succeed in quitting as he experienced severe depression and fatigue and restarted use to alleviate these withdrawal symptoms. He repeatedly asked his general practitioner (GP) for help but was told to stop using AAS and simply wait until the endogenous testosterone normalized. He explained how he had tried to quit many times and never got the help he needed when struggling with mental health

problems, in particular depression, suicidal ideation and a suicide attempt. He contacted the GP despite knowing that the GP did not have the knowledge or the means to help him. He did this because he felt he had no other options, as he had experienced that 'broscience' was of no use in this situation. Therefore, his relationship with his GP can be seen as a form of 'forced' trust. However, a new GP was informed about treatment options in the SUD outpatient clinic, and Alexander was offered an anonymous information session about such treatment. After an information session, he decided to seek SUD treatment.

Experiences of Seeking SUD Treatment

Alexander was then referred to an outpatient clinic and reflects on his first meeting:

> I ended up in a drug clinic. I never used drugs. So, I didn't understand why I should sit and wait in the same room as all these addicts. I was three, four times their size; I lived a 'healthy life' [making air-quotes]. Then these guys who just destroy themselves come and get help through a 'glass-box' [methadone and buprenorphine dispensing], medication, injections and things like that. When I came, I didn't get any injection or pills to help me. I got conversations. That's the difference. Where is my medical treatment? Where is my tapering paid by the government? I had to buy it on the street, illegally, and hope that I didn't get caught – while I was in treatment. I didn't get caught, but it is kind of the only way to do it, if you were to get any injections, because the government doesn't dispense it. So that's what's wrong.

To him, being referred to SUD treatment contradicted his healthy identity and made him feel alienated at the clinic. Initially, he did not experience that the SUD treatment field had the necessary means to help him. He felt that he needed legal tapering of testosterone and/or post-cycle therapy with endocrine treatment to restart the endogenous testosterone production in order to avoid the severe depressive symptoms that he experienced every time he attempted to cease use of AAS. However, he trusted the level of knowledge of his treatment provider and valued their frequent sessions during the withdrawal phase. He questioned the practice of giving clinical advice of tapering, without endocrine medication. He found it unethical to advice patients to buy illicit testosterone during treatment, a criminal act with legal consequences if caught. He called for treatment guidelines on how to examine and provide legal pharmacological treatment for persons who struggle to cease AAS use, as he has experienced this as the main weakness of the SUD treatment system and other parts of the specialist health service.

About half of the participants had experience with illicit psychoactive substances. Martin had been dependent on psychoactive substances and been in SUD treat-

ment. He was ambivalent about how the treatment of AAS-related health problems is organized within the SUD treatment system. He made a point out of the fact that there are different pathways into dependence of psychoactive substances and AAS, and treatment providers' knowledge and experiences of psychoactive substances cannot simply be transferred to AAS:

> No, I don't think that's OK, but it is better than nothing. Because before there was nothing at all…but placing it [AAS-treatment] there [in outpatient SUD treatment] – I would never do it, because it has to do with two different things [...] And they [treatment providers] have been working way too long with people who've used completely different things that have nothing to do with steroids. And then suddenly this expertise is supposed be used for the others [persons who struggle to cease AAS], and it's not the same. Because it has nothing – unfortunately it's called dope and doping, but it sure as hell has nothing to do with each other.

Rune had also been in outpatient treatment for psychoactive substance use and tended to switch between various illicit substances and AAS use. To him, organizing AAS treatment within SUD treatment clinics was unproblematic, but he was unsure how this may be experienced for those who use only AAS:

> It didn't have to be placed there, maybe, so maybe it's the slightly wrong department, but I don't know. It's hard; no, I don't know, for me it doesn't matter, more or less, but for others who are not using drugs maybe it matters that it sounds a bit more [like the wrong place], but I don't know.

Kristoffer, on the other hand, was clear that the SUD treatment clinic is the right place for those struggling to cease AAS use:

> Because to me, it is both a physical and mental disturbance, being dependent on something, whatever it is. Yes, steroids give you a high; those denying it are idiots. If it didn't [give you a high], they would quit.

Erik was desperate after the incident with his family and decided to seek treatment. He had made use of 'broscience' ever since he started using AAS, but now asked for help within the health services for the first time and experienced that health professionals were not knowledgeable about AAS use or treatment:

> I didn't know what to do, but I contacted my parents and asked for help and we went together to the emergency ward, and they helped me, but it was a blurry diagnose. I don't remember what they called it, mixed substance abuse or something like that was

> what they called it. My primary problem was the anabolic steroids, and some drug use, but I wasn't dependent on it [drugs]. I used it more like self-medication… I was referred to *rusbehandling* [SUD treatment]. [..]…experienced their level of knowledge about steroids to be low [at the emergency ward], what it is, what it does. Definitely. There were no follow-up questions regarding anything really.

Erik participated in the present study several years after he had been in outpatient SUD treatment. He was clear that long-term AAS use is a form of dependence, but that his view changed during the course of treatment:

> I who've been in SUD treatment see it [long-term AAS use] as a form of dependence. I see that it has to do with many of the mechanisms you find in all kinds of dependencies, including [psychoactive] substance use. So, to me, it [placing the treatment in the SUD clinics] is the most natural thing in the whole world, but it isn't as clear for a steroid user who is in the middle of it all to see it like that. They feel like – 'I'm not dependent.'

Discussion

In this study, men with AAS-related health problems and previous or current difficulties with ceasing AAS use found seeking treatment within the SUD treatment services alienating because of their healthy identity and perception of a healthy lifestyle. In addition, they understood their chronic use of and struggle to stop using AAS as a different form of dependence than that of psychoactive substances, for several reasons: AAS use does not give an immediate high, it has a prolonged effect on muscle volume, and there is a delayed withdrawal syndrome based on disturbance of the sex hormone system. On note, several participants had vulnerable and/or abusive background and linked their struggle to stop using AAS to secondary effects of AAS use; a psychological need to have a muscular body to enable physical self-protection, to get a new identity, and achieve a desired, more extroverted social behavior.

However, AAS users diagnosed with AAS dependence are found to have structural brain characteristics similar to other dependencies (Hauger et al 2019), and, relying on the neurobiological model, this may imply a shared vulnerability for dependencies. Chronic use of AAS increases the risk for 'adverse effects on physical, psychosocial, or occupational functioning' (Kanayama et al. 2009) as well as use of psychoactive substances (Kanayama et al. 2003; Molero, Bakshi and Gripenberg 2017; Schwingel, Zoppi, and Cotrim 2014). Co-occurring AAS and substance use is found to be a motivation for seeking SUD treatment (Skårberg, Nyberg and Engström 2008). Although potential SUD treatment users may fulfil the diagnostic criteria for AAS dependence (Pope et al. 2010) and be at risk for further health problems and illicit substance use, the participants' understandings and experi-

ences of AAS dependence and why it is so difficult to cease use, points to the importance of exploring motivations for initiation of AAS use, continued use, wanted and unwanted effects, as well as the motivation for cessation, if present. This approach may be experienced as more meaningful and less alienating for potential service users who do not necessarily consider themselves as dependent when entering treatment. However, it should be noted that participants who entered treatment found SUD treatment to be useful and necessary to be able to cease AAS use and improve social relations and function without use of AAS. In addition, in the course of treatment, several found their use of AAS to be a form of dependence similar to that of psychoactive substances. This may not be surprising given the explanation model within SUD treatment.

The participants in this study were reluctant to seek SUD treatment due to lack of trust in treatment providers and the treatment system. The concept of trust can be understood using the trust model described by Grimen (2009) for a relationship between a patient and a physician/treatment provider. Grimen stated that if a person A with a health problem trusts a physician/treatment provider B, then A will leave the health problem in B's custody *and* transfer discretionary powers to B for a period of time. In addition, the patient expects that the health professional will not do something that harms his/her interests, is competent and has the necessary means to take care of the health problem. The participants did not trust that health professionals could care for their AAS-related health problems, particularly because these professionals would not or could not[3] use endocrine therapy to address hormonal disturbances following cessation of AAS. Some were also advised by their treatment providers to taper AAS or testosterone although this implied buying and using illegal substances that is a criminal act according to the Norwegian law and could lead to a criminal case with a criminal record. Participants who entered treatment and received clinical advice to continue AAS-related illegal behavior experienced this as a potential harmful and unethical clinical advice resulting in lack of trust in both the treatment provider and the treatment system. Therefore, legal endocrine therapy was desired by some participants to address their health problems during AAS cessation. Furthermore, it was viewed that treatment providers' knowledge and experiences of psychoactive substances cannot simply be transferred to treatment of individuals who struggled to cease AAS use.

AAS has many beneficial/desired effects, and many individuals will continue using AAS, balancing desired effects and health risks (Christiansen, Vinther and Liokaftos 2017; Zahnow et al. 2018). Most users of AAS with or without health problems who desire to cease use, are likely to do so without seeking health services (Jørstad, Skogheim, and Bergsund 2018; Zahnow et al. 2017). They may instead seek help in the gym environment (Christiansen, Vinther, and Liokaftos

[3] Physicians are reluctant to prescribe hormone therapy during AAS cessation as there is a lack of research exploring whether testosterone tapering and/or use of endocrine therapy reduce withdrawal symptoms among individuals with long term AAS use.

2017) and online communities on how to avoid or treat unwanted effects during use and cessation (Griffiths et al. 2017; Rahnema et al. 2014; Sagoe et al. 2015). In the present study, several participants had made use of 'broscience', in particular PCT, but also non-prescribed antidepressants to avoid and/or self-medicate health problems without success and sought help in the SUD treatment system as a last resort.

It is expected that an increasing number will seek treatment for adverse health consequences, in particular cardiovascular diseases (Pope, Khalsa and Bhasin 2017). AAS use is associated with increased morbidity, mortality and suicide (Pope et al 2013, Petersson et al 2006, Lindquist et al, 2014) and is considered by many to be a public health concern (Dunn, McKay and Iversen 2014; Pope, Khalsa, and Bhasin 2017; Tighe et al. 2017) in need of available treatment options. Indeed, some of the participants in the present study had experienced severe somatic health problems as motivation to cease AAS use and/or seek SUD treatment.

Both in Europe and worldwide, there are few publicly available specialist health services designed to meet the health challenges of AAS users, and the existing ones have both strengths and weaknesses. The Swedish centralized model is placed in an addiction clinic at Örebro University Hospital, where an experienced and skilled multidisciplinary team examines AAS use along with psychoactive substance use, socioeconomic, mental and physical health status. Treatment needs are explored together with the person in question and documented in a final report (Örebro University Hospital 2016) to be followed by local treatment units, with a risk of meeting unexperienced treatment providers. The Dutch model started as a local initiative at Spaarne Gasthuis in Haarlem and became a centralized outpatient clinic of the Department of Endocrinology, providing physical examination and endocrine treatment when indicated for individuals with current or previous AAS use. Still, psychosocial therapy of AAS-dependence and mental health problems are not provided (Smit and de Ronde 2018).

The Norwegian decentralized SUD treatment model has some clinics with broad experience, whereas others have few or no patients in treatment for primarily AAS-related health problems, and every clinic needs to cooperate with their local medical departments who also have various degrees of experience with the patient group. To increase knowledge about health risks related to AAS use and treatment options, among health professions and users, a national project was established. Health professionals provide tailored individual information sessions covering AAS-related health problems, SUD treatment and potential treatment outcome for anonymous AAS users, either as personal or phone meetings. In a mixed methods study, it was found that anonymity and a flexible, easily accessible service with experienced clinicians, who provided information based on individual user needs facilitated SUD treatment seeking. Service users emphasized that being informed about what SUD treatment is or may be was useful. In addition, receiving help to initiate the treatment entry process through information about treatment rights, the referral process and establishing contact with SUD treatment providers

who have experience with treatment of the patient group, was important (Havnes, Jørstad, and Wisløff 2019).

Strengths and Limitations

A strength of this study is the novel information about barriers to seeking SUD treatment in Norway, where there was a recent legal change and a political decision to include AAS in the politics and treatment of substance use. In addition, the participants are a heterogeneous sample with different backgrounds, ages, AAS histories, and severity of health problems. Some study limitations should be recognized. The sample was selected on the basis of gender and having AAS-related health problems and the findings cannot be generalized to all users of AAS. The findings should instead be seen as a contribution to a more nuanced understanding of some male users of AAS, their experiences of AAS-related health problems, and their views on meeting their health issues within the SUD treatment system, and the potential clinical implications. The interviews were conducted by researchers with education and work experience within the health services (medicine, psychology, addiction and psychiatry), and addressed sensitive topics such as health problems and actions defined by the law as illegal – all of which may have influenced the participants' retrospective reflections and their decisions to share particular experiences.

Clinical Implications and Further Research

To increase trust in treatment providers and facilitate treatment seeking among potential health service users with AAS-related health problems, treatment providers need to increase their skills and level of knowledge about AAS, desired and unwanted effects, and treatment. Further research on ways to cease AAS use and whether endocrine treatment reduces AAS withdrawal symptoms may enable clinicians to give advice on and initiate endocrine treatment, if indicated. To design a treatment service that meets the needs of AAS users who struggle to cease their use, user experiences among service users in different treatment contexts and treatment models should be analyzed. This, and experienced barriers towards seeking SUD treatment should be taken into account when planning, organizing and implementing health services for individuals with AAS-related health problems.

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Acknowledgements

The authors are grateful to the participants who shared their stories, experiences and views. We would also like to thank the five persons with previous AAS use experiences who contributed on the development of the interview guide. The authors are grateful to Ashley Muller, for language editing of the manuscript. Finally, we would like to thank Ida Halvorsen Brenna and Marie Lindvik Jørstad for conducting interviews, and for discussions during the early analytical phase.

References

American Psychiatric Association. 2013. Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Andreasson, Jesper, and Thomas Johansson. 2019. Bodybuilding and fitness doping in transition. Historical transformations and contemporary challenges. *Social Sciences* 8, no. 3: 80. https://doi.org/10.3390/socsci8030080

Baggish, Aaron L, Rory B Weiner, Gen Kanayama, James I Hudson, Michael T Lu, Udo Hoffmann, and Harrison G Pope. 2017. Cardiovascular toxicity of illicit anabolic-androgenic steroid use clinical perspective. *Circulation* 135, no. 21: 1991-2002. https://doi.org/10.1161/CIRCULATIONAHA.116.026945

Bilgrei, Ola Roed, and Thomas Anton Sandoy. 2015. Should the use of anabolic androgenic steroids be considered a major public health problem in the Nordic countries? *Nordic Studies on Alcohol and Drugs* 32, no. 1:25-26. https://doi.org/10.1515/nsad-2015-0004

Bilgrei, Ola Røed. 2017. Broscience: Creating trust in online drug communities. *New Media & Society*: 1461444817730331. https://doi.org/10.1177/1461444817730331

Bjørnebekk, Astrid, Kristine B Walhovd, Marie L Jørstad, Paulina Due-Tønnessen, Ingunn R Hullstein, and Anders M Fjell. 2017. Structural brain imaging of long-term anabolic-androgenic steroid users and non-using weightlifters. *Biological psychiatry* 82, no. 4: 294-302. https://doi.org/10.1016/j.biopsych.2016.06.017

Braun, Virginia, and Victoria Clarke. 2006. Using thematic analysis in psychology. *Qualitative research in psychology* 3, no. 2: 77-101. https://doi.org/10.1191/1478088706qp063oa

Brower, Kirk J, Frederic C Blow, James P Young, and Elizabeth M Hill. 1991. Symptoms and correlates of anabolic-androgenic steroid dependence. *British journal of addiction* 86, no. 6: 759-68. https://doi.org/10.1111/j.1360-0443.1991.tb03101.x

Christiansen, Ask Vest, Anders Schmidt Vinther, and Dimitris Liokaftos. 2017. Outline of a typology of men's use of anabolic androgenic steroids in fitness and strength training environments. *Drugs: Education, Prevention and Policy* 24, no. 3: 295-305. https://doi.org/10.1080/09687637.2016.1231173

Copeland, Jan, Richard Peters, and Paul Dillon. 2000. Anabolic-androgenic steroid use disorders among a sample of Australian competitive and recreational users. *Journal of Drug and alcohol dependence* 60, no. 1: 91-96. https://doi.org/10.1016/S0376-8716(00)80011-3

Dodge, Tonya, and Margaux F. Hoagland. 2011. The use of anabolic androgenic steroids and polypharmacy: A review of the literature. *Drug and Alcohol Dependence* 114, no. 2-3: 100-109. https://doi.org/10.1016/j.drugalcdep.2010.11.011

Dunn, Matthew, Richard Henshaw, and Fiona H J McKay. 2016. Do performance and image enhancing drug users in regional Queensland experience difficulty accessing health services? *Drug and alcohol review* 35, no. 4: 377-82. https://doi.org/10.1111/dar.12363

Dunn, Matthew, Fiona H. McKay, and Jenny Iversen. 2014. Steroid users and the unique challenge they pose to needle and syringe program workers. *Drug and Alcohol Review* 33, no. 1: 71-77. https://doi.org/10.1111/dar.12085

Griffiths, Scott, Richard Henshaw, Fiona H McKay, and Matthew Dunn. 2017. Post-cycle therapy for performance and image enhancing drug users: a qualitative investigation. *Performance enhancement & health* 5, no. 3: 103-107. https://doi.org/10.1016/j.peh.2016.11.002

Griffiths, Mark. 2005. A 'components' model of addiction within a biopsychosocial framework. *Journal of Substance use* 4: 191-97. https://doi.org/10.1080/14659890500114359

Grimen, Harald. 2009. Power, trust, and risk: some reflections on an absent issue. *Medical anthropology quarterly* 23, no. 1: 16-33. https://doi.org/10.1111/j.1548-1387.2009.01035.x

Hauger, Lisa E, Lars T Westlye, Anders M Fjell, Kristine B Walhovd, and Astrid Bjørnebekk. 2019. Structural brain characteristics of anabolic-androgenic steroid dependence in men. *Addiction* 114, no. 8: 1405-11415 https://doi.org/10.1111/add.14629

Havnes, Ingrid A, Marie L, Jørstad, Marie-Claire van Hout, Jim Mcveig and Astrid Bjørnebekk. 2019a. The anabolic androgenic steroid treatment gap: a national study of substance use disorder treatment (under review)

Havnes Ingrid A, Marie L Jørstad and Christine Wisløff. 2019. Anabolic-androgenic steroid users receiving health-related information; health problems, motivations to quit and treatment desires. *Substance Abuse Treatment, Prevention, and Policy* 14, no. 1: 20. doi:10.1186/s13011-019-0206-5 https://doi.org/10.1186/s13011-019-0206-5

Jørstad, Marie Lindvik, Thea Steen Skogheim, and Hans Bugge Bergsund. 2018. 'Mer hjelp, mindre moralpreken' Hva brukere av anabole-androgene steroider ønsker fra helsetjenestene. ['More help, less sermons on morality': what users of anabolic- androgenic steroids want from health services] *Nordic Studies on Alcohol and Drugs* 35, no. 1: 69-76: 1455072517748871. https://doi.org/10.1177/1455072517748871

Kanayama, Gen, and Harrison G Pope Jr. 2018. History and epidemiology of anabolic androgens in athletes and non-athletes. *Molecular and cellular endocrinology* 464: 4-13. https://doi.org/10.1016/j.mce.2017.02.039

Kanayama, Gen, Geoffrey H. Cohane, Roger D. Weiss, and Harrison G. Pope, Jr. 2003. Past anabolic-androgenic steroid use among men admitted for substance abuse treatment: An underrecognized problem? *Journal of Clinical Psychiatry* 64, no. 2: 156-160. https://doi.org/10.4088/JCP.v64n0208

Kanayama, Gen, Kirk J. Brower, Ruth I. Wood, James I. Hudson, and Harrison G. Pope, Jr. 2009. Anabolic-androgenic steroid dependence: An emerging disorder. *Addiction* 104, no. 12: 1966-1978. https://doi.org/10.1111/j.1360-0443.2009.02734.x

Kicman, Andrew T. 2008. Pharmacology of anabolic steroids. *British journal of pharmacology* 154, no. 3: 502-521. https://doi.org/10.1038/bjp.2008.165

Kimergård, Andreas, and Jim McVeigh. 2014. Environments, Risk and Health Harms: A qualitative investigation into the illicit use of anabolic steroids among people using harm reduction services in the UK. *BMJ open* 4, no. 6: e005275. https://doi.org/10.1136/bmjopen-2014-005275

Lindqvist, Anne-Sophie, Tommy Moberg, Christer Ehrnborg, Bengt O Eriksson, Claudia Fahlke, and Thord Rosén. 2014. Increased mortality rate and suicide in Swedish former elite male athletes in power sports. *Scandinavian journal of medicine* 24 no. 6: 1000-05. https://doi.org/10.1111/sms.12122

Lundholm, Lena, Kerstin Kall, Sussi Wallin, and Ingemar Thiblin. 2010. Use of anabolic androgenic steroids in substance abusers arrested for crime. *Drug and Alcohol Dependence* 111, no. 3: 222-226. https://doi.org/10.1016/j.drugalcdep.2010.04.020

Molero, Yasmina, Ann-Sofie Bakshi, and Johanna Gripenberg. 2017. Illicit drug use among Gym-Goers: a cross-sectional study of Gym-Goers in Sweden. *Sports medicine-open* 3, no. 1: 31. https://doi.org/10.1186/s40798-017-0098-8

Nesvaag, Sverre, and Terje Lie. 2010. The Norwegian substance treatment reform: Between new public management and conditions for good practice. *Nordic Studies on Alcohol and Drugs* 27, no. 6: 655-666. https://doi.org/10.1177/145507251002700610

Nøkleby, Heid, and Finn Skårderud. 2013. Body practices among male drug abusers. Meanings of workout and use of doping agents in a drug treatment setting. *International Journal of Mental Health and Addiction* 11, no. 4: 490-502. https://doi.org/10.1007/s11469-013-9434-5

Petersson, Anna, Mats Garle, Per Holmgren, Henrik Druid, Peter Krantz, and Ingemar Thiblin. 2006. Toxicological findings and manner of death in autopsied users of anabolic androgenic steroids. *Drug and alcohol dependence* 81, no. 3: 241-49. https://doi.org/10.1016/j.drugalcdep.2005.07.003

Piacentino Daria, Georgios Kotzalidis, Antonio Del Casale, Maria Rosaria Aromatario, Cristoforo Pomara, Paolo Girardi, and Gabriele Sani. 2015. Anabolic-androgenic steroid use and psychopathology in athletes. A systematic

review. Current Neuropharmacology. 13, no. 1: 101 *Current Neuropharmacology* 21. https://doi.org/10.2174/1570159X13666141210222725

Pope, Catherine, Sue Ziebland, and Nicholas Mays. 2000. Qualitative research in health care: analysing qualitative data. *British Medical Journal* 320, no. 7227: 114. https://doi.org/10.1136/bmj.320.7227.114

Pope, Harrison G, Jag H Khalsa, and Shalender Bhasin. 2017. Body image disorders and abuse of anabolic-androgenic steroids among men. *Jama* 317, no. 1, 23-24. https://doi.org/10.1001/jama.2016.17441

Pope Jr, Harrison G, Ruth I Wood, Alan Rogol, Fred Nyberg, Larry Bowers, and Shalender Bhasin. 2013. Adverse health consequences of performance-enhancing drugs: An Endocrine Society scientific statement. *Endocrine reviews* 35, no. 3: 341-375. https://doi.org/10.1210/er.2013-1058

Pope, Harrison G., Jr., Gen Kanayama, Martin Ionescu-Pioggia, and James I. Hudson. 2004. Anabolic steroid users' attitudes towards physicians. *Addiction* 99, no. 9: 1189-1194. https://doi.org/10.1111/j.1360-0443.2004.00781.x

Pope, Harrison G., Jr., Joseph Kean, Adam Nash, Gen Kanayama, Douglas B. Samuel, Warren K. Bickel, and James I. Hudson. 2010. A diagnostic interview module for anabolic-androgenic steroid dependence: Preliminary evidence of reliability and validity. *Experimental and Clinical Psychopharmacology* 18, no. 3: 203-213. https://doi.org/10.1037/a0019370

Rahnema, Cyrus D, Larry I Lipshultz, Lindsey E Crosnoe, Jason R Kovac, and Edward D Kim. 2014. Anabolic steroid-induced hypogonadism: diagnosis and treatment. *Fertility and sterility* 101, no. 5: 1271-1279. https://doi.org/10.1016/j.fertnstert.2014.02.002

Rasmussen, Jon J, Morten Schou, Per L Madsen, Christian Selmer, Marie L Johansen, Peter Hovind, Peter S Ulriksen, Jens Faber, Finn Gustafsson, and Caroline Kistorp. 2018. Increased blood pressure and aortic stiffness among abusers of anabolic androgenic steroids: potential effect of suppressed natriuretic peptides in plasma? *Journal of hypertension* 36, no. 2: 277-285. https://doi.org/10.1097/HJH.0000000000001546

Rasmussen, Jon Jarløv, Christian Selmer, Peter Busch Østergren, Karen Boje Pedersen, Morten Schou, Finn Gustafsson, Jens Faber, Anders Juul, and Caroline Kistorp. 2016. Former abusers of anabolic androgenic steroids exhibit decreased testosterone levels and hypogonadal symptoms years after cessa-

tion: a case-control study. *PloS one* 11, no. 8: e0161208. https://doi.org/10.1371/journal.pone.0161208

Sagoe, Dominic, Jim McVeigh, Astrid Bjornebekk, Marie-Stella Essilfie, Cecilie Schou Andreassen, and Stale Pallesen. 2015. Polypharmacy among anabolic-androgenic steroid users: A descriptive metasynthesis. *Substance Abuse Treatment, Prevention, and Policy*, 10, no. 12. https://doi.org/10.1186/s13011-015-0006-5

Sagoe, Dominic, Helge Molde, Cecilie S Andreassen, Torbjørn Torsheim, and Ståle Pallesen. 2014. The global epidemiology of anabolic-androgenic steroid use: a meta-analysis and meta-regression analysis. *Annals of epidemiology* 24, no. 5: 383-398. https://doi.org/10.1016/j.annepidem.2014.01.009

Sagoe, Dominic, Torbjorn Torsheim, Helge Molde, Cecilie Schou Andreassen, and Stale Pallesen. 2015. Anabolic-androgenic steroid use in the Nordic countries: A meta-analysis and meta-regression analysis. *Nordic Studies on Alcohol and Drugs* 32, 1: 7-20. https://doi.org/10.1515/nsad-2015-0002

Schwingel, Paulo Adriano, Claudio Cesar Zoppi, and Helma Pinchemel Cotrim. 2014. The influence of concomitant use of alcohol, tobacco, cocaine, and anabolic steroids on lipid profiles of Brazilian recreational bodybuilders. *Substance Use & Misuse* 49, no. 9: 1115-1125. https://doi.org/10.3109/10826084.2014.903753

Skårberg, Kurt, Fred Nyberg, and Ingemar Engström. 2008. The development of multiple drug use among anabolic-androgenic steroid users: Six subjective case reports. *Substance Abuse Treatment, Prevention, and Policy*, 3, no. 24. https://doi.org/10.1186/1747-597X-3-24

Smit, Diederik L, and Willem de Ronde. 2018. Outpatient clinic for users of anabolic androgenic steroids: an overview. *The Netherlands Journal of Medicine* 76: 167-75.

Tighe, Boden, Matthew Dunn, Fiona H McKay, and Timothy Piatkowski. 2017. Information sought, information shared: exploring performance and image enhancing drug user-facilitated harm reduction information in online forums. *Harm reduction journal* 14, no. 1: 48. https://doi.org/10.1186/s12954-017-0176-8

van de Ven, Katinka, Renee Zahnow, Jim McVeigh, and Adam Winstock. 2019. The modes of administration of anabolic-androgenic steroid users (AAS): are non-injecting people who use steroids overlooked? *Drugs: Education, Pre-*

vention and Policy:
https://doi.org/10.1080/09687637.2019.1608910

Volkow, Nora D, George F Koob, and A Thomas McLellan. 2016. Neurobiological Advances from the Brain Disease Model of Addiction. *New England Journal of Medicine* 374, no. 4: 363-71. https://doi.org/10.1056/NEJMra1511480

World Health Organization (2019). International Statistical Classification of Diseases and Related Health Problems (11th ed.). https://icd.who.int/

Yu, Jessica, Thomas Hildebrandt, and Nicholas Lanzieri. 2015. Healthcare professionals' stigmatization of men with anabolic androgenic steroid use and eating disorders. *Body Image* 15: 49-53. https://doi.org/10.1016/j.bodyim.2015.06.001

Zahnow, Renee, Jim McVeigh, Geoff Bates, Vivian Hope, Joseph Kean, John Campbell, and Josie Smith. 2018. Identifying a typology of men who use anabolic androgenic steroids (AAS). International Journal of Drug Policy 55: 105-112.
https://doi.org/10.1016/j.drugpo.2018.02.022

Zahnow, Renee, Jim McVeigh, Jason Ferris, and Adam Winstock. 2017. Adverse effects, health service engagement, and service satisfaction among anabolic androgenic steroid users. *Contemporary Drug Problems* 44, no. 1: 69-83.
https://doi.org/10.1177/0091450917694268

Örebro University hospital. 2016. *Dopning - Oversikt, vård och behandling*. [Doping - Overview, care and treatment]. Sweden, Region Örebro län: Örebro.

JOURNAL of EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 116-140 https://doi.org/10.5617.7365

Article

Narrating the Unspeakable

Making Sense of Psychedelic Experiences in Drug Treatment

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Abstract

The use of psychedelic substances has been described as an 'unspeakable primary experience,' one that is personal and ultimately indescribable. The ineffable quality of such an experience, however, does not prohibit or invalidate attempts to explain it. The struggle to narrate one's experience is instead an important endeavor. But, how does narration work if the psychedelic experience is truly unspeakable? What kind of narratives are possible? What kinds of narrative work do psychedelics foreclose? This article addresses these questions by analyzing narratives generated about the use of psychedelics for drug treatment. Drawing on 16 months of ethnographic research at drug treatment centers in Baja California, Mexico, this article examines what narration looks like in the context of a psychedelic-based drug treatment modality. It pays particular attention to how people in treatment retell – or struggle to retell – their experiences with psychedelics to make sense of them and then articulate them for the researcher. I argue that psychedelic experiences pose a unique challenge for the anthropological study of these substances, particularly their therapeutic use. I show how these experiences resist narrativization in multiple ways, presenting both ethnographic and epistemological obstacles to the production of anthropological knowledge.

Keywords

addiction, drug treatment, narrative, psychedelics, Mexico

Introduction

Ethnobotanist and psychedelic advocate Terence McKenna describes the use of psychedelic substances as an 'unspeakable primary experience,' one that is 'private, personal … and ultimately unspeakable' (McKenna 1991, 257). According to McKenna, the inexpressible quality of such an experience, however, does not fully prohibit nor invalidate attempts to explain it. The struggle to narrate one's experience is instead a necessary endeavor: 'The more you know the quieter you get. The explanation is another matter and can be attempted. In fact, it must be

told' (McKenna 1991, 257). But, how does narration work if the psychedelic experience is truly unspeakable? What kind of narratives are possible? What kinds of narrative work do psychedelics foreclose?

This article addresses these questions by analyzing the narratives generated about a particular kind of psychedelic use: therapeutic use for drug treatment. Drawing on ethnographic research in Mexico, I examine what narration looks like in the context of a psychedelic-based drug treatment modality. I pay specific attention to the ways in which people in treatment retell — or struggle to retell — their psychedelic experiences in an effort to make sense of them. In other words, the psychedelic experience is re-created narratively for potentially therapeutic ends. In the ethnographic moment, this narrative process is also an attempt to articulate the experience for the listening researcher.

This kind of narrative work has long been a central part of ethnographic research. Narrative is 'a mode of thinking, a way of making sense of experience' (Garro and Mattingly 2000, 23). Medical anthropologists, for instance, have analyzed 'illness narratives' (Frank 1995; Good 1994; Kleinman 1988) in order to understand how people make sense of their experiences with illness, ranging from HIV/AIDS (Ezzy 2000) and anorexia (Shohet 2007) to psychosis (Thornill, Clare, and May 2004). However, anthropologists have also drawn attention to the ways in which the production of narrative can prove difficult. Gay Becker (1997, 26) argues that 'narrative is our primary means of accessing the world of bodily experience and is essential to our understanding of that experience.' But, this may not always the case, as illustrated by the work of gender scholar Jenni Millbank (2017, 97), which illustrates how women struggle to express their relationship to their stored in vitro fertilization embryos; they are 'something of-the-body but not within the body, neither self nor other, person nor thing.' This relationship, she argues, is inevitably ineffable. Moreover, the production of narrative and the experiences they are meant to convey can also be confounding for the ethnographer. E. Valentine Daniels (1996), for instance, poignantly discusses the difficulty of writing ethnographically about the violence he encountered in Sri Lanka during the country's civil war in the 1980s. He writes of the 'enormous difficulty entailed in mediating or communicating [an experience of violence] … and the impotency one feels in trying to do so' (Daniels 1996, 4).

Drawing on this research and the problems that narrative analysis can entail, I argue that psychedelic experiences pose a unique challenge for the anthropological study of these substances, particularly the analysis of their therapeutic uses. I show how the 'unspeakable' quality of the psychedelic experience resists narrativization in multiple ways, presenting both ethnographic and epistemological obstacles to the production of anthropological knowledge. Consequently, this article urges us to consider whether the ineffability of psychedelic experiences limits our ability to ethnographically study these substances, particularly in therapeutic contexts, or if it simply creates new research opportunities that deserve consideration and exploration.

Methods

This article is based on 16 months of ethnographic fieldwork at ibogaine centers in Baja California, Mexico, between 2015 and 2019. I conducted fieldwork in Mexico because the U.S. Food and Drug Administration criminalized ibogaine by classifying it as a Schedule I drug in 1967 (Alper and Lotsof 2007). This scheduling means that the U.S. government considers ibogaine to be unsafe, and to have a high potential for abuse and no recognized therapeutic use. The prohibition of ibogaine in the U.S. has not obstructed its use for drug treatment in neighboring countries; in fact, it has been a main driver. Centers offering ibogaine have been established, particularly in Mexico, where it is an unregulated substance. These centers have proliferated across Mexico over the last decade and capitalize on their close proximity to the U.S. in order to attract a primarily American clientele that wants to undergo drug treatment with ibogaine legally. As a result, my fieldsites are ibogaine centers that cater primarily to Americans along the Gold Coast of Baja California, an area of Mexico known for its cross-border healthcare industry (Guendelman and Jasis 1992; Oberle and Arreola 2004).

I collected data using several methods. First, I carried out extensive participant observation at two ibogaine centers in Baja California, which included observing treatment sessions, spending time with clients[1] and providers of pre- and post-treatment, accompanying clients and staff to and from the U.S.-Mexico border, and assisting staff with everyday tasks at the treatment centers. These centers were small; one treated up to four clients at a time while the other treated up to six. The smaller center was located in a house in a residential neighborhood about one hour south of the border. It was owned and operated by self-proclaimed 'hippies,' one of whom used ibogaine in the past to treat their own heroin addiction and used a combination of biomedical and 'alternative' healing modalities to offer treatment. The larger center had two facilities, a medical detox clinic in Tijuana where clients receive treatment and a recovery house in a residential area about one hour south where clients stayed pre- and post-treatment to recuperate. Owned by a doctor living in the U.S. and operated by a team of American and Mexican staff members, the center could be described as a more biomedical facility than its smaller counterpart.

Second, I conducted 30 interviews with people receiving or providing psychedelics for drug treatment. Interviews with clients focused on their drug use history, experiences with mainstream drug treatments, knowledge of and experiences with the psychedelics they traveled to Mexico to receive, and their post-treatment experiences. Interviews with providers focused on their experiences offering drug treatment as well as their views on the psychedelic substances they administer and their therapeutic value. This research received Institutional Review Board approval prior to initiation.

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[1] The providers and staff at my fieldsites use 'clients' or 'guests' – as opposed to 'patients' – to refer to the people who receive treatment at their centers. In this article, I have opted to follow this linguistic choice by using 'client.'

I analyzed verbatim interview transcripts and fieldnotes from participant observation for key themes using open coding. This inductive data analysis process involved 'breaking data apart and delineating concepts to stand for blocks of raw data' (Corbin and Anselm 2008, 195). Using this coding system, I further refined the data by identifying sub-themes and patterns (DeWalt and DeWalt 2011; Fetterman 2010). This coding strategy helped establish the structural and theoretical framework for the analysis discussed in this article. As discussed below, one prominent theme that emerged was that ineffability appeared to be central feature of most of my participants' experiences with psychedelics during the course of their drug treatment.

Treating Addiction with Psychedelics

The therapeutic use of psychedelic substances is not a new phenomenon. In the global north, researchers and 'psychonauts' – those who use psychedelics as a means to explore the psyche – have explored the therapeutic potential of such substances, such as lysergic acid diethylamide (LSD) and mescaline, since at least the early 20th century (Dyck 2008; Grof 1975; Unger 1963). The use of psychedelics, of course, has a much longer history, with many indigenous and spiritual groups working with them for millennia (Dobkin de Rios 1984; Furst 1972; Labate and Cavnar 2016). Numerous legal and institutional restrictions hindered the study of psychedelics in the global north for over 50 years. However, some restrictions have eased somewhat in the U.S. as well as other countries, leading to new and renewed interest in psychedelics within academic, scientific, medical, and other healing circles. For instance, recent work has examined the role of psilocybin mushrooms in treating cancer-related anxiety and depression (Ross et al. 2016) as well as the use of MDMA to treat post-traumatic stress disorder (Mithoefer et al. 2013). This 'psychedelic renaissance' (Sessa 2012) has contributed to the increased study and utilization of these substances for specific therapeutic ends. The use of psychedelics for drug treatment – the focus of this article — is one notable example. Various psychedelics[2], such as ayahuasca, peyote, and psilocybin, are increasingly employed to treat addiction[3] in ceremonial or clinical settings (Halpern 2007; Johnson, Garcia-Romeu, and Griffiths 2017; Labate et al. 2010; Webb 2011; Winkelman 2014). The most prevalent of these is ibogaine, a naturally occurring psychoactive substance found in various plants, including the Tabernanthe iboga plant native to Central Africa. Those who ingest it experience a dream state

2 There are different opinions regarding the term used for these substances. Depending on their context of use and how is using them, they may be referred to as psychedelics, sacred medicines, plant teachers, or sacraments.

3 'Addiction' is not a straightforward or self-explanatory term. There is a growing literature that demonstrates the concept's multiplicity and variability across and within fields (Fraser, Moore, and Keane 2014; Keane 2002; Raikhel and Garriott 2013). Anthropologists and critical drug scholars have shown that the term 'addiction' is increasingly applied to a wide array of substances and conditions (Campbell 2007; Glasser 2012; Schüll 2014) and variously identified as either a disease, moral failing, lack of free will, or a result of political-economic forces (Garcia 2010; Raikhel 2015; Reith 2004; Vrecko 2010). Although contested, I have nonetheless chosen to use 'addiction' in this article because it is the word my participants employ to discuss the issues that they are addressing through drug treatment.

while awake and often have visions that can last up to 24 hours (Popik, Layer, and Skolnick 1995). In Gabon and Cameroon, practitioners of the Bwiti religion use preparations containing ibogaine for ritual and healing purposes (Fernandez 1982). Scientists and health practitioners have also worked with ibogaine to examine its potential for drug treatment (Schenberg et al. 2014; Mash et al. 1998; Popik et al. 1995). This work, including observational studies (Brown and Alper 2018; Noller et al. 2018) and case studies (Alper et al. 1999; Lotsof and Alexander 2001; Sheppard 1994), note ibogaine's capacity as a so-called 'addiction interrupter' because of its potential to reduce physical cravings for and withdrawal symptoms from opiates and other drugs after one dose. Research also suggests that ibogaine can be used as a tool for introspection that allows for self-reflection about one's addiction and path out of it (Cloutier-Gill et al. 2016; Frenken 2001). Thus, ibogaine purportedly works by addressing both the physical and 'psycho-spiritual' dimensions of addiction, treating both its sources and its symptoms.

Ibogaine is sometimes offered in conjunction with other psychedelics as part of the drug treatment protocol. One such substance is 5-methoxy-N,N-dimethyltrypatime (5-meO-DMT), which is found in high concentrations in the venom produced by the Sonoran Desert Toad or Colorado River Toad (*Bufo alvarius*) native to northern Mexico and the southwestern U.S. Some work suggests that this substance, known colloquially as 'toad' or 'toad medicine,' may have historically been used by indigenous groups native to the region (Weil and Davis 1994). Current research, however, claims that its widespread use is a more recent development, especially within the drug treatment community (Cortina 2018). Toad is a potent and fast-acting psychedelic; it takes effect within 10 seconds of inhalation and lasts approximately 20 minutes. Toad is often administered in order to elevate mood, alleviate residual physical or emotional discomfort, and help with insomnia a few days after receiving ibogaine.

Both of my fieldsites in Mexico utilized both ibogaine and toad in their drug treatment program. As discussed below, the effects of these substances contrast greatly according my research participants; one called them 'different animals from different kingdoms.' Nevertheless, providers couple ibogaine with the toad because they see them as complementary medicines that are both effective in treating addiction.

Partial Accounts

When asked about their experiences with ibogaine or toad, all of my participants provided some sort of narrative description. Some people vividly recounted what they felt and saw, but most offered vague depictions, as some did not remember much or had difficulty relaying their experiences. Still people attempted to describe their accounts with these psychedelics when asked about them, no matter how partial.

A common narrative trend among my participants' accounts with ibogaine was the unpleasantness of the experience. First, almost all of them mentioned either physical or emotional discomfort after swallowing the ibogaine capsules. They described nausea, motion sickness, and ataxia, common physiological responses to high doses of ibogaine like those administered at the treatment centers where I conducted my fieldwork. As a woman who had an intense physical reaction explained, 'Oh my god, it was rough! It was really rough. It was hard, it was really hard. I vomited a lot. I wasn't prepared for it to be that harsh.' Many of my participants also recalled dark imagery or emotions, using such words as 'creepy,' 'bad,' and 'scary' to convey the effect. One client, for example, described the 'really eerie, haunting feeling' she experienced while on ibogaine:

> It just got really creepy really fast … For me it was less visual, it was more of a feeling. It just was very gloomy and dark. I felt like I was kind sinking down underneath the ground into something kind of like hell, you know like walls and darkness, kind of like spirits flying around in all directions … It's very like dungeon like. I had a feeling that it was like hell realms.

Another woman described her disquieting ibogaine experience in the following way:

> At one point I just felt like just immense grief and like sadness and I, I just started crying. I couldn't stop crying and I had some pretty scary visuals too, you know? One was like I was running through grass and the grass was razor blades cutting up my body piece by piece and I could feel everything, like I felt it, my body felt it. Each slice going through my body and just like blood everywhere.

Sometimes the visuals that clients remember were troubling because they involved friends or family members. For one client, this meant fictional but distressing images. He said, 'I didn't expect for it to be that disturbing for me. It was really, really bad…I would just see like fire and burning and be like … I don't know. It was just really, really messed up. And I would see like my mom's funeral, like my mom crying over like my addiction, like just really, really bad stuff.'

Many clients' narratives also included memories, some of which were unpleasant or depressing. One client recalled a lot from his past during his time on ibogaine:

> You know how they say people say that they watch life stories and things in their life happen? To the T that happened. That happened on a *bunch* of occasions. I mean, I went through my *whole* life at different times … I just remember different times and different things and different people I was close with, and

> different friends and different things I wanted to do with different friends.

Some of these memories, though, were upsetting, including when he and his friends had an altercation that led to someone's death. He continued by admitting, 'I relived that murder. I relived that, I mean, to the exact of it happening. The whole scenario.' Another man also described a sad childhood memory he relived during his ibogaine experience. He explained, 'Dad got pulled over one time when I was a little kid. I was probably like 4 years old, and he had a bunch of guns in the car and I remember standing on the side of the road and I was crying like, "Please don't take my dad to jail."'

Figure 1. 5-meO-DMT treatment session, photo by Shana Harris (author), 2019, Baja California, Mexico.

The way my participants spoke of their experiences with ibogaine contrasted with the manner in which they described those with toad. They often spoke of love, radiance, and unity, all of which are frequently reported characteristics of smoking toad (Davis et al. 2018). When asked about her experience, a client simply said, 'Just light and hope and just a lot of light.' Another client likewise was very brief in his description: 'It was very, I don't know, it was blissful.' One man just called it 'an explosion of joy.'

Some clients were able to offer more detailed accounts, which included similar descriptions, but also discussed a level of intensity while on toad. For instance, one client called her toad experience 'super intense':

> It was like a very, very vibrant like mandalas and spirals and fractals, very colorful, expanding, and contracting. And it felt I had a feeling that that was like a glimpse of where you wanna go when you die, like bliss realm like nirvana like heaven connecting with everything like being one.

Another client highlighted the intensity of his experience as such:

> I felt like this tingling coming all over my body and I started to see just lights. It was like not too intense, it was like orange and yellow light and it became *super* intense, super intense. It became so intense I thought I was dying. Like there's no way I'm going to make it through this; it's hard to breathe. I keep telling myself, slow down your breathing. So, I'm trying to breathe through it, and I was thinking, 'I hope this doesn't last too long.' It's unexplainable.

Physical and emotional release was also a common feature of many accounts. After smoking toad, for example, a client recalled:

> I remember writhing, literally writhing on the ground, moaning, half-screaming. And there was this visceral mass that was just trying to contain me. You know, I wasn't trying. It was just trying to contain me. It was an internal mass, um, just below my rib cage above my belly button maybe. And I was just writhing. It was just making me convulse on the ground. And then after doing that for about five or ten minutes, I just remember, you know, my mom saying, 'Let go. Just let go. Just let go. You're holding stuff in. Just let go, like, surrender.' So, I laid back … It was, I don't know, just unreal. They're all just saying, 'Let go and just feel the energy, feel the love, and don't think, you know, *don't* think. Just feel it.'

Another client provided a similar description:

> I was shot into another dimension, and I was terrified. Here wasn't here anymore. I was surprised I was here. But then I felt a peace, love feeling. Just let go. Everything is OK. You're loved. I felt connection. I wanted to cry. I never felt like that before.

The emotional side of the toad experience was also discussed by a different client. She explained, 'I had tears … I'd seen my old self and my new self and then I kind of talked with my old self and my new self about who I wanted to be, being positive and do new things … Just letting it go, just getting it out.'

As evidenced by these excerpts, there are some similar components of my participants' narratives about undergoing treatment with ibogaine and toad. Some recall or share more details than others, yet everyone's experiences are different and wholly their own. However, one observable commonality was the difficulty of articulating their experiences. They were unable to fully convey in narrative form what it was like to use these substances that had powerful effects of them in various ways.

The Limits of Language

One of the biggest challenges of understanding my participants' psychedelic experiences is linguistic in nature. For most people who have psychedelic experiences, they cannot easily or fully be put those experiences into words. As one client clearly explained, 'It's hard to really put words to something that is un-describable.' Another confirmed this point, stating, 'It was weird. I don't even know how to describe it.' These admissions relate to the 'unspeakable' character of psychedelic experiences. If the 'unspeakable' is, as McKenna (1994) claims, 'that which lies beyond the domain of language,' then the language in which we use to describe psychedelic experiences is likely highly flawed. An ibogaine provider spoke of this when he explained, 'We don't have a vocabulary to articulate the experience … Language is a symbolic representation of a felt sense of perception, so words don't accurately or adequately describe what you experience.' You cannot, therefore, do justice to your experience by describing it in words.

Various researchers have discussed this linguistic limitation in relation to mystical states of consciousness. Over a century ago, psychologist William James claimed that ineffability is one key component of mystical experience. He writes that such experience 'defies expression…no adequate report of its contents can be given in words… [I]t cannot be imparted or transferred to others' (James 1902, 830). He goes on to claim that direct experience is the only way to truly understand another's mystical encounter: 'No one can make clear to another who has never had a certain feeling, in what the quality or worth of it consists. One must have musical ears to know the value of a symphony; one must have been in love one's self to understand a lover's state of mind' (James 1902, 830). Mystical experiences produced specifically by psychedelics have also been described in such a way. Psychiatrist Walter Pahnke (1969, 151) argues that a part of mystical psychedelic experience is alleged ineffability: '[T]he experience is felt to be beyond words, nonverbal, and impossible to describe.' He and his colleague, psychologist William Richards, elaborate more on this inexpressible quality of the psychedelic-induced 'mystical consciousness':

> When a subject attempts to communicate mystical consciousness verbally to another person, he usually claims that the available linguistic symbols – if not the structure of language itself – are inadequate to contain or even accurately reflect such experience. Perhaps the reason such experience is felt to be beyond words is to be found in a frustration with language, which, in turn, arises out of the paradoxical nature of the essential phenomenon and the incomparable uniqueness of the experience itself. [Pahnke and Richards 1966, 181-182]

While this inadequacy of language to convey mystical states – whether induced by psychedelics or not – is widely acknowledged, research shows that they *can* be described in meaningful ways (Doyle 2011; Pollan 2018; Sells 1994). For instance, David B. Yaden et al. (2016) find that people who provide detailed descriptions of their mystical experiences often do so in ordered ways. Using quantitative linguistic analyses of written accounts of mystical experiences, they identify possible underlying linguistic features of these supposedly unspeakable experiences. Understanding these features, they argue, can 'make headway into "effing" the ineffable' (Yaden et al. 2016, 250).

I would be remiss if I did not acknowledge as well that some researchers have effectively collected and analyzed narratives related specifically to ibogaine-induced experiences. In his classic ethnography of Bwiti religious practices among the Fang in Gabon, anthropologist James Fernandez (1982) includes elaborate descriptions of visions and spiritual experiences that were the result of Bwiti practitioners ingesting the sacrament of iboga, a plant whose root bark contains ibogaine. The frequent expression and detailed nature of these descriptions are arguably a result of the ritual structure and culture in which Bwiti practitioners operate. As Fernandez shows, both their experiences with iboga and their subsequent narratives are shaped and bounded by cultural and ceremonial expectations that leave little room for variation. In other words, it is not difficult for them to describe what they underwent. More recent research on ibogaine has also gathered narrative data about the experience of using the psychedelics for drug treatment (Camlin et al. 2018; Schenberg et al. 2017). Thomas Kingsley Brown, Goeff Noller, and Julie Denenberg (2019), for example, examine how ibogaine's psychotropic effects are described by those who used it to treat opioid use disorder. Notably, their research participants spoke of visual and auditory phenomena, feelings of remorse and regret, and spiritual transformation in some detail.[4] Psychiatrist James Rodger (2018) likewise was able to gather the testimonies of 'addicts' who used ibogaine through interviews, surveys, and online forums and message boards. His extensive analysis outlines the cultural formation and interpretations of their 'visionary ex-

[4] It is worth noting that only 20 of their 44 participants generated enough written material to be included in their textual analysis. Of the 24 who were excluded, 11 provided drawings, 11 provided nothing, and two provided limited text (Brown, Noller, and Denenberg 2019, 157). Although not discussed in the article, it is possible that many of their participants – like mine – found it difficult to put their psychedelic experiences into narrative form.

periences' with the psychedelic to demonstrate what considers its healing potential (Rodger 2018, 105).

Such research demonstrates that it is possible to convey a mystical or psychedelic experience. Nonetheless, many of my participants admittedly struggled when asked about their experiences with ibogaine and toad. I can only speculate as to why they grappled more than others with narration. Many of my participants had a history of trauma – be it physical, familial, sexual, or structural – and perhaps the effects of trauma made narration even more complicated (Kirmayer 1996). Or, as I discuss briefly below, there may have been factors related to the treatment context that affected my participants' narrative abilities. But, rather than venture too much about possible reasons or potential causes, what *is* evident is that the linguistic tools available to my participants inhibited them in part from fully articulating what they went through with these psychedelics.

Another factor that can contribute to my participants' inability to speak of their experiences is ego death. Ego death – the loss or distortion of one's self, or 'ego' – is considered a common feature of many individuals' experiences with various psychedelics (Grof 1975; Leary, Metzner, and Alpert 1964; Lebedev et al. 2015; Savage 1955). Ego death is characterized by the dissolution of one's self and unification with one's surroundings. Several of my participants mentioned feeling their ego dissolve, particularly while taking toad. One person explained:

> Mentally I was dying. And once I let go of myself, of dying — I was kind of fighting it in the beginning because I didn't want to die, right? I was kneeling. I was shaking, fighting until [the provider] came and he was holding me back and laying me down and that's when I had, like, I let myself go. I was able to, like, I felt my skin, my entire body became one with the dirt. I was becoming the circle of life.

Struggling for words, another client said, 'It's unexplainable. It's like it had control of my body and just locked everything up. At the tip of that intensity is when I started to release. I started to yell uncontrollably. It's like demon sounds, and I felt like I was releasing my ego.'

Author Michael Pollan (2018) reflects on his own ego death when writing about his experience with LSD. He states:

> 'I' now turned into a sheaf of little papers, no bigger than Post-its, and they were being scattered to the wind. But the 'I' taking in this seeming catastrophe has no desire to chase after the slips and pile my old self back together. No desires of any kind, in fact. Whoever I now was was fine with whatever happened. *No more ego?* [Pollan 2018, 263].

The phenomenon of ego death poses an interesting linguistic challenge for my participants: How does one talk about oneself and the effect of a psychedelic experience when the 'self' dissolves? Pollan (2018, 263-264) himself asks a similar question: '[W]ho was this "I" that was able to take in the scene of its own dissolution? Good question. It wasn't *me*, exactly...In order to completely make sense of the divide that had opened up in my perspective, I would need a whole new first-person pronoun.' Once again, as Pollan points out, the very words available to use to speak of such a diffusive experience may not do that experience justice. Perhaps then the psychedelic experience is fundamentally beyond our grasp in terms of communication, posing rhetorical challenges to the client as well as the ethnographer.

The Therapeutic Value of Narrative

If the 'unspeakable' character of psychedelic experiences also refers to, as McKenna (1994) claims, 'things that we would rather not speak about,' then there is likely an emotional element to these experiences that may inhibit talking about them. This point makes sense having worked with people seeking to overcome addiction. As mentioned above, their descriptions of their ibogaine experiences are usually characterized by dark or negative images or memories, whether its demons, hellscapes, the death of a loved one, or even their own funeral. Relaying these difficult, frightening, or even shameful visions and feelings – freshly faced or relived – can also contribute to the difficulty in communicating what they experienced. These may be encounters that they are not willing or eager to share.

For self-described 'addicts,' the possible difficulty and even inability to talk in-depth about their experiences with ibogaine and toad contrasts – sometimes starkly – with their past encounters with mainstream drug treatment modalities. It is important to note that nearly all of the clients at my fieldsites have tried to 'get clean' with mainstream treatments – such as medication-assisted treatment like methadone or buprenorphine and 12-step programs – at least once before coming to Mexico. With treatment modalities like 12-step or outpatient or residential programs, there is a narrative imperative to 'tell your story' (Carr 2010). Usually these personalized narratives follow a particular sequence involving trauma, 'hitting rock bottom,' and the like in order to disclose one's past shortcomings. As sociologist Allison McKim (2017, 117) explains, this ritual of telling's one's story – this narrative of 'inevitable decline' – is a central technique to producing the 'addict identity.' Many researchers also discuss the importance of narrative in the process of addiction recovery (Hänninen and Koski-Jännes 1999; Larkin and Griffiths 2002; McIntosh and McKegany 2000; Rafalovich 1999) and point to the therapeutic value that narrative can play in drug treatment and beyond.[5] For those undertaking ibogaine treatment, unlike with some mainstream modalities, such nar-

[5] The therapeutic importance of processing experiences through narrative is by no means exclusive to addiction recovery. In the field of psychology, for example, narration plays an important role in many approaches, such as psychoanalysis (Schafer 1980) and various trauma therapies (Kirmayer 1996).

ratives are not offered in order to access services or as a way to evaluate someone's progression in treatment. They are certainly told by clients as reasons for why they traveled to Mexico to try this alternative treatment; for many, it is their last resort. Yet this narrative form – especially a linear one – breaks down once they take the psychedelics.

I noticed during my fieldwork that clients spoke about their experiences with ibogaine and toad primarily as a means to process those experiences. It is one of the multiple ways to make meaning out of what they endured physically, emotionally, and often times spiritually. I argue that this process of meaning making through the attempted re-creation of the experiences is part of the therapeutic value of these psychedelics.

According to James (1902), mystical experiences have a 'noetic quality,' the ability to reveal hidden knowledge or insights otherwise inaccessible. He asserts that mystical states are 'states of insight into depths of truth unplumbed by the discursive intellect. They are illuminations, revelations, full of significance and importance, all inarticulate though they remain; and as a rule they carry with them a curious sense of authority for after-time' (James 1902, 380-381). Psychedelic experiences can also possess this noetic quality; they can evoke 'truth' and meaning for those who go through them. Clients' experiences with ibogaine and toad certainly speak to this point. What these substances reveal or illustrate to each client – and even what going that experience can teach them – can be incredibly powerful. For several clients, this came in the form of a warning or wake-up call. One client, for example, said:

> It just really made me see what's at stake, what I have to lose. You know, other places can tell you that, but if you don't wipe your brain clean, I feel like you're just gonna go back to your old way of thinking, you know? And now like, it's like I have like, it was like a very heavy trip so I have like a little fear barrier. But, it's a *good* fear barrier…It made me know where I stand at life and why I can't fuck up. And, you know, just like I said, I just… I always knew what was at stake and people always told me what I could lose, but it never really sunk in.

Another client spoke of a similar message she received:

> I think it was a real eye opener without a doubt, like this is a reality, like this is what's going to happen. This is what's going to happen if you're like a bad person, if you continue in your addiction. I'm an alcoholic. And then it was a glimpse of like, you know, I have something really to strive for, that there's like perfect, like bliss and peace out there.

The knowledge acquired from these kinds of experiences is part of what makes people promote these psychedelics as a form of drug treatment. A common claim of many providers I worked with is that ibogaine in particular helps 'break the cycle of addiction' in ways that other treatments cannot. I heard more than one provider assert, 'It's like 20 years of psychotherapy in one night.' This is a source of ibogaine's reputation as an 'addiction interrupter.' Supporting this position, one client called it a tool to 'get to the root of why you're in pain.' After his treatment, he believed the power of these substances was the self-awareness they enabled. He explained:

> Just to have the awareness of things that have happened, and a lot of people didn't even realize the things that they saw had any serious meaning until they were seeing it in the context, in the way ibogaine showed it. And then again, just as a way of making you feel a certain way and then you understand. Even if you don't necessarily agree, you just understand it and so … It's pretty crazy on how many levels the treatment can benefit somebody's life.

Gaining such insights can be significant and therapeutic, and this is arguably possible through the narrative process. At the ibogaine centers where I conducted my research, providers encouraged their clients to talk about what they saw, heard, and felt while on ibogaine and toad. Whether speaking to another person or writing in a private journal, narrative can help derive meaning from an experience and to engage in self-reflection, a step the providers deemed important in addressing the 'psycho-spiritual' dimensions of addiction based on their psychedelic experiences. The way in which they can engage in such introspection, however, is complicated by several factors.

In addition to linguistic barriers, the treatment environment itself may have limited how narration could occur at these centers. First, clients were urged but not required to re-tell their experiences with the psychedelics. There was no consequence if a client engaged minimally, shared information selectively, or remained silent. It was ultimately up to each individual client to determine how much effort they wished to exert post-treatment. Second, the centers provided opportunities, including space and time, for clients to participate in the narrative process, whether verbally or written. But, staffing issues at both centers made the availability of therapists and counselors with whom clients could work inconsistent. This lack of personnel, therefore, may have inhibited some clients from processing their psychedelic experiences through a more structured and therapeutic narrative exchange. Lastly, the centers offered a 7-day drug treatment program, which meant that clients had only just begun to process their experiences before leaving the center. Given their programs' short duration, providers and staff members at either center did not expect clients to narrate their experiences for therapeutic integration, the practice of translating experiences that occur during a psychedelic experience into actual changes in one's life, during a 7-day program. In fact, both cen-

ters referred their clients to coaching services or 'aftercare' facilities specializing in addiction recovery and psychedelic integration precisely because they were unable to provide these long-term services after their clients left Mexico.

These complications do not necessarily diminish my participants' attempts to articulate and re-create their psychedelic experiences nor do they obviate the therapeutic value of that narrative process. What they do provide is more food for thought.

Epistemological and Ethnographic Challenges

Given such high therapeutic potential, it seems necessary for ethnographers to try to overcome the various narrative limitations of speaking about experiences with psychedelics. This is particularly so given the fact that ethnographers traffic primarily in narratives. The challenge then is how to reconcile the ineffability of psychedelic experiences with the practical necessity of re-creating such experiences in the form of narratives for analysis and then dissemination.

There may be multiple ways to confront such a challenge. One potential starting place is to consult and analyze online forums and websites that publish so-called 'trip reports,' what rhetorician Richard Doyle (2011, 47) describes as 'scripts for the better or worse ingestion of psychedelic compounds and plants.' They are 'rhetorical programs' produced by individual users in order to re-create their psychedelic experience so that others can learn from it (Doyle 2011). What these reports can possibly provide for ethnographers is a way to represent – in the language available to us – what our participants describe during fieldwork. They may serve as models for how to write about these experiences, as windows into how one begins to articulate them in a written, narrative form. In Doyle's own words, 'We must read them as if they are less failed signs of the ineffable than symptoms of, and subsequent frames for, psychedelic states' (Doyle 2011, 54). Trip reports, therefore, can possibly teach us something about what an ineffable or unspeakable experience can look like when translated into narrative prose by using the users' own narrative construction as a point of departure.

Another method that psychedelic researchers have long engaged in is self-experimentation. Historians Laura Stark and Nancy Campbell (2018) examine how mind-body researchers in the mid-20th century used multiple methods to understand another person's ineffable, interior experiences. One technique, which they call 'methods of ingression,' was a means to 'know another consciousness by climbing inside that experience' (Stark and Campbell 2018, 791). Self-experimentation with psychedelic substances was one such method to create 'in the researcher's own body and mind the experience of another person' in a drug-induced altered state of consciousness (Stark and Campbell 2018, 791). Psychedelic researcher Kenneth Tupper and anthropologist Beatriz Labate (2014, 77) also discuss how self-experimentation was 'self-evidently and uncontroversially standard practice' to gain knowledge about psychedelics. Quoting well-known researchers

who engage in self-experimentation, they argue that it is important to have first-hand experiences with the substances one is studying. They claim this offers significant 'epistemic insights' and ask, '[W]ho is in a more advantageous epistemic position: the astronomer who looks through a telescope, or the one who does not' (Tupper and Labate 2014, 77)?

In principle, I agree that self-experimentation can provide substantial insight into the effects of psychedelic substances. However, I am less convinced that doing so is a *required* part of ethnographic research. Stark and Campbell (2018) correctly assert that ethnographers use their own methods of ingression in the form of participant observation. Learning through experience, ethnographers 'actively deploy [techniques] to access the interior experience of other beings through their own interiority' (Stark and Campbell 2018, 810). However, participant observation and the texts produced as a result of it are understood as inherently partial, 'committed and incomplete' (Clifford 1986, 7). Thus, if an individual's psychedelic experiences are subjective, personal, and non-generalizable, is self-experimentation necessary for working with people whose own experiences and motivations for using psychedelics are wholly different from the ethnographer? Would having your own psychedelic experience provide a level of ethnographic understanding unachievable through other means? The questions provide fodder for future debate. But I contend that first-hand experience does not eliminate the narrative challenges posed by psychedelics.

As an ethnographer, I am tasked with not just collecting data from my participants, but also the narrative re-creation of their very intimate, personal experiences for anthropological audiences. As Garro and Mattingly (2000, 22) attest, 'Narratives never simply mirror lived experience or an ideational cosmos, nor is a story a clear window through which the world, or some chunk of it, may be seen. Telling a story, enacting one, or listening to one is a constructive process.' Thus, this is a project of representation, which presents its own challenges around not misrepresenting or speaking for the 'Other' from a position of authority, ethnocentrism, or judgment. As such, the focus must remain on the descriptive and phenomenological, *not* on truth-claims made by the ethnographer. Rather, it is important to stay true to the perplexing character of psychedelic experiences and instead focus attention on what those experiences *mean* for those that use psychedelics therapeutically, and, in case of the research I present in this article, what they mean for drug recovery.

Conclusion

During the course of my research, my interactions with ibogaine clients and providers forced me to ask myself how much I can understand and then represent psychedelic experiences ethnographically. The questions and issues I have raised in this article with respect to these concerns are important to the study of psychedelics in general, but more specifically psychedelic-based drug treatment. I also

believe that they are becoming increasingly consequential given the growing interest in many fields in the therapeutic potential of psychedelics.

The psychedelic renaissance in which we currently find ourselves has occurred in anthropology and is gaining steam (Doyle 2012; Fotiou 2012; Langlitz 2012; Letcher 2007). Ethnographic studies are making important contributions to our understanding of policies, practices, socialities, knowledges, and experiences associated with the contemporary use of psychedelics, recreationally, religiously, and therapeutically around the world. I believe this is crucial to the amassing and production of knowledge about these substances. The knowledge created by clinical trials and quantitative surveys, while incredibly important, is not enough to appreciate the full effects that psychedelics have on people's lives or — in the case of my research — drug recovery. Ethnographic research offers something that other methods do not, namely a way of examining the lived experiences and meanings associated with the use of psychedelics, not just *what* someone experiences but what they *make* of that experience. This involves engaging with narrative in some form and thus the challenges presented by narration. This is a worthy endeavor, but one that will take work and likely some creativity to overcome if we mean to seriously engage in knowledge production in this psychedelic renaissance.

The conclusions I draw in this article are not definitive; they are part of an ongoing search for tools and techniques for engaging in the anthropological study of psychedelics. What this article offers is a foundation for thinking about how we may need novel ways to conduct ethnographic research when the experiences we are attempting to understand, document, and analyze resist narrativization.

Author bio

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References

Alper, Kenneth R., and Howard S. Lotsof. 2007. The Use of Ibogaine in the Treatment of Addictions. In *Psychedelic Medicine*, edited by Michael J. Winkelman and Thomas B. Roberts, 43-66. Westport: Praeger.

Alper, Kenneth R., Howard S. Lotsof, Geerte M.N. Frenken, Daniel J. Luciano, and Jan Bastiaans. 1999. Treatment of Acute Opioid Withdrawal with

Ibogaine. *American Journal of Addictions* 8(3): 234-242. https://doi.org/10.1080/105504999305848

Becker, Gay. 1997. *Disrupted Lives: How People Create Meaning in a Chaotic World*. Berkeley: University of California Press.

Brown, Thomas Kingsley, Geoff E. Noller, and Julie O. Denenberg. 2019. Ibogaine and Subjective Experience: Transformative States and Psychopharmacotherapy in the Treatment of Opioid Use Disorder. *Journal of Psychoactive Drugs* 51(2): 155-165. https://doi.org/10.1080/02791072.2019.1598603

Brown, Thomas Kingsley, and Kenneth Alper. 2018. Treatment of Opioid Use Disorder with Ibogaine: Detoxification and Drug Use Outcomes. *American Journal of Drug and Alcohol Abuse* 44(1): 24-36. https://doi.org/10.1080/00952990.2017.1320802

Camlin, Thaddeus James, Donald Eulert, Arthur Thomas Horvath, Steven F. Bucky, Joseph P. Barsuglia, and Martin Polanco. 2018. A Phenomenological Investigation into the Lived Experience of Ibogaine and Its Potential to Treat Opioid Use Disorders. *Journal of Psychedelic Studies* 2(1): 24-35. https://doi.org/10.1556/2054.2018.004

Campbell, Nancy. 2007. *Discovering Addiction: The Science and Politics of Substance Abuse Research*. Ann Arbor: University of Michigan Press. https://doi.org/10.3998/mpub.269246

Carr, E. Summerson. 2010. *Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety*. Princeton: Princeton University Press. https://doi.org/10.1515/9781400836659

Clifford, James, 1986. Introduction: Partial Truths. In *Writing Culture: The Poetics and Politics of Ethnography*, edited by James Clifford and George E. Marcus, 1-26. Berkeley: University of California Press.

Cloutier-Gill, Laurie, Evan Wood, Trevor Millar, Caroline Ferris, and M. Eugenia Socias. 2016. Remission of Severe Opioid Use Disorder with Ibogaine: A Case Report. *Journal of Psychoactive Drugs* 48(3): 214-217. https://doi.org/10.1080/02791072.2016.1180467

Corbin, Juliet, and Anselm Strauss. 2008. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Los Angeles: Sage Publications. https://doi.org/10.4135/9781452230153

Cortina, Ali. 2018. *Toad Medicine: New Psychedelic Knowledge Under Construction?* Chacruna, November 27. https://chacruna.net/toad-medicine-new-psychedelic-knowledge-under-construction

Daniels, E. Valentine. 1996. *Charred Lullabies: Chapters in an Anthropology of Violence*. Princeton: Princeton University Press. https://doi.org/10.1515/9781400822034

Davis, Alan K., Joseph P. Barsuglia, Rafael Lancelotta, Robert M. Grant, and Elise Renn. 2018. The Epidemiology of 5-methoxy-N, N-dimethyltryptamine (5-MeO-DMT) Use: Benefits, Consequences, Patterns of Use, Subjective Effects, and Reasons for Consumption. *Journal of Psychopharmacology* 32(7): 725-731. https://doi.org/10.1177/0269881118769063

DeWalt, Kathleen M., and Billie R. DeWalt. 2011. *Participant Observation: A Guide for Fieldworkers*. Walnut Creek: AltaMira Press.

Dobkin de Rios, Marlene. 1984. *Visionary Vine: Hallucinogenic Healing in the Peruvian Amazon*. Prospect Heights: Waveland Press.

Doyle, Richard M. 2011. *Darwin's Pharmacy: Sex, Plants, and the Evolution of the Noösphere*. Seattle: University of Washington Press.

Doyle, Richard. 2012. Healing with Plant Intelligence: A Report from Ayahuasca. *Anthropology of Consciousness* 23(1): 28-43. https://doi.org/10.1111/j.1556-3537.2012.01055.x

Dyck, Erika. 2008. *Psychedelic Psychiatry: LSD from Clinic to Campus*. Baltimore: Johns Hopkins University Press.

Ezzy, Douglas. 2000. Illness Narratives: Time, Hope, and HIV. *Social Science & Medicine* 50(5): 605-617. https://doi.org/10.1016/S0277-9536(99)00306-8

Fernandez, James W. 1982. *Bwiti: An Ethnography of the Religious Imagination in Africa*. Princeton: Princeton University Press.

Fetterman, David M. 2010. *Ethnography: Step-By-Step*. Newbury Park: Sage Publications.

Fotiou, Evgenia. 2012. Working With 'La Medicina': Elements of Healing in Contemporary Ayahuasca Rituals. *Anthropology of Consciousness* 23(1): 6-27. https://doi.org/10.1111/j.1556-3537.2012.01054.x

Frank, Arthur W. 1995. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: University of Chicago Press. https://doi.org/10.7208/chicago/9780226260037.001.0001

Fraser, Suzanne, David Moore, and Helen Keane. 2014. *Habits: Remaking Addiction*. Houndsmill: Palgrave Macmillan. https://doi.org/10.1057/9781137316776

Frenken, Geerte. 2001. From the Foots Up: Ibogaine and Addict Self-Help. *The Alkaloids* 56: 283-292. https://doi.org/10.1016/S0099-9598(01)56019-8

Furst, Peter T. 1972. *Flesh of the Gods: The Ritual Use of Hallucinogens*. New York: Praeger.

Garcia, Angela. 2010. *The Pastoral Clinic: Addiction and Dispossession along the Rio Grande*. Berkeley: University of California Press.

Garro, Linda C., and Cheryl Mattingly. 2000. Narrative as Construct and Construction. In *Narrative and the Cultural Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro, 1-49. Berkeley: University of California Press. https://doi.org/10.1525/california/9780520218246.003.0001

Glasser, Irene. 2012. *The Anthropology of Addictions and Recovery*. Long Grove: Waveland Press.

Good, Byron J. 1994. *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.

Grof, Stanislav. 1975. *Realms of the Human Unconscious: Observations from LSD Research*. New York: Viking Press.

Guendelman, Sylvia, and Monica Jasis. 1992. Giving Birth Across the Border: The San Diego-Tijuana Connection. *Social Science & Medicine* 34(4): 419-425. https://doi.org/10.1016/0277-9536(92)90302-7

Halpern, John. 2007. Hallucinogens in the Treatment of Alcoholism and Other Addictions. In *Psychedelic Medicine*, edited by Michael J. Winkelman and Thomas B. Roberts, 1-14. Westport: Praeger.

Hänninen, Vilma, and Anja Koski-Jännes. 1999. Narratives of Recovery from Addictive Behaviours. *Addiction* 94(12): 1837-1848. https://doi.org/10.1046/j.1360-0443.1999.941218379.x

James, William. 1902. *The Varieties of Religious Experience: A Study in Human Nature*. London: Longmans, Green, and Co. https://doi.org/10.1037/10004-000

Johnson, Matthew W., Albert Garcia-Romeu, and Roland R. Griffiths. 2017. Long-term Follow-up of Psilocybin-facilitated Smoking Cessation. *American Journal of Drug and Alcohol Abuse* 43(1): 55-60. https://doi.org/10.3109/00952990.2016.1170135

Keane, Helen. 2002. *What's Wrong with Addiction?* New York: New York University Press.

Kirmayer, Laurence J. 1996. Confusion the Senses: Implications of Ethnocultural Variations in Somatoform and Dissociative Disorders for PTSD. In *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research, and Clinical Applications*, edited by Anthony J. Marsella, Matthew J. Friedman, Ellen T. Gerrity, and Raymond M. Scurfield, 131-163. Washington, D.C.: American Psychological Association. https://doi.org/10.1037/10555-005

Kleinman, Arthur. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.

Labate, Beatriz Caiuby, and Clancy Cavnar, eds. 2016. *Peyote: History, Tradition, Politics, and Conservation*. Santa Barbara: Praeger.

Labate, Beatriz Caiuby, Rafael Guimarães dos Santos, Brian Anderson, Marcelo Mercante, and Paulo César Ribeiro Barbosa. 2010. The Treatment and Handling of Substance Dependence with Ayahuasca: Reflections on Current and Future Research. In *Ayahuasca, Ritual, and Religion in Brazil*, edited by Beatriz Caiuby Labate and Edward MacRae, 205-227. London: Routledge.

Langlitz, Nicolas. 2012. *Neuropscyhedelia: The Revival of Hallucinogen Research Since the Decade of the Brain*. Berkeley: University of California Press. https://doi.org/10.1525/california/9780520274815.001.0001

Larkin, Michael, and Mark D. Griffiths. 2002. Experiences of Addiction and Recovery: The Case for Subjective Accounts. *Addiction Research and Theory* 10(3): 281-311. https://doi.org/10.1080/16066350211866

Leary, Timothy, Ralph Metzner, and Richard Alpert. 1964. *The Psychedelic Experience: A Manual Based on the Tibetan Book of the Dead*. London: Penguin Classics.

Lebedev, Alexander V., Martin Lövdén, Gidon Rosenthal, Amanda Fielding, David J. Nutt, and Robin L. Carhart-Harris. 2015. Finding the Self By Losing the Self: Neural Correlates of Ego-Dissolution Under Psilocybin.

Human Brain Mapping 36(8): 3137-3153. https://doi.org/10.1002/hbm.22833

Letcher, Andy. 2007. Mad Thoughts on Mushrooms: Discourse and Power in the Study of Psychedelic Consciousness. *Anthropology of Consciousness* 18(2): 74-97. https://doi.org/10.1525/ac.2007.18.2.74

Lotsof, Howard S., and Norma E. Alexander. 2001. Case Studies of Ibogaine Treatment: Implications for Patient Management Strategies. *The Alkaloids* 56: 293-313. https://doi.org/10.1016/S0099-9598(01)56020-4

Mash, Deborah C., Craig A. Kovera, Billy E. Buck, Michael D. Norenberg, Paul Shapshank, W. Lee Hearn, and Juan Sanchez-Ramos. 1998. Medication Development of Ibogaine as a Pharmacotherapy for Drug Dependence. *Annals of the New York Academy of Sciences* 844: 274-292. https://doi.org/10.1111/j.1749-6632.1998.tb08242.x

McIntosh, James, and Neil McKegany. 2000. Addicts' Narratives of Recovery from Drug Use: Constructing a Non-Addict Identity. *Social Science & Medicine* 50: 1501-1510. https://doi.org/10.1016/S0277-9536(99)00409-8

McKenna, Terence. 1991. I Understand Philip K. Dick. In *In Pursuit of Valis: Selections from the Exegesis-Philip K. Dick*, edited by Lawrence Sutin, 253-261. Novato: Underwood-Miller.

McKenna, Terence. 1994. *Language About the Unspeakable*. YouTube. Accessed November 20, 2017. https://www.youtube.com/watch?v=6hv_TPlmjkQ

McKim, Allison. 2017. *Addicted to Rehab: Race, Gender, and Drugs in the Era of Mass Incarceration*. New Brunswick: Rutgers University Press. https://doi.org/10.2307/j.ctt1pwtdfw

Millbank, Jenni. 2017. Exploring the Ineffable in Women's Experiences of Relationality with Their Stored IVF Embryos. *Body & Society* 23(4): 95-120. https://doi.org/10.1177/1357034X17733523

Mithoefer, Michael C., Mark T. Wagner, Ann T. Mithoefer, Lisa Jerome, Scott F. Martin, Berra Yazar-Klosinski, Yvonne Michel, Timothy D. Brewerton, and Rick Doblin. 2013. Durability of Improvement in Post-Traumatic Stress Disorder Symptoms and Absence of Harmful Effects or Drug Dependency After 3,4-methylenedioxymethamphetamine-assisted Psychotherapy: A Prospective Long-Term Follow-Up Study. *Journal of Psychopharmacology* 27(1): 28-39. https://doi.org/10.1177/0269881112456611

Noller, Geoffrey E., Chris M. Frampton, and Berra Yazar-Klosinski. 2018. Ibogaine Treatment Outcomes for Opioid Dependence from a Twelve-month Follow-up Observational Study. *American Journal of Drug and Alcohol Abuse* 44(1): 37-46. https://doi.org/10.1080/00952990.2017.1310218

Oberle, Alex P., and Daniel D. Arreola. 2004. Mexican Medical Border Towns: A Case Study of Algodones, Baja California. *Journal of Borderland Studies* 19(2): 27-44. https://doi.org/10.1080/08865655.2004.9695625

Pahnke, Walter N. 1969. Psychedelic Drugs and Mystical Experience. *International Psychiatry Clinics* 5(4): 149-162.

Pahnke, Walter N., and William A. Richards. 1966. Implications of LSD and Experimental Mysticism. *Journal of Religion and Health* 5(3):175-208. https://doi.org/10.1007/BF01532646

Pollan, Michael. 2018. *How to Change Your Mind: What the New Science of Psychedelics Teaches Us About Consciousness, Dying, Addiction, Depression, and Transcendence*. New York: Penguin.

Popik, Piotr, Richard T. Layer, and Phil Skolnick. 1995. 100 Years of Ibogaine: Neurochemical and Pharmacological Actions of a Putative Anti-Addictive Drug. *Pharmacological Reviews* 47(2): 235-253.

Rafalovich, Adam. 1999. Keep Coming Back! Narcotics Anonymous Narrative and Recovering-Addict Identity. *Contemporary Drugs Problems* 26: 131-157. https://doi.org/10.1177/009145099902600106

Raikhel, Eugene. 2015. From the Brain Disease Model to Ecologies of Addiction. In *Revisioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health*, edited by Laurence J. Kirmayer, Robert Lemelson, Constance A. Cummings, 375-399. Cambridge: Cambridge University Press. https://doi.org/10.1017/CBO9781139424745.018

Raikhel, Eugene, and William Garriott, eds. 2013. *Addiction Trajectories*. Durham: Duke University Press. https://doi.org/10.1215/9780822395874

Reith, Gerda. 2004. Consumption and Its Discontents: Addiction, Identity, and the Problems of Freedom. *British Journal of Sociology* 55: 283-300. https://doi.org/10.1111/j.1468-4446.2004.00019.x

Rodger, James. 2018. Understanding the Healing Potential of Ibogaine Through a Comparative and Interpretive Phenomenology of the Visionary Experi-

ence. *Anthropology of Consciousness* 29(1): 77-119. https://doi.org/10.1111/anoc.12088

Ross, Stephen, Anthony Bossis, Jeffrey Guss, Gabrielle Agin-Liebes, Tara Malone, Barry Cohen, Sarah E. Mennenga, Alexander Belser, Krystallia Kalliontzi, James Babb, Zhe Su, Patricia Corby, and Brian L. Schmidt. 2016. Rapid and Sustained Symptom Reduction Following Psilocybin Treatment for Anxiety and Depression in Patients with Life-Threatening Cancer: A Randomized Controlled Trial. *Journal of Psychopharmacology* 30(12): 1165-1180. https://doi.org/10.1177/0269881116675512

Savage, Charles. 1955. Variations in Ego Feeling Induced by D-Lysergic Acid Diethylamide (LSD-25). *Psychoanalytic Review* 42: 1-16.

Schafer, Roy. 1980. Narration in the Psychoanalytic Dialogue. *Critical Inquiry* 7(1): 29-53. https://doi.org/10.1086/448087

Schenberg, Eduardo Ekman, Maria Angélica da Castro Comis, João Felipe Morel Alexandre, Luís Fernando Tófoli, Bruno Daniel Rasmussen Chaves, and Dartiu Xavier da Silveira. 2017. A Phenomenological Analysis of the Subjective Experience Elicited by Ibogaine in the Context of a Drug Dependence Treatment. *Journal of Psychedelic Studies* 1(2). https://doi.org/10.1556/2054.01.2017.007

Schenberg, Eduardo Ekman, Maria Angélica de Castro Comis, Bruno Rasmussen Chaves, and Dartiu Xavier da Silveira. 2014. Treating Drug Dependence with the Aid of Ibogaine: A Retrospective Study. *Journal of Psychopharmacology* 28(11): 993-1000. https://doi.org/10.1177/0269881114552713

Schüll, Natasha Dow. 2014. *Addiction by Design: Machine Gambling in Las Vegas*. Princeton: Princeton University Press.

Sells, Michael A. 1994. *Mystical Languages of Unsaying*. Chicago: University of Chicago Press.

Sessa, Ben. 2012. *The Psychedelic Renaissance: Reassessing the Role of Psychedelic Drugs in 21st Century Psychiatry and Society*. London: Muswell Hill Press.

Sheppard, Simon G. 1994. A Preliminary Investigation of Ibogaine: Case Reports and Recommendations for Further Study. *Journal of Substance Abuse Treatment* 11(4): 379-385. https://doi.org/10.1016/0740-5472(94)90049-3

Shohet, Merav. 2007. Narrating Anorexia: 'Full' and 'Struggling' Genres of Recovery. *Ethos* 35(3): 344-382. https://doi.org/10.1525/eth.2007.35.3.344

Stark, Laura, and Nancy D. Campbell. 2018. The Ineffable: A Framework for the Study of Methods Through the Case of Mid-Century Mind-Brain Sciences. *Social Studies of Science* 48(6): 789-820. https://doi.org/10.1177/0306312718816807

Thornill, Hermione, Linda Clare, and Rufus May. 2004. Escape, Enlightenment, and Endurance: Narratives of Recovery from Psychosis. *Anthropology & Medicine* 11(2): 181-199. https://doi.org/10.1080/13648470410001678677

Tupper, Kenneth W., and Beatriz C. Labate. 2014. Ayahuasca, Psychedelic Studies, and Health Sciences: The Politics of Knowledge and Inquiry into an Amazonian Plant Brew. *Current Drug Abuse Reviews* 7: 71-80. https://doi.org/10.2174/1874473708666150107155042

Unger, Sanford M. 1963. Mescaline, LSD, Psilocybin, and Personality Change: A Review. *Psychiatry* 26(2): 111-125. https://doi.org/10.1080/00332747.1963.11023344

Vrecko, Scott. 2010. Birth of a Brain Disease: Science, the State, and Addiction Neuropolitics. *History of the Human Sciences* 23: 52-67. https://doi.org/10.1177/0952695110371598

Webb, Hillary S. 2011. The Use of Peyote as Treatment for Alcoholism Within the NAC Community. *Anthropology of Consciousness* 22(2): 234-244. https://doi.org/10.1111/j.1556-3537.2011.01051.x

Weil, Andrew T., and Wade Davis. 1994. Bufo Alvarius: A Potent Hallucinogen of Animal Origin. *Journal of Ethnopharmacology* 41: 1-8. https://doi.org/10.1016/0378-8741(94)90051-5

Winkelman, Michael. 2014. Psychedelics as Medicines for Substance Abuse Rehabilitation: Evaluating Treatments with LSD, Peyote, Ibogaine, and Ayahuasca. *Current Drug Abuse Reviews* 7: 101-116. https://doi.org/10.2174/1874473708666150107120011

Yaden, David B., Johannes C. Eichstaedt, H. Andrew Schwartz, Margaret L. Kern, Khoa D. Le Nguyen, Nancy A. Wintering, Ralph W. Hood, Jr., and Andrew B. Newberg. 2016. The Language of Ineffability: Linguistic Analysis of Mystical Experiences. *Psychology of Religion and Spirituality* 8(3): 244-252. https://doi.org/10.1037/rel0000043

JOURNAL *of*
EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 141-149 https://doi.org/10.5617.6722

Essay

Patient Is the New Black

Treatmentality and Resistance Toward Patientization

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Two promises prompt Norwegians addicted to heroin to join opioid substitution treatment (OST): the pharmaceutical promise of normality and the promise of social de-marginalization. The power of both promises has been strengthened by the liberating narrative of the Substance Treatment Reform of 2004. This reform transferred responsibility for treatment of addiction from social services to specialized health care and afforded patient rights to those diagnosed with opioid dependence. In addition to organizational, administrative, and financial changes, the reform bore significant moral undertones. In a testimony regarding the reform proposal, the Standing Committee on Labor and Social Affairs strongly encouraged the government to grant 'addicts' patient status as this would 'liberate [persons with substance "addiction"] from the degrading and stigmatizing [social] client stamp they have had' (Sosialkomiteen 2003). The social stigma of addiction became politicized in new, more explicit terms.

Health advocates, user activists, politicians, and researchers have adopted and repeatedly used the expression 'from client to patient' in various iterations ever since the reform was planned and came into force (Enghaug 2002; Skretting 2005; Stugu, Eilertsen, and Nordrik 2008). Drug users have applied this narrative of transformation not only to their rights, as informed of them, but also to their expectations of how professionals and the public should perceive people with drug related problems. This narrative, then, broadened their perceived space for creating new selves.

This redefinition of 'addicts' from clients to patients and of substance addiction and dependence from a solely social problem to a medical or quasi-medical issue is a deliberate political strategy (May 2001). The committee's recommendations expressed an explicit desire to construct a new identity, a patient identity. This redefinition, I argue, also reflects a desire to govern identities. What is at stake here is the logic of liberating 'them' by 'us.' 'We,' the policy makers and society, are replacing the label (social clients) that we previously *gave* to drug users with a new,

liberating label—*patients to be treated*. The key question is: What does this political desire tell us about our understanding of addiction and drug use?

In this essay, I challenge the ways in which global drug policy initiatives call for more humane drug policy and decriminalization. Although these initiatives promote human dignity and agency, they also encourage a particular approach to drug use and addiction. Embracing *patientism* in their liberating narratives of 'treatment, not punishment,' these voices take for granted the advantages of their proposed approach (Mol 2008). Drawing on my experiences with Norwegian OST, I illustrate patients' engagement and resistance towards the politically hyped social categories and ask how we can understand this socio-political desire for a narrative transformation.

'I'm not a Patient'

Anne, Brit, Sofie, and I were having lunch, taking a break from a meeting. Anne and Sofie were OST patients, and Brit's son was in OST. They had met to help Brit file a complaint to the County Medical Officer on behalf of her son. During earlier discussions, I had noticed that Sofie constantly used the term 'OST client' (*LAR-klient*), a clear contrast to the post-reform narrative which focuses on patientization of drug users and the language used to describe and address them. Sofie's use of the word 'client' caught my attention because in many other instances my other interlocutors had stressed that they were 'not clients anymore' and had reiterated their patient status, which was emphasized throughout OST arenas: clinical, legal, and political. The image and experience of the 'stigmatizing client stamp' thus ran deeply both among the users and the professional actors around them.

Well into the conversation, Anne responded to one of the consultation stories Sofie shared: 'Yeah, because you are a patient, just like anyone else.' Sofie responded quickly, 'I'm not a patient!', adding proudly, 'I am a client.' I could not help but ask her about this. I admitted that I had been long pondering her linguistic choices because most people I had spoken to were not eager to refer to themselves as 'clients'. When I shared my thoughts, Anne retorted:

> Anne: No, no. I am not any client. I am a patient, with patients' rights. I have a job and I am not a social [service] client.
>
> Sofie: But I am not sick. I receive a service from the OST. If I break a leg, I go to the hospital, and then I am a patient. Now I am perfectly fine. I am a service receiver. A client. They will not make me be sick.
>
> Anne: OK, but a client ... I do not want to be called a 'client.' It sounds ... you know ... 'oh, these social clients.'

> Sofie: Maybe it is because I have never been a social client, so it doesn't sound like that to me.

Both Anne and Sofie referred to the circulating social meanings of roles and labels: clients, patients, service receivers, and customers. I acknowledged that Sofie made an important point here. Not only did she describe herself as a 'client', but she also did so proudly – an unusual combination among my interlocutors. She used the term client in the context of 'customer/consumer', which emphasized her independence, even as she distanced herself from the 'needy' drug dependent users often associated with 'social clients'. On the other hand, she drew a distinction between a sick patient and a person with opiate dependence. Fraser and Valentine studied the associative relationship between drug dependencies and dependency on the welfare state, highlighting the representation of OST patients as 'dependent, passive and otherwise problematic' (Fraser and Valentine 2008, 15). Their work relates to Australia, but as they have suggested, their remarks are relevant to other liberal democracies characterized by:

> a marked upswing in the rhetorical and political organization of certain kinds of people as 'dependent'. [Methadone maintenance treatment] clients are recipients of health services and, as such, very much affected by changes to health policy and the provision of public services. They are also classified, by definition, as 'dependent' and so occupy an invidious relationship to the normative 'participating' worker citizen and proper liberal subject. Treatment clients often spend some time out of the formal labour force and so their status as dependent is multiple: both welfare dependent and drug dependent, they are doubly excluded from the imaginary communities of the 'reformed' welfare state (Fraser and Valentine 2008, 13).

The conversation between Anne and Sofie mirrors these associations and the women's idiosyncratic experiences with them. We understand that names and social categories matter, but they mean different things to different people. Highlighting these differences gives us a better understanding of the processes of identity formation as well as of responses to the policies aimed at governing identities. For Anne, becoming a patient was a kind of social upgrade with the possibility of participating in the broader community of normal sick citizens. She needed that status in order to break with the role of a social client, and it gave her new narrative resources to speak of herself and engage in social relations. She internalized the liberating narrative, and she was not a client *anymore.* Sofie, on the other hand, resisted the patient identity. As she had never experienced the stigma of being (called) a social client, she did not need the new label. Sofie came from a wealthy family, and after joining the OST, she developed a network of friends and family outside the illicit drug scene. She continued her relatively wealthy, mainstream life, and only the weekly pickups of methadone at the pharmacy kept her 'out of the loop'. She did not see patientization as the way to social normalization, to the con-

trary. For Sofie, being regarded as a chronic patient interfered with her idea of normality, a narrative she experienced as disabling.

Normal Deviants

These examples show that people have different reasons to accept or resist the transformation narratives that policy makers, user advocates, and professionals may offer. Those interlocutors who welcomed patientization perceived being a patient as a social norm and a way to be included and to normalize their lives. The increasing medicalization and pathologization of human behavior facilitate this logic (Parsons 1951; Freidson 1970; Zola 1972; Conrad and Schneider 1992). From that perspective, being sick is regarded as within the range of social normality. While 'addicts' represent a social deviance, 'patients' represent a standard. The redefinition of addiction/dependence—and people with those conditions—in medical patient terms produces the expectation of being a 'normal deviant' or representing a culturally accepted deviance. For my interlocutors who previously had felt excluded from the narrative benefits of patients, this socio-political relabeling functioned as a welcome mechanism of 'de-othering'.

Figure 1. Drug Users Day 2012 (Stoffbrukerdagen 2012), Oslo. ©Daniel Gihlemoen.

Annemarie Mol, ethnographer and philosopher, introduced the idea of *patientism* as a common human condition (Mol 2008). The concept of patientism suggests that patients living with disease can constitute a standard rather than a divergence from a standard. The concept 'does not seek equality between "patients" and "healthy people," but tries to establish living with a disease, rather than "normali-

ty" as the standard. It stresses that it is our common condition that from dust we come and to dust we shall return' (Mol 2008, 31). Drawing on feminism, Mol points to narratives of emancipation that follow patientism. To be allowed to be like other patients was the greatest wish of my interlocutors. Many of them said or wrote: 'we should be treated like other patients,' 'we are patients like any other patient,' and 'we are patients like anyone else' (Bartoszko 2018). According to Mol, 'citizenship is a way of celebrating autonomy, [while] patientism is about exploring ways of shaping a good life' and 'exploring how a good life may be lived is, just like diabetes, chronic' (Mol 2008, 41). I agree with Mol to some extent. As I have shown, patientism in the field of substance addiction has much to do with celebrating autonomy by breaking with the old roles and lauding the logic of choice and patients' rights. But patientism among people with drug addiction is also a consequence of *treatmentality*. Let me explain.

Treatmentality

In contrast to empirical examples indicating that not everybody wants or needs to become (or be called) a patient (see also Frank 2017), patientization is taken for granted in the liberating, homogenizing narrative of the Substance Treatment Reform. Besides the 'from client to patient,' another mantra of the reform was 'from Plata to Rikshospitalet', with Plata being an open drug scene near Oslo's main train station frequently visited by law enforcement agents and Rikshospitalet a national hospital. The transformation narrative is mirrored in that geographical metaphor. This logic of liberation through patientization is even more vivid in the current Norwegian drug policy, influenced by recent global calls to change the paradigms and approaches to drug use and addiction. In 2016, the Norwegian government introduced a nationwide judge-led program in which the courts may sentence convicts with addiction to treatment programs instead of imprisonment. Politicians were quick to describe the program in positive terms, reinvigorating the reform's official narrative. In reference to people with addiction *and* non-problematic illicit drug use, 'sick' became the new buzzword in the daily press and in political debates. Hadia Tajik, chair of the Standing Committee of Justice and member of Parliament for the Labor Party, said with her party colleagues that: 'We have to understand that people with strong drug addiction are patients, not criminals' (Tajik et al. 2016). The Minister of Health and Care Services (the Conservative Party) Bent Høie broadened the medical approach to encompass *all* users of illicit drugs: 'Follow-up of those taken for use of narcotics should be moved from the juridical system to health care [...]. The use of narcotics is first and foremost a health problem' (Høie 2016). Being a patient and regarded as sick is presented as *an alternative* to being a criminal – as if it were natural and good to be a patient. This illustrates how deeply treatmentality has penetrated the cultural models for understanding substance use and addiction.

In his theorizing about treatment for drug users, the anthropologist Steffen Jöhncke asked:

> Which is the better way to handle the users of illegal drugs in civilized society—to regard them as criminals and punish them for their misbehaviour and the ills they cause to themselves and to the rest of society, or to regard them as patients suffering from a [*sic*] uncontrollable habit or urge, and addiction to mind-altering drugs for which they need to be treated? (Jöhncke 2009, 14).

He concluded that given this choice, 'most people who consider themselves knowledgeable in these matters … would opt for the latter alternative: *treatment*' (Jöhncke 2009: 13). Precisely this choice is at the core of the increasing global acceptance of the medical approach to drug use that produces narratives of 'the good of treatment' and 'the evil of punishment.'

This is the polarized landscape in which the patients I met found themselves and that they were trying to navigate. The treatment, pharmaceutical or not, had become an assumption, taken for granted as the culturally and morally preferred solution to drug use and addiction. Jöhncke's main point is that 'the idea and practice of treatment govern what it is possible for all of us to think and say about drug use ... Treatment is such a brilliant idea and such an attractive promise that we no longer imagine the world without it' (Jöhncke 2009, 15). He called this governing function treatmentality. Inspired by the Foucauldian concept of governmentality (Foucault 1991), the term refers to 'the sheer obviousness of drug use treatment as a cultural and social institution that is placed beyond our questioning and that, therefore defines in important ways the limits of our understanding of drug use as a social phenomenon' (Jöhncke 2009, 17). Jöhncke considered addiction treatment as 'an institution in the more general, cultural sense—i.e., as a particular and relatively stable ideological formation in our conception of the world' (Jöhncke 2009, 16). In this sense, what treatment does is a secondary phenomenon, because as Jöhncke asks, 'What else would you do?' I ask: What other forms of inclusion can we imagine for people with addiction other than making them patients?

(No) Place for New Labels

This limited conceptual form of managing both drug use and drug users shaped the way my interlocutors related to the status of being patients. The policy change, which aimed at facilitating new identities or 'making up new people', in Hacking's words (Hacking 1985), was a reaction to the established management of drug addiction and the stigma surrounding social clients *and* criminals. The socio-historical context of the Substance Treatment Reform and patients' rights appeared to be significant in the OST patients' self-definition and understanding, and patient status had no value in itself. To understand the variation in internalization of the patient discourse and, thus, the power of policy to influence or produce new identities, it is crucial that we look at other alternatives people have or do not have. My interlocutors engaged with patient status in the context of these alternatives. For them, becoming a patient was much more than health, sickness, and the restora-

tion narrative. The desire for de-clientization, de-stigmatization, and pharmaceutical and social de-othering was as significant as becoming 'healthy'. As Thomas, a 40-year-old OST patient, said regarding the challenges with OST: 'You just have to accept it, otherwise the alternatives are bad.'

At the same time, resistance towards patientization reveals, not for the first time, that socio-political innovations disregard the lifeworlds and subjectivities of people they address. Policy makers, activists, and scholars tend to replace one label with another in the hope of changing social reality. In the process, they often end up fetishizing the inventions while neglecting the continuities of structural logics and social control. The political desire to regulate drug use and drug users by patientization and treatmentalization highlights this. As such, the ambition of designing new identities—the patients—fails in its attempt of liberating the 'addicts' as it does not consider why, and if, the 'addicts' desire for such liberation or specific defined social inclusion in the first place.

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References

Bartoszko, Aleksandra. 2018. From hope to §3-1: Legal selves and imaginaries in the wake of substance treatment reform in Norway. Journal of Legal Anthropology 2(1): 1-25. https://doi.org/10.3167/jla.2018.020102

Conrad, Peter, and Joseph W. Schneider. 1992. Deviance and Medicalization: From Badness to Sickness. Philadelphia: Temple University Press.

Enghaug, Pål. 2002. Rusmisbrukere kan få pasientrettigheter. [Addicts Can Receive Patients' Rights] Aftenposten, January 11. Accessed December 2017. https://www.aftenposten.no/norge/i/PpJx7/rusmisbrukere-kan-faa-pasientrettigheter

Foucault, Michel. 1991. 'Governmentality.' In The Foucault Effect: Studies in Governmentality, edited by C. Gordon G. Burchell and P. Miller, 87-104. London: Harvest/Wheatsheaf.

Frank, David. 2017. '"I Was Not Sick and I Didn't Need to Recover": Methadone Maintenance Treatment (MMT) as a Refuge from Criminalization.' Substance Use & Misuse 2: 311-322. https://doi.org/10.1080/10826084.2017.1310247

Fraser, Suzanne, and Kylie Valentine. 2008. Substance and Substitution: Methadone Subjects in Liberal Societies. Basingstoke, England: Palgrave Macmillan.

Freidson, Eliot. 1970. Profession of Medicine: A Study of the Sociology of Applied Knowledge. New York: Dodd, Mead & Co.

Hacking, Ian. 1985. Making Up People. In Reconstructing Individualism, edited by T. L. Heller, M. Sosna and D. E. Wellbery, 161-171. Stanford, CA: Stanford University Press.

Høie, Bent. 2016. 'Hjelp, ikke straff, narkotikabrukere.' [Support, Not Punish Drug Users] Dagbladet, October 5. Accessed October, 5, 2016. https://www.dagbladet.no/kultur/hoie-hjelp-ikke-straff-narkotikabrukere/63942984

Jöhncke, Steffen. 2009. 'Treatmentality and the Governing of Drug Use.' Drugs and Alcohol Today 9(4): 14-17. https://doi.org/10.1108/17459265200900036

May, Carl. 2001. 'Pathology, Identity and the Social Construction of Alcohol Dependence.' Sociology 35(2): 385-401. https://doi.org/10.1177/S0038038501000189

Mol, Annemarie. 2008. The Logic of Care: Health and the Problem of Patient Choice. London: Routledge. https://doi.org/10.4324/9780203927076

Parsons, Talcott. 1951. The Social System. London: Routledge & Kegan Paul.

Skretting, Astrid. 2005. 'From Client to Patient.' Nordic Studies on Alcohol and Drugs 22, supplement no. 1: 167-173. https://doi.org/10.1177/145507250502201S06

Sosialkomiteen. 2003. Innst. O. nr. 4 (2003-2004) Innstilling fra sosialkomiteen om lov om endringer i lov 13. desember 1991 nr. 81 om sosiale tjenester mv. og lov 2. juli 1999 nr. 61 om spesialisthelsetjenesten m.m. (Rusreform II og rett til individuell plan). [Hearing comment from the Social Committee regarding Substance Treatment Reform]. Oslo: Sosialkomiteen. Accessed

July 15, 2012. https://www.stortinget.no/no/Saker-og-publikasjoner/Publikasjoner/Innstillinger/Odelstinget/2003-2004/inno-200304-004/?lvl=0

Stugu, Stein, Roar Eilertsen, and Bitten Nordrik. 2008. Når de svakeste taper [When the Weakest Lose]. Oslo: De facto Kunnskapssenter for fagorganiserte.

Tajik, Hadia, Torger Micaelsen, Kari Henriksen, and Ruth Grung. 2016. 'Syke rusavhengige hører hjemme i helsevesenet.' [Ill Addicts Belong in Health Care] Dagbladet, February 23. Accessed February 24, 2016. https://www.dagbladet.no/kultur/syke-rusavhengige-hoslashrer-hjemme-i-helsevesenet/60158475

Zola, Irving Kenneth. 1972. 'Medicine as an Institution of Social Control.' The Sociological Review 20(4): 487-504 https://doi.org/10.1111/j.1467-954X.1972.tb00220.x

JOURNAL *of*
EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 150-160 https://doi.org/10.5617.6924

Essay

Recovery in the US 'Opioid Crisis'

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Dave, a Euro-American man in his early 30s and a newly admitted resident at Sunrise[1] drug treatment center, could not escape thoughts of death as we sat in a cold, dim group therapy room in the winter of 2014. 'If I use, I will die, because I OD'd seven times. If I don't quit, I will *die*,' he told me. 'I wanna live a little longer,' he continued, 'I just gotta do it right. It's not an option.' Dave entered treatment devastated by the recent heroin overdose death of his mother. The loss intensified his conviction to save his own life by making the 'right' treatment choices. Yet treatment at Sunrise was far from straightforward; it was filled with contradictions and ambivalence intensified by the recent rise in opioid use and overdose death.

Addiction and its treatment are now central concerns in the United States. In the last decade, public concern has mounted with the highly publicized opioid overdose deaths of socially privileged individuals. The spectacles of suburban White prom queens in recovery, parents overdosing in cars with children present, and 'mobile morgues' used to manage the overwhelming number of dead bodies have escalated moral panic surrounding what is now commonly referred to as the 'opioid crisis.' In 2017, the *National Academies of Sciences, Engineering, and Medicine* released a report on opioid use, stating:

> Not since HIV/AIDS epidemic has the United States faced as devastating and lethal a health problem as the current crisis of opioid misuse and overdose … Current national trends indicate that each year more people die of overdoses—the majority of which involved opioid drugs—than died in the entirety of the Vietnam War, the Korean War, or any armed conflict since the end of World War II. (NAS 2017, 187).

[1] The center and all resident and staff names are pseudonyms to protect participant confidentiality. This research protocol was approved by the Case Western Reserve University Institutional Review Board.

The magnitude of the problem is reflected in stark figures. From 2000 to 2014, the opioid-related overdose death rate increased by 200 percent (Rudd et al. 2016).

Carr, in a commentary in this special issue, challenges us to critically examine what is produced when we frame opioids in the language of 'crisis.' Crisis, she writes, demands a certain temporality—an urgency—in which there is, 'No time for deliberation,' we must, 'do now, think later. This or that. Right or wrong. Yes or no' (Carr 2019, 2). What, she asks, is foreclosed and inspired by thinking of opioids through the lens of crisis?

In this essay, I draw on in-depth ethnographic research conducted in and around Sunrise, a treatment center located in a US state that has been characterized as the 'overdose capital of America' (Soboroff 2017), from 2014 to 2015. Inspired by Carr's call to question the work of 'crisis,' I explore the meanings, experiences, and stakes of recovery for Sunrise residents in the context of the 'crisis.' The urgency to intervene in the 'opioid crisis,' I will argue, intensifies the stakes and dilemmas of treatment for individuals like Dave, who are attempting to recover the 'right' way under the threat of death. This urgency exacerbates tensions between co-existing, and often contradictory, biomedical and 12 Step models of recovery rooted in disparate ways of framing the role of medications and relapse in recovery.

Recovery is often an unquestioned good, yet it is an inconsistent construct. Questioning recovery presents a unique opportunity to examine lived experiences that are occluded by interventions undertaken under the urgency of a 'crisis.' In critiquing the very concept of recovery and illuminating lived experiences of it, I hope to create space to imagine alternative models.

What Is Recovery? Biomedical and 12 Step Models

Under the impetus to intervene in response to the 'opioid crisis,' a so-called 'gentler approach' to the War on Drugs has emerged. This approach emphasizes a biomedical model of addiction as a 'chronic, relapsing brain disease' (McClellan 2002). It draws on a definition of addiction as a disease of dysfunctional neurological circuits responsible for reward, motivation, and memory (ASAM 2011) and promotes the use of Medication Assisted Treatment (MAT) that is purportedly blameless and designed for the promotion of public health and social integration versus surveillance and punishment (Hansen 2017; Netherland and Hansen 2016).

Yet this 'gentler' approach exists uneasily alongside the 12 Step model of recovery that has been the foundation of treatment in the US since the mid-20th century (Valverde 1998). In the 12 Step model, addiction is understood as a 'spiritual disease.' The goal of recovery is abstinence from all 'mind altering substances' achieved through adopting a primary identity as an 'addict,' accepting powerlessness over alcohol and other drugs, and progressing through a series of spiritual and pragmatic steps of self-transformation with the support of peers. Twelve Step

meetings, the central platform of this mode of recovery, are organized around social acceptance and mutual exchange of personal experiences. In meetings, participants share their most stigmatized experiences of drug use and its costs, as well as everyday struggles, in a community of peers who are expected to provide non-judgmental support. The use of MAT medications, such as methadone and buprenorphine, however, has traditionally been considered continued drug use in the 12 Step recovery community, and individuals who take these medications risk stigmatization as they may be seen as 'dirty,' 'active users.'

As opioid use and overdose has intensified, policymakers, scholars, and activists have advocated for the use of MAT, with increasing urgency (Volkow et al. 2014; NAS 2019). With this shift, biomedical and 12 Step interventions increasingly coexist in the same therapeutic landscapes, presenting individuals in treatment with double-binds: How does one recover when its very meaning is contested? By accepting MAT and faithfully taking one's medications? By eschewing pharmaceutical treatment for a life free of 'all mind-altering substances,' focusing on self-transformation through 12 Steps practices? How does one navigate these contrasting models in social settings steeped in death, where no less than one's life is at stake?

Recovery in the Shadow of Death

Each day at Sunrise, residents[2] attended group sessions including lectures and discussions on the neurological, psychological, and social dynamics of addiction. While multiple models of addiction were presented, the 12 Step model had long been the program's foundation. Twelve Step is particularly significant at Sunrise because it is located near the birthplace of Alcoholics Anonymous (AA), not far from where the first meetings took place. There is strong local pride in 'the program.' All residents were required to participate in several onsite 12 Step meetings daily, and offsite meetings several evenings a week.

Twelve Step offered participants much sought-after social inclusion. Many residents became intensely involved in 12 Step recovery, finding social connection that seemed out-of-reach as they felt judged by and excluded from mainstream society, and socially isolated by the loss of friends, family members, and peers to overdose. At 12 Step meetings, residents often remarked that they recognized themselves in the 'war stories' of alcohol/drug use told by their peers (Singer et al. 2001). They admired 12 Step group members who had been 'clean and sober' for 20-, 30-, 40-years. They were comforted by often-repeated mantras: 'There is a solution,' 'One day at a time,' and 'I just need to not put one [alcoholic drink/drug] in me.' At the best meetings, they felt emotional warmth, elusive love, and social acceptance.

Knowledge derived from direct experience among members of the 12 Step community garnered precious social status elusive to 'addicts.' Experience generated

[2] While most administrators encouraged use of the term 'patient' to promote the biomedical addiction model, the majority of treatment staff and individuals in treatment used the term 'resident.' In this essay, I adopt the most commonly used term 'resident.'

authority that competed, and largely outweighed, biomedical authority on matters of recovery. Residents often saw the 'experience, strength, and hope' (a common 12 Step mantra) of 12 Step members as more convincing evidence that a life worth living is attainable compared to biomedical explanations. This significantly challenged biomedical explanations of recovery delivered by treatment professionals, focused on individual brains and behavior change, and MAT adherence. MAT remained controversial in treatment, as it was viewed by staff, peers, and 12 Step recovery fellows as continued problematic drug use. Yet many residents were on MAT[3], often at the urging of judges and parole officers. They were often ambivalent about their medication use due to concerns that they would be stigmatized as being 'dirty' and using MAT as a 'crutch.'

Risk, Relapse, and Certain Death

Death loomed over this tense therapeutic setting. As opioid-related overdose death rose sharply in the region, reporting the number of overdoses residents survived became common practice when introducing oneself to the therapy group: 'once, and never again,' (Tina), 'five times,' (Aaron), 'seven,' (Dave), 'I've lost count' (Linda). In formal and informal group discussions, residents recounted near death by overdose, overdose deaths of intimate others, and fears of relapse (i.e., returning to alcohol/drug use), which was increasingly framed by residents, treatment staff, and members of the local 12 Step recovery community as inevitable death. In Dave's words: 'If I don't quit, I will *die*.' Residents came to understand themselves as perpetually at risk of death.

How do individuals understand their risk of relapse—and by extension, overdose death—in the urgency of the 'opioid crisis' when contrasting biomedical and 12 Step models of recovery co-exist? Rose asks scholars to think diagnostically about risk: 'To ask where risk thinking has emerged (in which problem field?); how it has emerged (in relation to what knowledge and expertise?); and with what consequences (under new technologies of power and relations of authority, what new ethical dilemmas are generated?)' (Rose 2002, 214). How can we think diagnostically of risk in relation to recovery and its contradictions intensified by the 'opioid crisis'?

In the biomedical model, relapse is understood as rooted in biological craving, with the addicted brain hypersensitive to drug-related stimuli (Vrecko 2016). Relapse is a chronic risk to be expected; an accepted, if unfortunate, part of a chronic disease process that is managed pharmaceutically. In the 12 Step recovery model, relapse is also understood as an ongoing threat, but one that is to be avoided through 12 Step recovery processes of self-transformation. Relapse is explained as failure to 'work a good [12 Step] program'; if one follows the dictates of the program, they will avoid relapse. As members of the 12 Step community say, 'the

[3] MAT was dosed at an off-site clinic administered by the same organization that operates Sunrise.

program is perfect' (Christensen 2017). Residents who adopted the 12 Step recovery model often repeated the phrase, 'relapse is not a part of *my* recovery,' challenging the biomedical model of recovery and positioning themselves in opposition to it.

Rally for Recovery at the Ohio Statehouse on September 29, 2017, Columbus, Ohio. Image credit: Karen Kasler, Statehouse News Bureau, Ohio Public Radio and TV.

Treatment staff also challenged biomedical framings of recovery, adding to residents' ambivalence toward it. As we discussed the recent rise in people seeking services related to opioid use, Derrick (African American man, 40s), a case manager[4], clearly described his belief that relapse is a *failure* to recover:

> Derrick: I think the treatment needs to be precise and definite. Needs to be corrective. It has to be immediately corrective. It can't be, 'Okay. We're gonna play this out. We're gonna play this out. We're gonna play this out.' You play it out, play it out, play it out, because then you have a constant stream of individuals who utilize [services].
>
> Allison: What do you mean by that?

[4] While many Sunrise case managers identify as 'in recovery' following the 12 Step model, Derrick did not.

> Derrick: You can play it out because you don't have to be—maybe it doesn't get corrected this time. It gets corrected on the fourth time. Ain't really a sense of urgency. Again, it's based on the individual. If it's serious to you, it's gonna happen. I don't believe that relapse is part of the recovery process, personally.
>
> Allison: You don't?
>
> Derrick: No [*firm tone*]. It's the relapse process. It's a failure to recover.

Derrick's comments reflect a stance toward relapse common among treatment staff, many of whom critique the acceptance of it in the chronic brain disease model. Recovery, in their view, should not include relapse. If you are 'serious,' you will not return to drug use.

In discussions among residents and staff at Sunrise, in 12 Step meetings, at the MAT clinic, and in everyday social life outside of treatment, relapse became a lightning rod for the politics of recovery. Residents carefully negotiated their allegiance to 12 Step and biomedical models to position themselves socially. These negotiations were framed by tensions between how the two models regard the role of medications and relapse in recovery.

Navigating Competing Models of Recovery

Residents attempted to negotiate 12 Step and biomedical models in this high-stakes and morally-charged therapeutic context, yet their engagement with these models was ambivalent. Many sought MAT as treatment staff and peers framed medications as the most effective way to manage cravings and prevent relapse. Other peers and staff adherent to the 12 Step model, however, challenged relapse as a part of recovery. To manage cravings, they promoted stronger adherence to the 12 Steps instead of medications.

Rather than choose either 12 Step or biomedical models of recovery, most residents attempted to engage both. Dave, who was sure he would die if he did not 'do it [recovery] right,' became a vocal proponent of 12 Step recovery and also went on MAT (methadone). By the time he entered Sunrise, he had lost all but one family member to drug-related deaths. He was court-mandated to treatment, and his parole officer (PO) strongly suggested he go on MAT. Dave described 'intense cravings' in his early days in treatment: vivid dreams in which he injected heroin and repetitive thoughts and sensations of injecting that were constant reminders of his risk of relapse. They further influenced him to begin MAT, which he saw as 'life-saving.'

Yet Dave was also highly critical of MAT, especially at doses he believed induce euphoria associated will illicit drug use. He suspected other residents were 'drug

seeking': attempting to use MAT to 'get high.' Dave was careful to distinguish himself from these individuals who were socially marginalized in treatment as they visibly struggled to remain awake in groups due to sedation attributed by residents and staff to MAT (Schlosser 2018). Instead of viewing methadone as a 'drug,' Dave re-framed it as a 'medication' taken to avoid any chance of return to illicit drug use. In this way, he constructed his MAT use as consistent with the 12 Step belief that recovery excludes relapse. For Dave, both the 12 Steps *and* medications were necessary. 'I'm gonna use every tool in my toolkit,' he told me, 'but I'm not going to be on it [methadone] forever.' He often made this assertion in group sessions and research interviews, reflecting his ambivalence about the treatment and fear that he would be tethered to the MAT clinic for life.

Dave also took an active role in the 12 Step recovery community. He attended both AA and Narcotics Anonymous (NA) groups, but quickly focused his participation on AA as these groups had a reputation for being comprised of individuals of higher socioeconomic status with longer periods of abstinence from alcohol, and other drug use. 'They have what I want,' he explained. In the absence of kin, Dave relied on what he called his 'AA family' to weather the stresses of treatment and life after leaving the center. He grew up in a working-class family that tipped into poverty with the loss of local manufacturing jobs, and his lack of higher education and felony record limited his ability to access formal work. His AA sponsor gave him under-the-table construction work he desperately needed to pay transitional housing fees and bus fare to the MAT clinic post-treatment. Other AA members took Dave fishing to ease his anxiety from days filled with trips to the MAT clinic, appointments with his PO, and anxiety-inducing empty time.

Yet his acceptance in this community that he relied on for social, emotional, and instrumental support was tenuous due to his use of MAT. Dave carefully navigated his engagement with biomedical and 12 Step recovery models to access the support offered by 12 Step participation, and the medication he viewed as lifesaving. He negotiated a fine line in his mind, and within the Sunrise and broader 12 Step communities, between MAT as relapse preventive and MAT as illicit drug use.

This tenuous position led Dave to hide his MAT use from his 12 Step recovery network, fearing judgment. While he was able to re-frame his methadone as 'medication' in his own mind, he did not attempt to do this within the social world of 12 Step recovery. He does not lie about it, he explained, but does not discuss it either. This comes at a psychic cost because by withholding this information Dave is breaching the central AA decree to be fully 'honest' in recovery. 'The secrets keep you sick,' is often said in 12 Step recovery circles. But Dave tells me he will do 'anything that keeps me off the needle.'

How Does One Recover? Imagining Alternative Models

In the moral panic swelling with the rise in opioid-related overdose death, and the language of 'crisis' framing the problem, biomedical intervention is promoted with

ever-greater urgency. Yet biomedicine is no all-powerful monolith. It takes shape in particular socio-historical moments, in local communities, and in lives with unique histories and stakes. It intersects with extant and longstanding models for understanding the meanings 'addiction' and 'recovery.' It is delivered through a fractured treatment system and broader cultural context that continues to divide individuals along moral lines of 'clean' or 'dirty,' and place substances in contested categories of 'drug' or 'medicine.'

What is uncovered by examining this urgent response from the ground up, contextualizing it in the everyday lives of individuals who must live in and through the 'crisis' at hand? Experiences of Dave illustrate how individuals subject to distinct and contradictory recovery discourses engage multiple models at once within a system that inconsistently promotes and discourages them. Residents were positioned, and positioned themselves, in relation to these models in ways that shaped their standing within the communities that matter most to them—families, friends, and peers—as well as in relation to powerful institutions with power to grant them freedom from incarceration and access to essential resources. Residents like Dave initiated MAT to live in the wake of the deaths of loved ones, easing fear that they would meet the same end, yet largely hid their treatment from 12 Step recovery communities to maintain longed-for belonging in these social worlds in which they could find rare social acceptance. All the while, they struggled under the affective burden of the largescale panic of the 'opioid crisis,' and an uncertain path to recovery.

These experiences provide a window into the ways in which various models of recovery are entwined with everyday politics. They reflect the fluid and fraught distinction between 'bad' drugs and 'good' medicines, which scholars have long critiqued as socially-mediated categories defined in particular social, cultural, and political-economic contexts (Montagne 1996; Singer 2008). The dynamics the body of ethnographic research highlighting how lived experiences of (il)legal drug use defies the social categorization of these substances (Bourgois 2000; Fraser and Valentine 2008; Luhrmann 2010; Schlosser and Hoffer 2012). This knowledge is critical and is enabled by time for deliberation and careful consideration that 'crisis' may preclude.

I have attempted to suspend an understand of opioids as 'crisis' to delve deeper into the meanings and local articulations of recovery, the moral good of which is often taken-for-granted. By ethnographically tracing the cracks in recovery in local treatment landscapes, anthropologists have the opportunity to resist the ways in which this concept may obscure the voices and subjectivities of individuals most affected by the problem. I hope to have contributed to this work by throwing the meaning of recovery into question and contextualizing its expression in a community where opioid use and overdose death weighs heavily.

Questioning recovery lays essential groundwork for imagining alternatives obscured in the urgency to respond to the 'crisis.' Perhaps intervention in the context

of recovery is not the answer. Perhaps there are alternative spaces more suited to supporting the social inclusion and moral recognition desired by individuals labelled 'addicts.' Can we, as anthropologists of the extreme, resist the moral panic of the 'opioid crisis' to find and foster such alternative spaces?

Acknowledgements

I thank Sunrise staff and residents, who generously shared their lives with me to make this research possible. I am grateful for the dedicated mentorship of Drs. Lee Hoffer, Atwood Gaines, Eileen Anderson-Fye, and Susan Hinze, whose constructive feedback strengthened this scholarship. This research was supported by a National Science Foundation Doctoral Dissertation Research Improvement Grant (Behavioral and Cognitive Sciences Division) [#1324263] and several Case Western Reserve University fellowships, including: College of Liberal Arts and Sciences Writing Fellowship, Baker-Nord Center for the Humanities Graduate Research Grant, Richard A. Zdanis Graduate Research Fellowship Award, and Social Justice Institute Graduate Research Fellowship.

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References

American Society of Addiction Medicine [ASAM]. 2011. Definition of Addiction. Accessed June 1, 2018. https://www.asam.org/resources/definition-of-addiction

Bourgois, Philippe. 2000. 'Disciplining Addictions: The Bio-politics of Methadone and Heroin in the United States.' Culture, Medicine, and Psychiatry 24: 165-195. https://doi.org/10.1023/A:1005574918294

Carr, E. Summerson. 2019. 'The Work of "Crisis" in the "Opioid Crisis."' Journal of Extreme Anthropology Online First 2019, 2535-3241. https://doi.org/10.5617/jea.6851

Christensen, Paul. 2017. 'The Program is Perfect: Narcotics Anonymous and the Managing of the American Addict.' Medical Anthropology Theory 4(5): 23-45. https://doi.org/10.17157/mat.4.5.319

Fraser, Suzanne, and Kylie Valentine. 2008. Substance & Substitution: Methadone Subjects in Liberal Societies. New York, NY: Palgrave Macmillan.

Hansen, Helena. 2017. 'Assisted Technologies of Social Reproduction: Pharmaceutical Prosthesis for Gender, Race, and Class in the White Opioid "Crisis."' Contemporary Drug Problems 44(4): 321-338. https://doi.org/10.1177/0091450917739391

Luhrmann, Tanya M. 2010. 'Medication on the Street: Homeless Women in Uptown Chicago.' In Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology, edited by Janis H. Jenkins, 161-186. Santa Fe, NM: School for Advanced Research Press.

McClellan, A. Thomas. 2002. 'Have We Evaluated Addiction Treatment Correctly? Implications from a Chronic Care Perspective.' Addiction 97(3): 249-252. https://doi.org/10.1046/j.1360-0443.2002.00127.x

Montagne, Michael. 1996. 'The Pharmakon Phenomenon: Cultural Conceptions of Drugs and Drug Use.' In Contested Ground: Public Purpose and Private Interest in the Regulation of Prescription Drugs, edited by Peter Davis, 11-25. New York: Oxford University Press.

National Academies of Sciences, Engineering, and Medicine [NAS]. 2017. 'Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use.' Accessed February 1, 2018. http://www.nationalacademies.org/hmd/Reports/2017/pain-management-and-the-opioid-epidemic.aspx

--- 2019. 'Medications for Opioid Use Disorder Save Lives.' Washington, DC: The National Academies Press. Accessed March 25, 2019. https://doi.org/10.17226/25310

Netherland, Julie, and Helena Hansen. 2016. 'The War on Drugs that Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse.' Culture, Medicine, & Psychiatry 40(4): 664-686. https://doi.org/10.1007/s11013-016-9496-5

Rose, Nikolas. 2002. 'At Risk of Madness.' In Embracing Risk: The Changing Culture of Insurance and Responsibility, edited by Tom Baker and

Jonathan Simon, 209-237. Chicago, IL: University of Chicago Press. https://doi.org/10.7208/chicago/9780226035178.003.0009

Rudd, Rose A., and Noah Aleshire, Jon Zibbell, Matthew Gladden. 2016. 'Increases in Drug and Opioid Overdose Deaths - United States, 2000-2014.' Morbidity and Mortality Weekly Report 64 no. 50: 1378-82. https://doi.org/10.15585/mmwr.mm6450a3

Schlosser, Allison V. 2018. '"They medicated me out": Social Flesh and Embodied Citizenship in Addiction Treatment.' Contemporary Drug Problems 45(3): 188-207. https://doi.org/10.1177/0091450918781590

Schlosser, Allison V., and Lee D. Hoffer. 2012. 'The Psychotropic Self/Imaginary: Subjectivity and Psychopharmaceutical Use Among Heroin Users with Co-occurring Mental Illness.' Culture, Medicine, & Psychiatry 36(1): 26-50. https://doi.org/10.1007/s11013-011-9244-9

Singer, Merrill. 2008. Drugging the Poor: Legal and Illegal Drugs and Social Inequality. Long Grove, IL: Waveland Press, Inc.

Singer, Merrill, and Glenn Scott, Scott Wilson, Delia Easton, Margaret Weeks. 2001. '"War stories": AIDS Prevention and the Street Narratives of Drug Users.' Qualitative Health Research 11(5): 589-611. https://doi.org/10.1177/104973201129119325

Soboroff, Jacob. 2017. 'Opioid Addiction: How Ohio Became the Epicenter.' National Broadcasting Company [NBC], June 20. Accessed February 1, 2019. https://www.today.com/video/opioid-addiction-how-ohio-has-become-the-epicenter-971802691633

Valverde, Mariana. 1998. Diseases of the Will: Alcohol and the Dilemmas of Freedom. Cambridge, MA: Cambridge University Press.

Volkow, Nora D., and Thomas R. Frieden, Pamela S. Hyde, Stephen S. Cha. 2014. 'Medication-assisted Therapies: Tackling the Opioid-Overdose Epidemic.' The New England Journal of Medicine 370: 2063-2066. https://doi.org/10.1056/NEJMp1402780

Vrecko, Scott. 2016. 'Risky Bodies, Drugs, and Biopolitics: On Pharmaceutical Governance of Addiction and Other "Diseases of Risk."' Body & Society 22(3): 54-76. https://doi.org/10.1177/1357034X16644509

JOURNAL *of*
EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 161-166 https://doi.org/10.5617.6851

Commentary

The Work of 'Crisis' in the 'Opioid Crisis'

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This commentary is an edited version of discussant comments to the Executive Session panel 'Anthropological Interventions in the US Opioid Crisis' organized by Jennifer Carroll at the 117th Annual Meeting of the American Anthropological Association, San Diego, CA, November 14-18, 2018. The program can be accessed here.

With some trepidation, I want to propose a thought experiment—an experiment that has no intention of circumventing the injustices, suffering, and degradations that anthropologists of opioids work to document. It is an experiment that instead means to bore down into the very terms we use to critically engage U.S. opioids, inviting us to wonder together what lines of analysis, what modes of representation these terms constrain as well as enliven. The enlivening is obvious, as the papers in this panel shed light on how people who ingest, distribute, and witness the effects of opioids: from those who live and sometimes die by them, to those who comment upon those lives and deaths, sometimes with a shocking lack of nuance, sympathy, and humanity.

Even with all this important work in mind, I confess from the start that there is *one term* in particular that concerns me, makes me uneasy; a term adopted by many anthropologists studying opioids; a term that so often serves as the primary, sometimes even *indispensable,* qualifier in the public discourse about U.S. opioids that it seems impossible to speak responsibly without it. Like so many others—as anthropologists drawn together by concerns about opioids—we have collectively declared that a *crisis* is at hand.

Crisis: a largely unquestioned way of naming and seeing opioids and the people, places, and things that they serve, soothe, and so often ravage. Opioid crisis: devoid of poetic value, it still almost rolls off the tongue. From countless headlines, to

articles in medical journals, to Presidential Commissions we find this semantic ease, this fluency of drug-plus-alarming qualifier. It may be one of the surprisingly few things that 'the crack *epidemic*' of the late 20th century and 'the opioid *crisis*' of the early 21st have in common as folk and expert analytics, a point to which I will later return, with Helena Hansen's excellent research specifically in mind.

National Opioid Crisis Community Summit, Aberdeen Proving Ground, MD, December 11, 2018. US Army Photos by Sean Kief. Original image can be accessed here.

Now certainly, given the ethnographic work of the authors gathered here and the equally gruesome story that public statistics tell about the rising death toll due to overdose, 'crisis' seems a very appropriate moniker. After all, *a crisis*—colloquially—is much more than *a problem*. *A crisis* requires more action, if not also more thought and attention, from those who engage it. I want to propose that *crisis* also requires that our thought and action be *faster, more immediate.* Indeed, crisis—in its current usage in Anglophone US—seems to have hung onto its Greek origins: *krisis,* to decide. No time for deliberation, crisis tells us. Though totally disorienting, as if it comes out of nowhere, crisis nevertheless demands: do now, think later. This or that. Right or wrong. Yes or no.

Crisis is a not just a way of naming some phenomenon, but a way of assigning a kind of temporality to that phenomenon. And while there is much to say about the way that crisis manages time and historicity, here I want to underscore my

sense that crisis projects *urgency*, which is precisely why I hesitated to offer a thought experiment today in the first place, fearing it would strike some as irresponsibly tentative and irresolute. In this sense, crisis guards against experiment. It tells us that even if there are no good answers at the ready, something must be done here and now, there is no time to waste. And, in imposing a sense of urgency, crisis eagerly exploits the stubborn antinomy of theory and action, making the former seem even more 'out of touch' than ever.

To be sure, *crisis* is also way of naming a problem which suggests that established conceptual apparatus is ill-equipped to make sense of what is going on and offer adequate answers and solutions. And precisely because it exposes the limits of intelligibility, crisis has been taken as the starting point of so many philosophical projects, which arguably have the luxury of ignoring the urgency crisis demands on the ground, and which take crisis as the ground of critique. But, as Janet Roitman brilliantly argues, crisis has become *ontologized* in the meantime. We have too often forgotten, to quote Roitman, that 'crisis is not a condition to be observed, it is an observation that produces meaning' (Roitman 2013, 39).

Once we recognize crisis as a way of seeing rather than a self-evident state of affairs, we are set to begin our experiment, asking: when we think of opioids in terms of crisis, what do we foreclose and inspire? What does 'crisis' do to our attempts to ethnographically represent the widespread if patterned use of opioids? And what other terms might we experiment with?

What if we used the term 'opioid problem,' an idea I floated before, with the caveat that it just doesn't seem a strong enough qualifier. A 'problem,' however, effectively begs work toward solution, and in ways that allow for deliberation, debate, exploration, experimentation. 'Crisis' cleaves just this kind of reengagement of theory and practice in its insistence to *decide* and to do it now. How about 'the opioid symptom'? This might allow us to more effectively direct attention to the fraught politics of pharmaceuticals, the dense fields of human suffering, the moral paradoxes, divisions and failures, and infrastructural collapse that the anthropologists gathered here clearly believe opioids index.

As I understand it, Roitman is, just like her book's title, *anti-crisis* in large part because she believes that crisis functions as a 'non-place' that obviates anthropological attempts to ethnographically *situate* what we study. She worries, in other words, that 'crisis' staves off precisely the kind of critical engagements we are best equipped to undertake. This begs the question what other term might reverse the idea that the opioid phenomenon has no identifiable locus, no traceable trajectory?

How about terms that have been coupled with drugs in our recent past? What about *epidemic*? Recall that in the 1980s and 90s, we did not speak of a 'crack crisis' in the United States. Instead, the public worried over a 'crack epidemic'—with

a particularly revealing focus on the supposed ravages of one particular form of cocaine (the one affordable and attainable by black urbanites) on fetal and childhood development, claims that have been largely debunked (Chavkin 2001). This change in nomenclature from epidemic to crisis to describe opioids should give us some pause, especially given the medical connotations of epidemic, which are arguably far more relevant to the typical travels of opioids through pharmaceutical companies and doctors' offices than to a drug that is generally produced on household stoves.

So why do we find ourselves in a crisis rather than an epidemic when it comes to opioids? Helena Hansen's panel paper gives us some very good guidance here, in their exploration of how opiates have been whitened, whitewashed, and therefore deracialized in the stubborn cultural insistence that white is not a race, but a standard that should never be violated (see also Netherland and Hansen 2016, 2017). Let us add to this whitening project the choice of the term 'crisis' rather than the arguably more proximate 'epidemic.' Epidemic—is from the Greek *epidemios*—meaning: *upon the people*. Epidemic is a way of figuring a problem relative to *population* rather than historical situation. And as we all surely remember when it came to crack cocaine, we were repeatedly told that the problem was with a kind of person, and not the kind that sits comfortably in diners with American flags waving, after taking in baseball games (ibid.). Whereas the portraiture of opioids commonly features an innocent white heartland disrupted by crisis that seems to come from nowhere, the representational economy of crack implicated a population that was already publicly imagined to be plague/plagued by any number of pathologies and social problems.

Indeed, if crisis lodges itself in time, epidemic points to and ensnares a people. Accordingly, the solutions epidemic tends to suggest include quarantine, sterilization, mass incarceration, immigration restrictions, and other forms of population control—types of solutions Americans sadly tolerate when it comes to black and brown people, but ones almost inconceivable when it comes to white ones.

And so, we might wonder together what would lines of inquiry might we gain by reviving the term epidemic and applying it, with adequate care and without the necessary suggestion of the solutions I just mentioned, to US opioids. Could this be a chance to *racialize whiteness*—to make whiteness visible as Hansen puts it—a project that could have a myriad of positive effects, well beyond the distribution and use of opioids? And might 'opioid epidemic'—with its indexical insistence on categories of people—revive a *class analysis*, so stubbornly missing from the American imagination of social problems?

I don't have an answer, but I want us to experiment; I think it is worth it. And while we are at it, why not experiment with what we are qualifying

Why is this an *opioid* crisis and not something else? If we insist on crisis, why not: A prescription crisis? A pharma crisis? A poverty crisis? A white crisis? At the very least, we should remember the ways that particular drugs at specific historical junctures—in what we often retrospectively cast as drug panics—have been assigned agency, as if they simply trample the wills of users. This tends to focus attention on regulation or elimination of drugs, while obscuring their social life and ecologies which we as anthropologists are so well equipped to document.

In conclusion, I want to underscore what I hope is already obvious: this is not simply a semantic exercise. As I often tell my masters students, who are training to become clinicians, social service administrators, and policy makers: how we frame a problem—or some kind of phenomenon as a *particular kind* of problem—is of fundamental importance to how that problem is going to be understood, worked upon and treated in the world. To be a good practitioner is to be a sophisticated rhetorician, to know the history and anticipate the effects of the terminology one uses.

These students also come to understand that to be effective interventionists is to experiment, in the pragmatist sense of the word. Just like anthropologists, who have learned to ask what lines of analysis are opened and foreclosed by particular analytical terms, the various professionals who interact with opioids and their users need to keep questions alive and open, so that they may figure out what to do next based on what just happened as the result of their previous acts.

This, I dare say, suggests that we may have to forgo the urgency, the demand to decide and to act immediately, that comes with crisis, even when a definitive solution is so far from hand. Devoted to ongoing reflection and action, experiments such as those I have in mind abandon the fantasy of definite solutions—a hard thing to do when faced with so much decline and social suffering (see also, Carr 2015). But I fear there is no naloxone for the social life of opioids, or an antidote that—if delivered fast enough—will wipe away the myriad tragedies to which these papers point.

And so, those of us who care must continue to experiment. For anthropologists, this means continuing to experiment with research strategies and modes of representation, to track the effects of what we write and what we say, the terms of our analysis.

References

Carr, E. Summerson. 2015. 'Occupation Bedbug (Or, the Urgency and Agency of Professional Pragmatism.' Cultural Anthropology 30(2): 257-85. https://doi.org/10.14506/ca30.2.08

Chavkin, Wendy. 2001. 'Cocaine and Pregnancy-Time to Look at the Evidence.' JAMA: Journal of the American Medical Association 285(12): 1626-9. https://doi.org/10.1001/jama.285.12.1626

Netherland, Julie and Helena B. Hansen. 2016. 'The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse.' Culture, Medicine, and Psychiatry 40,(4): 664-686 https://doi.org/10.1007/s11013-016-9496-5

Netherland, Julie and Helena Hansen. 2017. 'White opioids: Pharmaceutical race and the war on drugs that wasn't.' Biosocieties 12(2): 217-238. https://doi.org/10.1057/biosoc.2015.46

Roitman, Janet. 2013. Anti-Crisis. Durham, NC: Duke University Press. https://doi.org/10.1215/9780822377436

JOURNAL *of*
EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 167-172 https://doi.org/10.5617.6901

Interview

Interview with Laurent de Sutter, author of *Narcocapitalism*

Tracy Brannstrom
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TB: Can you tell us about your background, and the way that this work fits within, say, ideas and bodies of literature that you have been exploring over the years, and your own body of work?

LdS: I am a survivor of law school, having been trained in classic civil law, but also legal theory and legal sociology. In 2000, I did my PhD on the constitutional principle of representation and how it was challenged by the then-new institutional experimentations in popular participation to political decision-making. This was part of a bigger research project involving several universities in France and Belgium, which gave me the unique opportunity to work closely with Bruno Latour and Isabelle Stengers, who have contributed immensely in shaping my intellectual world. At that time, I was also into Jean Baudrillard, Jacques Derrida, Jacques Lacan, Roland Barthes, Giorgio Agamben, Slavoj Žižek, Jacques Rancière, Alain Badiou and film critics like Serge Daney and Louis Skorecki.

Rather than attaching myself to one or two personalities, or to accept being the representative of any discipline, I have always taken great care in building what I could call 'ad hoc knowledge' – that is, a type of knowledge driven by the objects and problems that I encounter on my journey, and not by the requisites of any intellectual program or worldview. This is why my own body of work, counting almost twenty books written over a ten-year period, appears so disconcerting to many: since it is the object that always decides where I go, and since I don't have a preconception about what counts as an object, I will take the opportunity to think through *anything* that arises. Here, I have written a book born out of encounters with images, texts, persons, bodies, pills, institutions, rules, fictitious characters, and so on. Whereas theory does everything it can to secure the solidity of its position of making knowledge, my own position consists in giving up theory (and

judgment) through a post-critical gesture that nullifies the subject and puts the object up-front.

Laurent de Sutter © Géraldine Jacques._

As a reader, it's intriguing to find these seemingly disconnected 'encounters,' as you put it, within the same story. How did they come to fit together for you? What was the process?

My first intuition was that the description of the world that critical theory is defending is utterly wrong. If you read the way that social life of individuals is dealt with in critical circles, you can't help but notice how grim the portrayal is: human beings are manipulated, humiliated, made sick or depressed by abstract social powers wanting something from them. In particular, I was surprised by the insistence of ideas of mobilization, acceleration, excitability, and distraction, that lead to sketching a vision of human beings as laboratory rats whose conscience was prevented by the very processes keeping them too busy or too distracted to think. I then thought: what if the defining dimension of contemporary life is not excitation, but depression? What if what we lack is this 'excitation' that everybody is denouncing as alienating, pressuring, as a burden rendering our lives impossible? So, I decided to go down this road, and soon realized that there had been a specific moment in time when the idea arose in intellectual and public discourse.

This moment took place roughly around 1870 and saw the burgeoning disciplines of sociology and criminology walk hand-in-hand with the first experiments in psychoanalysis and the development of contemporary chemistry and surgery. From the invention of the first anesthetics to the fear of the masses, from female hysteria to the discovery of the power of drugs like cocaine, this moment seemed to me like a crossroads bringing together some of the most dramatic economic, political and technological changes in Western – but not only Western – history, with a series of devices, mostly chemical, aimed at fighting 'excitation' in every form. So, I decided to offer a very small, fast mapping of this moment and its consequences, gathering together a series of vignettes, hopefully helping the reader to see how this suspicion of excitation was used.

What kind of history, or counter-history, is one of narcocapitalism? In thinking about the histories that have been told about pharmacology, sedation, and political-economy, what is unique here?

To be fair, the original French title of the book is *The Age of Anesthesia*. Polity wanted me to change it into something more 'conceptual', and as I use this neologism in the text, I said, 'Why not?' But I have decided to write about 'narcocapitalism' because I didn't want to speak about capitalism. I am a bit fed up with the laziness with which critical theory tends to designate enemies so abstract that they can put almost everything to their credit: capitalism, colonialism, patriarchy, and the like. I think that these concepts render us blind to the actual agencies of logistics, technique, chemistry, etc., that define the frame within which we evolve. I wanted to speak of 'narcocapitalism' not as the enemy that we should fight, but as the definition of a moment when the functioning of the world was deemed to require the taming of 'excitation.' Why is it 'capitalism', then? Simply because this appeared at a moment when the true issue behind the fear of excitation was that things wouldn't *work* – individuals would become dysfunctional, masses would go crazy, the work of surgeons would be made impossible, and so on.

Now, is it unique? I wouldn't know. I believe that what is interesting, new or unique in a book is never the book itself, but how it allows those who encounter it to develop their own path, ideas, and practices. As a book, it only formulates a proposal, not a program, but I don't ask that it be applied, followed, believed, or trusted – but, to be useful as a tool in the toolbox of those who find it interesting. Some readers have compared my book to the work of Foucault, but it makes me cringe, as I don't like Foucault, who has always seemed to me a paradigmatic figure of the thinker who *knows* – who put himself in such a position that everything seems small compared to his almighty, all-encompassing gaze. If my book is Foucauldian, then it is a failure. I haven't tried to provide the ultimate explanation for a given phenomenon, or the key to finally understand a specific time period, but a hint at the possibility that we take so much for granted.

How can we think about your use of narco in this text? At times, you seem to be drawing on both drugs and sleep. Is there a double meaning here?

Yes, there is. As you know, 'narcosis' describes the result of the anesthesia of a person, as a state. The fact is that most drugs belong to the realm of anesthetics. As I explain it in the book, cocaine, the alkaloid of coca leaves, was first commercialized as a local anesthetic allowing for the performance of small surgical operations on patients that had to be kept awake. It is the paradox of a drug like cocaine that it puts you in a state of frenzy *while* being an anesthetic, and, taking cocaine doesn't affect your capacity to work the following day. Sigmund Freud, when he was young, experimented with cocaine with this specific purpose in mind, praising it for its remarkable efficacy. Well, my idea is that *efficacy* is precisely another name for *anesthesia*, because it is always in the name of efficacy that anesthesia has been promoted – first as an aid in surgery, then as an aid in keeping psychically ill patients quiet in hospitals, up to the proverbial broker relying on 'cocaine and hookers, my friend,' as Matthew McConaughey says in *The Wolf of Wall Street*, in order to produce wealth.

The idea behind the history of anesthesia, as it materialized in a whole series of products, is that a good subject is a sleeping subject – playing its role, staying in its place on the surgeon's table, in the psychiatric unit, at work, as a woman, etc. For me, the most important character in this story is none other than the inventor, in 1899, of the nosographical category of the ubiquitous category 'manic-depressive psychosis' – Emil Kraepelin. In his then world-famous *Manual of Clinical Psychiatry*, he describes what should be done in cases of 'excitation' (*Irresein*, in German) in a manic-depressive psychosis, which he thought should be avoided at all costs. The solution was a powerful sedative, chloral hydrate, used until the 1950s despites its terrible side effects. For Kraepelin, it was crucial that patients would not wander outside of the frontiers of their being, and this is what 'excitatio' means: *ex-citare*, in Latin, being 'called out', taken out of the reassuring limits of your home or your inside.

You argue that a certain version of selfhood is enforced within capitalist ideology and practice. Do you see this work as contributing to a lineage of ideas about subjectivity, in addition to politics?

I suppose it does, yes. You know, I started my theoretical endeavor in a context where the critique of subjectivity was an integral part of what was considered cool, because those who wanted to defend the primacy of the subject seemed so boring and paternalistic, pushing many in the other direction. Althusser's anti-humanism, Barthes' death of the author, Lacan's divided subject, even Foucault's death of man, are all part of my default setting. I continue to think that our insistence on trying to 'be' something is the source of many of our conceptual mistakes, and of the failures of the societies in which we live. Thinking of oneself as a

consistent entity whose core would remain 'me' is not only a metaphysical aberration, but it also is a complete denial of the fact that everything that allows 'us' to 'be' comes from the outside.

Much of contemporary leftist politics tend to forget about these lessons and has put identity at the forefront of the agenda. In the self-help sections of bookstores, you will notice that the very first suggestion is to 'be yourself' – to stop getting lost. In the Leftist world, this is translated as: be a woman, a queer, a black, a transgender, claim your 'self' in front of all those who are denying its expression and recognition. To me, this is a terrifying nightmare because there is nothing to recognize. I am not myself, but I'm *already* differing from myself, *becoming*. Well, it is my wager that the true political struggle has to take place not in the useless defense of what we would supposedly be, but where we can go.

In the end, you write that the unstable state of excitation, which is reduced under capitalist order, is 'the only thing that can give us hope.' Is this a comment on what you see as public indifference and disengagement – a kind of sedation – with politics today? And if so, what would a return to states of excitation look like in the political realm?

What we need is not more integration, organization or rationalization, but rather the opposite: disintegration, disorganization and irrationalization. What we need is to take human beings seriously for a change. I would never accept a claim such as the one stating that people are indifferent or disengaged with politics today. If politics is a matter of affection, then it is *everywhere*, and the issue is to find a way to transform our intellectual tools of perception in order to put us in a position where we could listen to it, or see it, or smell it, etc. Shifting towards 'excitation' is a mere suggestion – a way to put forth one possible tool of that kind. If we look at the world through the lens of a possible reconciliation with excitation, more things become imaginable than not: we can imagine a way out of being, a way out of work, a way out of organization, and a way out of theory as 'the practice of those who know.'

In my book, I give some examples of people having embraced excitation, in getting rid of the self in order to experiment with what it means to move beyond our limits: the drug experiments by Timothy Leary and his friends (which eventually ended up badly, but that is another story) and the xenofeminist hacking of hormonal programming through DIY pills. When xenofeminists say that we don't need less alienation but *more* alienation, I can't help but agree: we need to equip ourselves with all the means at our disposal to open up ourselves to our own alienation, our becoming-alien – allowing our lives to become experimentation rather than an attempt at building up a fortress within which we would, at last, be safe.

The book is written in short, non-linear acts. Why did you choose to write the book in this style?

My goal is to ignite your mind as fast as I can, by taking you on a short ride in a fast machine, to quote John Adams, and to force you to stay alert during the whole journey. Like Jorge Luis Borges, I don't see the point in producing thick books just for the sake of it. If you can say what you have to say (or, rather, what your object is telling you to say) in a couple of pages, stick to it. Today, there is no justification for seeing yourself as so fascinating and interesting that you could monopolize the attention of your readers. I find it utterly rude, and still relying upon an understanding of knowledge that goes back to the 19th century. Plus, I live in a culture (the French-speaking one) where knowledge still is a public issue, meaning that theory, philosophy and concepts are still part of the public debate, and are echoed in media. When I write, I don't write for academics alone, but for every person, be it an artist, a retired public servant, a high-school teacher on holidays, an architect, and whoever feels the tickle of curiosity about the world they inhabit. In a culture like the Anglo-American one, where knowledge and theory are debated in rarefied circles of professionals sharing the same *habitus*, things are different. But it is not the one I find myself at ease with, so I'll stick to my weird little paragraphs.

JOURNAL *of*
EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 173-176 https://doi.org/10.5617.6753

Book Review

Hansen, Helena. 2018. Addicted to Christ: Remaking Men in Puerto Rican Pentecostal Drug Ministries. Berkeley, CA: University of California Press.

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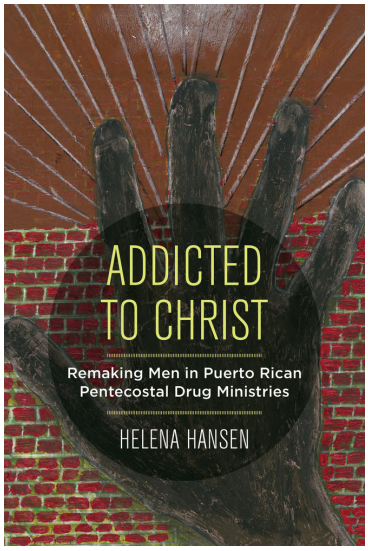

As a PhD-holding anthropologist *and* a double-board certified physician specializing in general as well as addiction psychiatry, Helena Hansen is an analytical force-to-be-reckoned-with. I first became familiar with her work while still a graduate student at the University of Washington, where she came to deliver grand rounds on the intersection of pharmaceutical marketing and Whiteness in the treatment of opioid use disorder. Since then, I have hungrily devoured anything she has had her hands on. Hansen has consistently impressed me with her keen eye for symbolic work and her ability to present holistic descriptions of the human experience that simultaneously surprise me with new insight and resonate with my own experiential knowledge, with things I have long known to be true but never singled out and bracketed as such. From one ethnographer to another, I can honestly think of no higher praise.

I have come to expect strong work from Hansen, and, in this regard, *Addicted to Christ* did not disappoint. It is an occasionally surprising, frequently touching, deeply honest ethnography about substance use and selfhood in evangelical communities of Puerto Rico. Hansen's rich ethnographic prose introduces readers to an evangelical street ministry called Victory Academy, which, like the many other street ministries in and around the city of Ponce on the southern coast of Puerto Rico, is a residential center as well as an active faith community with social and economic ties across the city. Through an intriguing series of political events, in which Puerto Rico's leaders undertook major healthcare reforms yet declined to

professionalize 'addiction' treatment by mandating minimum standards of care (detailed in Chapter 3), street ministries like Victory Academy developed a de facto monopoly on the management of chemically dependent bodies, accepting new residents in need of recovery from desperate families, underfund jails, and punitive court systems alike.

Early in her analysis, Hansen observes that the dominant biomedical paradigm of 'addiction' treatment, which largely consists of pharmaceutical intervention designed to 'disrupt the chemical reactions at neuroreceptors that consolidate memories and facilitate learning of new cues' (p. 38), fails to account for 'the ways in which human subjects shape their own external and internal environments to *create new cues*' (p. 38, emphasis mine). In other words, how are individuals on the receiving end of treatment and recovery efforts empowered to create their own narratives of transformation, and how do specific understandings of what 'addiction' really is open up or close off different possibilities for their future worldviews and their future selves?

The ministry staff at Victory Academy are wholeheartedly dedicated to ministering to 'addicts' and assisting them with their recovery and ultimate re-birth as spiritually-strong Christians. Through the course of her study, however, Hansen finds that the content of these 'addiction' treatment programs (like so many—if not all?—treatment programs) are driven by everything but the 'addiction' itself. At Victory Academy, 'addiction' is not a disease. To borrow a phrase from George Canguilhem, it is an anomaly—one that arises out of frayed ties in the social fabric and wreaks havoc on those afflicted as well as the surrounding community. Thus, when the leaders of the ministry act in ways that intervene on an individual's 'addiction,' they also aim to intervene on the way in which society relates to itself, in which wholeness and personhood and dignity are created from within (or from God), in which 'the remaking of relatedness, authority, and identity' (p. 134) open the doors for a new, stronger Puerto Rico forged by its new, stronger, Christian Puerto Ricans. 'Addiction,' then, is taken up by Victory Academy and other street ministries as an impetus for social transformation: for gender work, for boundary work, for the construction of identities and worldviews commensurate with evangelical ideology. The goal of recovery is not simply recovery; the goal is the formation of an entirely new habitus custom made for a world re-enchanted.

The Christian conversion process and the 'addiction' recovery process are, as a consequence, one and the same. New arrivals to the ministry go immediately to a semi-closed ward where they are expected to endure detoxification with no medication assistance or palliative care. In the eyes of the ministry, the pain of withdrawing from chemical dependency 'cold turkey' is a key step in the recovery process; pain allegedly makes one stronger by increasing the capacity to be patient and delay pleasure or relief. Detoxification is, therefore, a liminal state of conversion: these residents have come to the ministry, and thus are no longer of the world; yet they are not yet 'clean' and are not yet part of the daily life of the ministry. Experiencing withdrawal is celebrated as a 'voluntary' tribulation that bonds

the converts together through shared experience and practice. In an odd twist on Weber's notion of the protestant ethic (what Hansen in Chapter 2 smartly calls a re-enchantment of the protestant ethic), withdrawal is part of the healing process in a place where 'being healed' means willingly embracing physical and material poverty to enable spiritual gain.

According to Hansen's observations at Victory Academy, this re-enchantment of the protestant ethic can be a powerful and intoxicating discourse for contemporary residents of Puerto Rico. 'Addicts' at the ministry experience extreme social marginalization in a U.S. protectorate already burdened by economic, political, and democratic isolation on a national as well as inter-national scale. The ministry deprecates of the kind of material wealth and mobility that this marginalization denies in favor of a spiritual livelihood that privileges direct and personal interaction with the sacred. It thus presents new converts with a world-wide imagined community of Pentecostals that is able to transcend the oppression and exclusion that defines Puerto Rico's neo-colonial, post-industrial, economically fragile present. The ministry creates ties, distributes resources, and generates meaningful opportunities for redemption, respect, and social mobility for members who were denied these things outside of the church.

And yet the successes of the 'ex-addict' converts at Victory Academy always seemed somehow fleeting. The first half of the book, a zealous crescendo of storytelling that invites readers to embrace with hope the full potential of these street ministries to transform social lives and redeem personhoods through a locally-generated praxis, is followed by a more sober examination of how the most seemingly successful converts at Victory Academy have fared in the afterlives of their recovery. Women struggled to gain authority in the ministry, as its philosophies were egalitarian in name but patriarchal in content. Men were challenged by the absence of close family ties outside of Victory Academy, quickly faltering in their ability to uphold Christian ideals. Poverty, stigma, and obligations to provide for those they left behind brought many 'ex-addicts' back into proximity with the narcotics-fuelled black-market economy they had tried to separate themselves from in the first place. Conversion, Helena observes, is always 'an uncertain negotiation' (p. 134).

Addicted to Christ closes by bringing the reader full circle back into the biomedical psychiatric service where Hansen has worked as a physician in New York. Having traded her long skirts for a white jacket, the fierce southern sun for chillier climes, Hansen nevertheless sees echoes of the self-transformation her Puerto Rican informants sought at Victory Academy in the patients whose opioid use disorder she was helping to treat in the U.S. Were their stories really so different? 'Their metaphors and methods diverged, but ultimately both drew from Occidental mysticism and attempted to stem the effects of post-industrial social disintegration and displacement' (p. 155). The moral of the story, at least as I read it, is that discourses on 'addiction' (personal, spiritual, biomedical, or otherwise) so rarely have anything to do with 'addiction.' Though the underlying biological realities of chemi-

cal dependency are real, the ways in which we respond to 'addiction' are often little more than re-manifestations of the power structures that maintain the inequalities all around us. The 'illness' and the 'treatment' share a common cause and bracketing both as an individual pursuit closes off our ability to see the very literal forest of global neoliberal capitalism for the individual trees.

This book is well written and easy to follow. Readers will move easily from cover to cover, taking delight in the richness of Hansen's ethnographic voice and the insightfulness she brings to her grapples with anthropological theories and the complexity of human experience. The text is extremely well-balanced between exposition and rigorous analysis, making it ideal for both graduate and undergraduate classrooms. Hansen also grounds her ethnographic data in the historical context of Puerto Rico with such aplomb that this book should be used as an example of best practice in ethnographic writing courses. This is a must read for medical anthropologists working within or adjacent to the subject of substance use but may be an even more valuable contribution to those interested in religion, spirituality, and enchantment as technologies of the self as well as responses to global capitalism. I understand that Hansen is currently working on a second book-length manuscript, and I genuinely cannot wait to see it.

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JOURNAL *of*
EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 177-179 https://doi.org/10.5617.6900

Book Review

De Sutter, Laurent. 2018. Narcocapitalism: Life in the Age of Anesthesia. Cambridge, UK: Polity Press.

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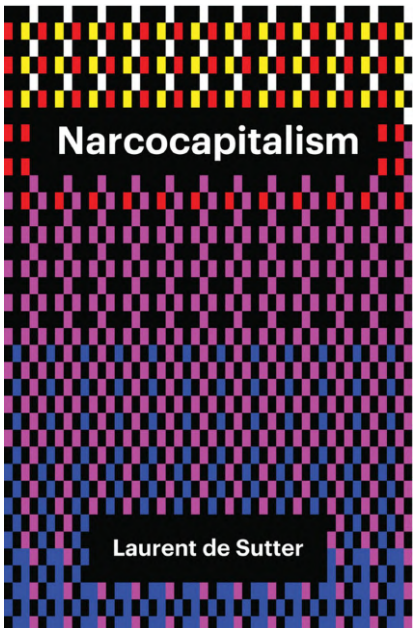

I happened to be browsing old advertisements of pharmaceutical drugs – yes, a typical hobby for a student of medical anthropology – when the essence of Narcocapitalism became clear: in order to produce a kind of subject that may be governed without much difficulty, many of the drugs that permeate our lives work to render us lifeless, to move us away from unmanageable states of irrationality and 'excitation.' We must not deviate from a neatly cohering inner world, like the subject of an ad for the antipsychotic Zyprexa – a woman who lives as an incomplete jigsaw puzzle and whose family is told, 'you're trying to piece her life together. She won't swallow it.' Her fragmented self is forbidden, but the impetus to 'put the pieces back together' is not just about improving her quality of life, bringing her to a state of normalcy, or initiating a cure. In Narcocapitalism, de Sutter suggests that in the 'age of anesthesia,' it is the calculated sedation of the individual and the collectivity that works for the logics and labor forces of capitalism.

The book is a playful mosaic of events, actors, drugs and other phenomena – a short text that considers bits and pieces of many objects' histories. De Sutter, a

scholar of legal theory at Vrije Universiteit Brussel, traces the concept of 'excitation,' beginning in the 19th century and linking it to the present moment. He shows that these objects – anesthetics, antidepressants and oral contraceptives, for example – are not simply about reducing pain, curing disease, or halting reproduction. Through the techniques of modern chemistry, they transform us into a particular kind of *self* – namely one that serves capitalist interests through the control of our bodies and psyches. 'To become the subject of an operation,' he writes in relation to the first chemical anesthetics, 'is to becomes, therefore, more or less organized matter, a material mass of organs and flesh available for fixing, repair, amputation, observation and so on' (109).

Chapter one, *Welcome to Prozacland*, is most clearly linked to de Sutter's overall thesis on the relationship between politics and metaphysics. He takes readers through the 19th century development and use of the anesthetic chloral hydrate. Those who sought to overhaul psychiatry with materialist notions of disease used the chemical to treat manic-depressive psychosis (what may now be called bipolar disorder) by inhibiting manic states that were seen as 'being flung out beyond the limits of one's being,' (13) and ultimately, a 'rupture in the world order' (9). Even if all enjoyment was eradicated in a patient and a state of depression is what remained, the medical establishments' fear of the manic, unpredictable subject was too great to refrain from sedating them.

To return to the image of the puzzle, the following chapters explore many seemingly disparate pieces: the development of cocaine products; the use of chloral hydrate to combat insomnia; the way that public street lighting systems were installed a means to police what goes on at night; the reinvention of sleep cycles which opened up new markets for the proliferation of night clubs; oral contraceptives as a means of deactivating and de-exciting hormonal processes and sex drives; ideas about the potential irrationality and danger of crowds, and a turn to the term 'masses' as a way of rendering them as objects for more efficient manipulation. But readers need not feel disoriented, or any pressure to conjoin these pieces with a seamless fit. The text will be a delightful, experimental device for some, and undoubtedly a maddening, garbled mess for others. For me, it was the former, and I see *Narcocapitalism* as a work that one can extract what's useful for one's own projects and curiosities, and as a text to return to, again and again, in seeking to comprehend its entirety.

In the concluding chapter, *The Politics of Overexcitement*, de Sutter's thesis reaches its height of clarity: in narcocapitalist states, the anesthetized, controlled subject is key, but de Sutter is as concerned with metaphysics as he is with politics. The unexcited category of being that he spends a majority of the text illustrating is the very foundation on which the logic and enactment of capitalism can flourish. Being excited is seen by those in power as a dangerous exit from one's self, and their anesthetic formulas are posed as a kind of solution that would allow us to find ourselves – a return to *being*. Ontology is the branch of metaphysics concerned with

the nature of being, and de Sutter's ontological project is to examine the conditions in which human beings are allowed to exist within narcocapitalist societies.

I did not have a difficult time accepting de Sutter's claim that many pharmacological products of the past and present are working to sedate us as a means of control, or that drugless social phenomena like crowd control are part of this overall anesthetized culture, or that endeavors to depress and deaden our bodies and minds will continually shape our fluid subjectivities. But I wonder whether the de-excited subject is really as productive for capitalism as he makes it out to be. What are the limits of a labor force composed of individuals who are taken over by apathy and other states of depression? I had a hard time, too, with the concept of *psychopolitics*, which is underdeveloped and yet, appears as a central theme that would tie everything together.

In the end, de Sutter suggests that what may provide solace in contemporary times is a return to experiences and perceptions that animate us, and propel us beyond ourselves – that we might 'finally come to terms with what forms the mad foundation of every human grouping – a madness which is the only thing that can give us hope' (107). Submitting to the madness in each of us may be a way that we can better understand ourselves and locate new social and political possibilities. But I'm not sure what these encounters would look like, and how they might vary among each of us, or how we might draw the line between forms of psychic excitation that are, on the one hand, creatively productive, and on the other, dangerously destructive. There are certainly instances in which self-exit can have harmful outcomes, and a more nuanced discussion about what kinds of exit-facilitating contexts are worthwhile could be of help here.

That the book raises such questions is enough to champion what de Sutter has put forth. It has an open-ended philosophical spirit that I love but is born from something even more experimental than a philosophical work, which can tend toward overly exerted arguments and a squeaky-clean fit between the thesis and the evidence that supports it. This text would be of interest for those drawn to studies of the body, mental health, subjectivity, pharmacology, and politics more generally. And especially for those who are open to an offbeat account of how chemical technologies have shaped, and continue to shape, who we are.

JOURNAL *of* EXTREME ANTHROPOLOGY
ISSN: 2535-3241 Vol. 3, No. 2 (2019): 180-183 https://doi.org/10.5617.7400

Book Review

Zigon, Jarret. 2019. A War on People: Drug User Politics and a New Ethics of Community. Berkeley: University of California Press.

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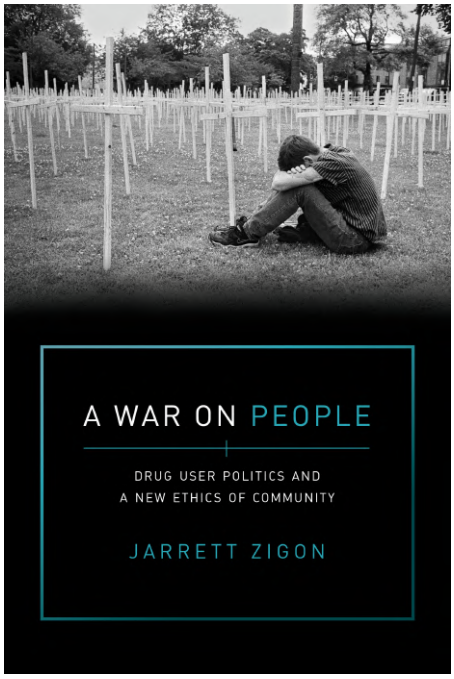

The War on Drugs is one of the most critical problems of our time. Its enduring effects on the individuals it targets, the communities it devastates, and the institutions that support it have been the subject of considerable debate, analysis, and critique. Anthropologists have made important contributions to this drug war conversation, and Jarrett Zigon in his new book, *A War on People*, is no exception.

Based on 15 years of research, A War on People offers a unique window into the drug war by emphasizing the responses to it by activists (whom Zigon calls 'agonists') in three locales: Vancouver, Copenhagen, and New York City. Their activities in these specific milieus serve as the book's ethnographic material. However, Zigon fervently argues from the outset that these examples speak volumes to the broader anti-drug war movement. In fact, he suggests that the drug war is best understood as a globally dispersed situation whose extensively networked movement consisting of diverse groups and organizations and so-called 'junkies' and 'addicts' offers an alternative socio-political vision for the future. Its main goal is to improve the lives of people who use drugs through political activity, such as legislation. But it is also about creating 'new worlds through political and ethical activities and relations' (p. 3). This worldbuilding takes center stage in Zigon's book as he examines how the anti-drug movement enacts a world that could be, how it invents a possible future

and way of being that not only counters the drug war but shows it for what it really is: a war on people.

To follow this political vision, Zigon engages in an anthropology of potentiality. He sees this kind of project as 'disclosing, tracing, and describing the contours of the not-yet' (p. 15), one that he argues does not easily lend itself to classic Geertzian 'thick description.' Zigon instead carries out an 'assemblic ethnography' to study the widely diffused phenomena and relations in which anti-drug war agonists are entangled across different scales. This is the book's methodological intervention. It is not an ethnography of a social movement, but one that follows various relations of the drug war as they become situated in certain locales. Moreover, it focuses not on overt political activity, but on 'onto-ethical-political activity' as a way to show how agonists create the type of change that is not possible through legislation alone.

The book begins with a discussion of the primary narrative of protection that undergirds and sustains the drug war. Populations need to be protected from drugs, so the story goes. However, it is not about protecting people at all. This is one of the book's critical anchors, as Zigon shows that the war produces two, distinct populations that are subject to differential forms of treatment. The war enacts several forms of violence against the first population – people who use drugs – through multiple physical, structural, and discursive mechanisms of marginalization. These same mechanisms create a second population that must be 'defended' against the scourge of drugs and those who consume them. In essence, the protection of one group stems from the exclusion of the other. What is so important about this are the ways in which agonists use this division to undertake the worldbuilding that is at the heart of this book. Demonstrating the violence that comes from this kind of partitioning allows the anti-drug movement to create new onto-ethical forms of being and relating; this is their strategy for long-term change. As Zigon notes, this 'sticking and enduring is key to a politics of worldbuilding' (p. 11). The book centers around this worldbuilding by analyzing three interrelated 'interventions' in which agonists are engaged.

The first intervention is addressing the drug war as a complex global condition, a 'non-totalizing and widely diffused complex phenomenon that manifests temporarily and locally as a situation' (p. 22). Zigon notes that an achievement of the anti-drug war movement is the illustration of this complexity. This 'situation' materializes differently around the world and intersects with other assemblages (anti-drug legislation, infectious disease surveillance, and the prison-industrial complex, to name just a few) that influence the site where it is temporarily localized. Zigon convincingly argues that it is necessary to approach the drug war as a situation and to attend to its 'situated manifestations' (p. 43) if it is to be politically addressed and effectively anthropologically analyzed.

An important part of Zigon's argument is showing how this situation provides the conditions for ways of 'being-in-the-world' for those entangled in the drug war.

One condition is the ideology that produces an 'Other' against with the war must be waged. If, as Zigon claims, war is a fundamental to biopolitical governance, then it is fought against internal enemies. In the drug war, the internal enemy/ Other is the 'addict' who is the personification of addiction, the 'evil' that supposedly threatens humanity's existence. The 'addict' is in turn also rendered subhuman and disposable. After all, Zigon asserts, it is the evil 'addict' whose 'expendability grounds the biopolitical order of things' (p. 56). The devaluation and dehumanization of the 'addict' has long been a topic of concern in the social sciences and humanities (cf. Singer and Page 2014). But, Zigon's analysis uniquely illustrates how agonists' efforts unsettle the 'fantasy world' where people who use drugs are considered less-than-human. Exposing the fiction that undergirds this construction lets agonists address its very real consequences, such as high overdose and incarceration rates. Such productively disruptive work paves the way for an important task: 'imagining new world possibilities for how to live in worlds with drugs and drug users without the latter being that world's exclusionary ground' (p. 73).

The second intervention is the creation and reconceptualization of concepts related to ethical ways of being. Zigon shows that the disruption undertaken by agonists enacts conditions that are inclusionary (rather than exclusionary) that allow for the reimagining of what the world could be like. He first examines how agonists' efforts help rethink the idea of 'being-with' in a community. Zigon tells us that community making is central to the anti-drug war movement because the war 'seems to foreclose the very possibility of community' (p. 80). How then is a sense of community regained for the excluded and those without a community? One way is a shared proximity to drug-related death. Those who have survived an overdose or who have experienced the death of a relative, friend, or even stranger from drugs are all part of community based on 'being-with' death. It is not restricted to certain members in a particular locale; it is a community 'open' to 'everybody that walks by' (p. 93).

The community building that Zigon thoughtfully describes in New York City, Vancouver, and Copenhagen is also characterized by a key component of the anti-drug war movement: freedom. However, it is a specific variety that is a 'condition of open potentiality' that permits beings 'always to be in a process of becoming' (p. 108). This 'disclosive freedom' is the openness to develop into something else. Zigon notes that those who arrive at the community fashioned by the anti-drug war movement are able to experience disclosive freedom because of what he calls 'attuned care.' Theories that envision 'care' as only 'caring-for' do not account for other ways in which care is experienced. Attuned care, rather, accommodates to different modes of being-human-together. It broadens the conceptual scope to show that care, when based on 'an openness that welcomes whoever and however one arrives' (p. 156), can provide the conditions for the possibility of creating another world and way of existing.

In the book's epilogue, Zigon briefly turns to the third and final intervention: thinking through and demonstrating the slow emergence of an 'otherwise' through sustained political activity. Zigon is very clear that this otherwise is not necessarily futures that are radically new, utopian, or even 'better' (p. 160). He instead reminds us that, when it comes to the anti-drug war movement, an otherwise – something different – emerges when there are small not big shifts in what is deemed possible.

A War on People is a theoretically complex book that grapples with issues of major global concern. Amidst the book's difficult conceptual material is ethnographic data that seems to support Zigon's multilayered argument. But, as an anthropologist and critical drug scholar whose research is primarily in Latin America, I am left wondering if Zigon's argument would look different if his research took him to the global south. Would it change if he included the work of agonists in places where the local 'situation' is heavily influenced by drug war geopolitics or other experiences that may not be observable in the global north? Zigon does speak to a "sharedness" of the global drug war's general condition, but what if there are specific conditions that are more distinct or spatially situated? These questions merit consideration in future analyses of a drug war that unfortunately still rages on.

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References

Singer, Merrill, and J. Bryan Page. 2014. The Social Value of Drug Addicts: Uses of the Useless. Walnut Creek: Left Coast Press.

JOURNAL *of*
EXTREME ANTHROPOLOGY

ISSN: 2535-3241 Vol. 3, No. 2 (2019): 184-195 https://doi.org/10.5617.7047

Visual Essay

To the Roots

Me, My Brother, Heroin and Iboga

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> This is the root of the Iboga plant.
> And here it is in its raw state.
> This is a sample I have uprooted, in order to show people.
> *Mallendi Nzamba, Traditional healer, Panga, Gabon*
> *Transcript of excerpt of the documentary 'Ibogaine - Rite of Passage'*

In July 2018 we met at the airport, my brother Haim and I. We were bound for Portugal, where my brother was about to undergo treatment for his heroin addiction. This was not the first time he'd attempted to get clean; but it was the first time he was going to try it with Iboga.

I came from Jerusalem, Haim came on a three-hour train from Acco (Acre), a Northern port city in Israel. Acco is our hometown, where we grew up, he and I and another brother, three siblings born to the first-generation immigrants who arrived to the temporary barracks for immigrants in Acco in 1949. My mother came from Morocco via Marseilles, my father from Bulgaria. My mother never felt at home in the Hebrew-Zionist land. She spoke Arabic fluently, she felt uncomfortable in a country which blatantly, racistly preferred immigrants from Europe; oddly, her birth certificate was never found, and we never celebrated her birthday. When I think of Acco, I think of an ancient beautiful port city, and of poverty, racism and ostracization.


My brother Haim & Me, Acco 1975; Our Mother Mazal Mezamer as a young nurse, 1964.

My mother died from a violent cancer in 2016. At the time of her death she had known for thirty years that her eldest boy was a heroin addict.

My brother used to internalize the feelings of dislocation as a personal failure and be only dimly aware of the adaptive function of his addiction.

> Parents of addicted people may see their children's addictions as inexplicable habit caused by addictive drugs or by genetic predispositions or brain dysfunction because acknowledging the adaptive functions that it actually serves would require facing up to the fragmented nature of the family – of their own (Alexander 2014).

In 1982, when I was 8, both of my brothers began serving in the Lebanon war, which began as what Israel defined as a military operation and which the Lebanese termed an invasion. This rapidly escalated into a war which led to twenty years of military Israeli presence in South Lebanon. They came home, for one weekend a month, during which they mostly slept. Very young men, frightened and thin. They saw men like themselves, friends, killed and maimed, and they saw unspeakable acts committed in their name in the villages and camps of Lebanon. An Israeli soldier's mandatory service is three years long; my brother Haim signed up voluntarily for three more years of service. None of us voiced the question: Why?

Years later we found out. He described Lebanon as a promised land of hash, opium (Afyūn), heroin – a promised land of self-forgetfulness, and self-treatment for the ongoing trauma of war.

Haim was sure that his time in Lebanon was at the root of his addiction.

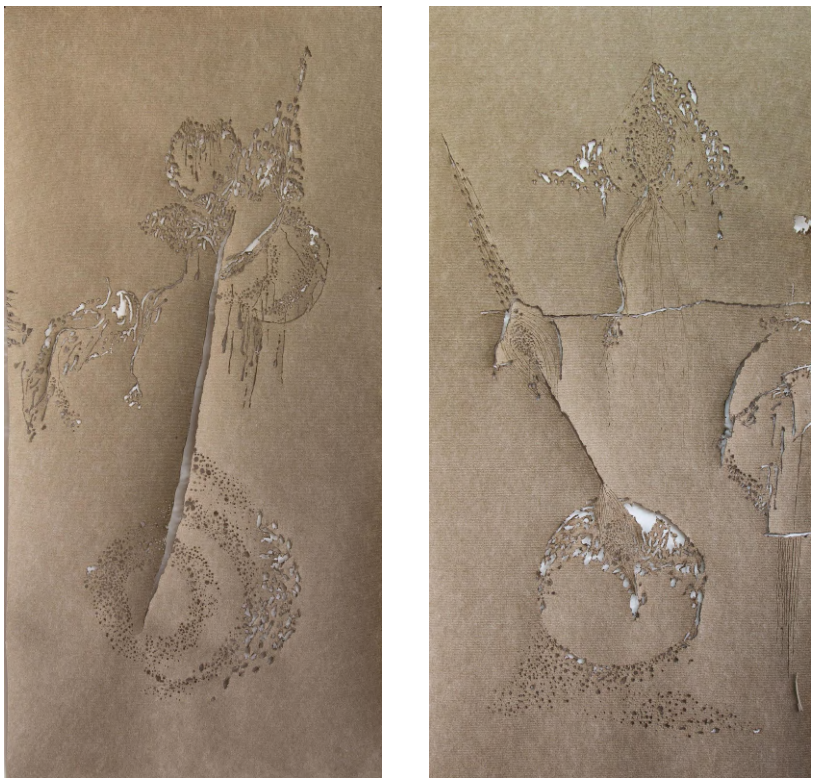
> During the initiation… a mirror is presented. It is placed in front of you. And your face is painted. From that moment you look at yourself in the mirror. So you begin to see your double personality. – *Mallendi Nzamba, Traditional healer, Panga, Gabon*

> Effects of ibogaine, the active alkaloid extract of Iboga, may begin anywhere from 45 minutes up to 3 hours after you take it. The entire experience may last approximately between 24-36 hours. During the first phase, usually people experience visual phenomena generally consisting of rapid imagery lasting approximately 6 hours. These visions may be quite intense. Some people have reported experiencing images or memories of their life appearing as if in a "waking dream". Ibogaine has been termed an "oneirophrenic", which essentially means a substance that causes a dream-like experience. – *Excerpt from 'Ibogaine Treatment - Patient Informed Consent Form', Portugal, 2018*

I was 12 when I found a letter, one that I was not meant to read. In it, Haim's friend from Florida wrote about their addiction. He thanked my brother for introducing him to these life-changing drugs, heroin and cocaine. I told my mother. She had worried for some time, but now it fell into place for her – she became the mother of a heroin addict. The mother of Opium.

All drawings are ink and watercolor on paper (2016-2019) by Sagit Mezamer.

For the following thirty years she held that role, and she did it well. At times it seemed her starring role, her only role: to circle him, feed him, care for him and debate if he was or wasn't using right now. She used to rotate the carpet on our living room floor so the burns from heroin, and Haim's passing out with a cigarette in his hand, were hidden. Until there were more holes than fabric.



Carpets, Burnt synthetic Felt Carpets

When she died, the family dis-integrated. The support was gone. My brother, now bereft of his one constant, tried, vainly, to drown his grief with heroin, cocaine, whatever came his way.

Two years after my mother died, he called me. He had collapsed, financially and physically. He was ready to do anything.

I asked him if he had heard of Iboga. He had. He was willing to try.

> Ibogaine is a naturally occurring plant-based alkaloid, extracted from the root bark of the plant Tabernanthe Iboga. It is especially sacred to the peoples of the Bwiti religion of Cameroon and Gabon where they use raw Iboga as a natural healer and in rites of passage ceremonies (Bastiaans 2004; Fernandez 1982; Lotsof and Alexander 2001).

In 1963, Howard Lotsof, a young man, addicted to heroin, living in the Bronx, inadvertently tried Ibogaine. To his surprise, as the effects wore off, he discovered he no longer craved heroin. Lostof decided to make studying Ibogaine and the effects it had on addiction his life's work (Taub, 2015).

Ibogaine treatment is illegal in Israel and most addicts and their families are unaware of this option. When I researched it for Haim, I found that most ibogaine treatment centers provide medical, spiritual and psychological guidance. We found a relatively new center in Portugal, the closest we could find. I skyped the center and we began our journey. One of the first communications from the center was a forty-page long Patient Informed Consent Form in which the risks of taking Iboga, such as adverse interactions with other drugs, allergic response, changes in blood pressure or pulse, dehydration, heart arrhythmias and possibly death were clearly stated.

> You enter and breach the mirror, because you have yourself in front of you. You penetrate your inner self… to discover exactly who you are on the inside. – *Mallendi Nzamba, Traditional healer, Panga, Gabon*

> Phase two is evaluative – People describe it as sort of a life review whereby the images they see become more personally related, and more connected to the process of life change. It is often a very personal experience and during this phase, people often

stop talking and remain silent and thoughtful. – *Excerpt from 'Ibogaine Treatment - Patient Informed Consent Form', Portugal, 2018*

Your heart, Mom, 2019, ink and watercolor on paper 56x76cm

Haim had to undergo preliminary medical tests, especially heart tests, to ensure he was physically fit enough to survive the treatment. Usually, the patient undergoes the treatment alone. But my brother speaks no English. He needed a translator. I went with him to the treatment center in Portugal.

When we were there, in the beautiful countryside, surrounded by professional and devoted people, my brother was asked to sign a contract headed Your Commitment to Return. The two paragraphs explain that Iboga takes you deep inside yourself, and also outside yourself. You might meet the dead; you might receive an invitation. But it is important to remember that you are loved and needed here, and your departure would be very distressing for your loved ones. Commit to return.

I translated and my brother agreed. He was afraid, but he was not more afraid of death than he was of the life he was trapped in. He could not sign his name in English. So, I signed for him.

A Day that Lasts an Eternity – Ibogaine Treatment

> The opposite of addiction is not sobriety; the opposite of addiction is connection. (Hari, 2015).

The night before the treatment, Haim suffered from withdrawal pains. He didn't want to participate in the ceremony that was being held for him, an intention setting ceremony. We sat without him, together with the healers and others who had completed treatment and read the intention Haim had written on a piece of paper. The healer conducting the ceremony asked for the forces of nature to be helpful and present during the treatment, which was to begin the next morning. I was anxious and tense.

The morning came. We gathered round Haim, praying for him like a tiny tribe, full of healing intention and focus. He burst into tears; then suddenly grabbed the Ibogaine capsules and swallowed them.

He was monitored for 36 hours. I prayed silently and held his hand, let go, held it again.

I watched the heart monitor, willing the rate not to drop. When it did, I prayed harder.

I could witness Haim passing through the three phases that had been outlined in the guidebook. At first, he was fitful, complaining of feeling hot, then cold, mumbling, incoherent. Crying, then laughing. He asked for water several times. Then, after a few hours, he became quiet. This quiet lasted a long time. In fact, it was only a day after the ibogaine wore off that he began to talk again. This is the third and last phase, a period of time where the visual effects start to subside and people

remain awake, often reviewing the experience. A return to normal consciousness occurs over time with some remaining stimulation.

> As a rule, whatever we don't deal with in our lives, we pass on to our children. Our unfinished emotional business becomes theirs. Children swim in their parents' unconscious like fish swim in the sea (Maté 2008, 253).

Haim, the therapist and I, as his translator, met for the integrative part of the session – understanding and reviewing what had passed; this is crucial, as Ibogaine not only eases withdrawal symptoms and suppresses the craving for the addictive drug, it also supplies insight into the roots of the need on which the addiction feeds.

Haim remembered meeting our grandmother, and our great grandmother. Then my mother appeared, only to turn into a wolf who seemed about to devour him. Haim always thought the roots of his terror, and the roots of his addiction, were to be found in the war. But he had no visions of the war – he found a more primal terror, himself as a young child; faced with an unsafe mother, afraid, looking for a way to disappear, to dissociate. He remembered things long buried – among them that his first use of opiates had not been in the Army, but that when he was fourteen, he had taken Afyūn, a kind of local opium, in Acco.

Iboga has been used for thousands of years to assist in profound spiritual growth and deep introspection, and to regain connection to the tribe (Taub 2015).

'Mother of Opium' is the name of a new artwork that I have been working on this past year or so.

'I met Mom, but only for a second, because she immediately turned into a frightening wolf.' *Haim Mezamer, after the Iboga treatment, 2018,* Ink and watercolor on burnt paper.

The work includes about twenty interviews with opiate addicts in Israel and the West Bank, together with drawings, photographs and a visual research archive. The name comes from the ancient rituals depicted in pottery of the Poppy Goddess, found in the area of Crete, dating back to the Bronze Age (1300 BCE). The earliest use of opiates for ritual and medicinal purposes is found here, in what is today Northern Israel, Lebanon and the Middle East (Carod-Artal, 2013). The first of my interviewees is Haim, my brother. In Hebrew, Haim means life.

My brother still sits nervously at the table. His leg still vibrates with pent up energy. He still smokes and does cocaine on a more or less regular basis. But he has gained weight. He has a job. He is no longer addicted to heroin.

He has a new tattoo. It reads Ha'tikkun Ha'ishi- Iboga. Tikkun is often translated as repair. But in Jewish religious tradition it has a wide range of meanings- to improve, repair, set up, or even just to imbue something with special intention. The highest meaning of the word refers to setting a thing right – especially – the soul. To restore the soul to its proper, undamaged state. I cannot think of a word that suffices in English.

So, my brother's tattoo reads – The personal Tikkun-Iboga.

My brother has redefined his role – he is the one who has located, and reconnected to the roots – for himself, and for our family.

Author Bio

Sagit Mezamer is an artist and curator, with MA in clinical psychology, a lecturer at the Bezalel Academy of Arts and Design, Jerusalem, and served as artistic director and curator of "Yaffo 23", Center for Art and Research in Jerusalem from 2010 to 2013. Mezamer curated The Curfew Tower residency in Northern Ireland 2014-2017 (with the artist Bill Drummond). Currently, she is working on the solo project The Mother of Opium, an anthropological docu-installation dealing with opiate addiction in Israel and the West Bank. The imagery in this essay is taken from drawings and photographs from this project, most being published for the first time. If you wish to use any content/images in this visual essay, a permission is needed from the author according to our copyright policy: sagit.m@gmail.com
All drawings are ink and watercolor on paper (2016-2019) by Sagit Mezamer.

References

Alexander, Bruce. 2014. 'Dislocation Theory of Addiction: The Rise and Fall of the Official View of Addiction'. https://www.brucekalexander.com/articles

Alexander, Bruce. 2008. The Globalization of Addiction: A Study in Poverty of the Spirit. New York: Oxford University Press.

Bastiaans, Ehud. 2004. Life after Ibogaine: An Exploratory Study of the Long-term Effects of Ibogaine. Science Internship Report, Vrije Universiteit Amsterdam, Faculty of Medicine.

Carod Artal, Francisco Javier. 2013. 'Psychoactive plants in ancient Greece'. Neurosciences and History 1(1): 28-38.

Fernandez, James.1982. Bwiti: An Ethnography of the Religious Imagination in Africa (ACLS Humanities E-Book). Princeton, N.J: Princeton University Press.

Hari, Johann. 2015. Chasing the Scream: The First and Last Days of the War On Drugs. London: Bloomsbury Circus

Lotsof, Howard F. and Norma E. Alexander, 2001. "Case Studies of Ibogaine Treatment: Implications for Patient Management Strategies". The Alkaloids: Chemistry and Biology 56: 293-313.

Maté, Gabor. 2008. In the Realm of Hungry Ghosts: Close Encounters with Addiction. Berkeley, California: North Atlantic Books.

Nzamba, Mallendi. 2004. Transcript of the documentary 'Ibogaine - Rite of Passage', director: Ben De Loenen. https://www.youtube.com/watch?v=vt0E8N4FRFY&ab_channel=ICEERS

Taub, Benjamin, 2015. Hitting Reset: The Experience of Ibogaine Treatment for Opiate Addiction. M.Sc. dissertation, University of London.

JOURNAL *of*
EXTREME ANTHROPOLOGY

Treating Addictions: On Failures, Harms, and Hopes of Success
Guest editors: Aleksandra Bartoszko & Paul Christensen

Vol. 3, No. 2. (2019)
ISSN: 2535-3241