

## Questioning addiction

### Conversations with long-term heroin users in Amsterdam

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*Het medisch beeld van heroïne heeft geleid tot een ideologische constructie van 'verslaving' waarbij heroïne-gebruikers gezien worden als fysiek afhankelijk van de drug tot schade van hun leefsituatie. In de Westerse maatschappij draagt heroïne een stigma: het botst met belangrijke culturele waarden zoals productiviteit, zelfbeheersing, en een 'gezond lichaam'. Het is deze verslavingsideologie, gecreëerd en versterkt door beleidsmakers, (para)medici, vertegenwoordigers van volksgezondheid en politici, die heeft vorm gegeven aan het type zorg dat aangeboden wordt aan gebruikers van heroïne. Vanuit het perspectief van de gebruiker krijgen wij echter een geheel ander beeld van het effect van heroïne op gezondheid en welzijn. Uit gesprekken met vijf langdurige gebruikers van heroïne wordt duidelijk dat er een grote diversiteit is in typen van heroïne-gebruikers en dat sommigen van hen in staat zijn met gebruik te stoppen of een normaal leven te leiden met heroïne. Dit artikel pleit voor verandering in het beleid van institutionele en maatschappelijke ondersteuning aan heroïne-gebruikers en voor vermindering van het stigma dat op hen geplakt wordt.*

*[langdurig heroïne-gebruik, verslaving, geneeskunde, beleid, mythen, stigma, gezondheid, welzijn, Nederland]*

This paper challenges the idea that heroin use inevitably leads to destruction. In most biomedical views, heroin is regarded as a harmful drug because of its addictive qualities. Heroin addiction is characterized here in the classical sense: a process of repeated use followed by a tendency to escalate dosage until the individual endures a painful withdrawal process, faces a 'born again' process, or simply dies. I argue that heroin addiction, as presented in biomedicine, is not as unequivocal as the general public takes it to be. By exploring the lives of five individuals who were able to live long lives with heroin use, I question the popular views toward heroin addiction as an unachievable lifestyle. Perhaps health is not as dependent upon the taking of one drug as it is on the overall environment in which a person resides. Moral opposition to heroin use is based upon the views of the general public, of psychologists and addiction workers that living a life that involves regular heroin use is not and cannot be 'normal.' I sought to interview people from a drug users' network rather than one from a medical institution, in order to lessen the social distance and power dynamics between the people who used

heroin and a student. By comparing the current attitudes held by the general public and traditional views toward heroin with these five individuals, I question the seemingly definite ideas of heroin addiction through the lives of people who lived a long life with prolonged heroin use.

Since this research began as a Fulbright funded comparative study of services offered to injection drug users in Amsterdam and Chicago, I limited the research to the public health initiatives geared toward a group with 'high risk' behaviors. I began by searching for ways in which needle exchanges can be improved with the assumption that injection drug users desired improved needle exchanges. It was not until I discarded the top down approach that I was able to explore not only what kind of help injection drug users wanted, but also that 'injection drug users' was a category constructed by the public health community to target a 'high-risk group' within the HIV/AIDS epidemic. As a result, I chose to focus on the drug that propelled the 'harm reduction' approach where health workers would work to decrease public health risks if they could not achieve an abstinence only approach: heroin. Although many drug users, including the ones interviewed, use other drugs in combination with heroin, I specifically focused on heroin because of its symbolic representation as the ultimate 'addiction' and its consequent status as one of the most 'dangerous' drugs.

Conventionally, heroin is viewed through a pharmacological lens, which overlooks the positive effects of heroin and exaggerates the harms caused by heroin use. Strong social forces and environmental factors induce 'junkie' behavior, rather than the drug itself. Through an examination of aging individuals with long-term heroin use, heroin addiction can be better understood as a product of cultural, political, and economic factors instead of biology. In addition, viewing heroin from a perspective different from biomedicine enables health and social workers to approach drug users as individuals and not addicts. A medical anthropological perspective helps to reframe research that benefits the people receiving health programs more than the people who create them.

It is frequently asserted that individuals who engage in prolonged heroin use will face health problems, whether due to the pharmacological makeup of the substance or lifestyle factors related to drug dependency (Korf et al. 1999: 5, Australian Drug Foundation URL July 13, 2003). According to the National Institute of Drug Abuse, "heroin abuse is associated with serious health conditions, including fatal overdose, spontaneous abortion, collapsed veins, and infectious diseases, including HIV/AIDS and hepatitis" (NIDA URL July 5, 2003). One drug treatment center in the U.S., Spencer Recovery Centers, Inc. explains the process heroin upon drug users:

Heroin effects attack the body, the mind, and the spirit. The body will begin to atrophy, and the user will not be able to ingest or digest food correctly. The mind will no longer function properly; the user will no longer make clear decisions. The inner peace of the heroin user will quickly slip through their fingers as they reach for more heroin... Towards the final stages of heroin addiction on the mind is so immersed in the addiction that the user can no longer tell right from wrong (Spencer Recovery Centers, Inc. URL July 7, 2003).

Although this description is more dramatic than others, it is not far from the common perceptions of heroin use. There are numerous clinical trials and biological studies that state the physiological effects heroin has upon the body, one of which is physical dependence, and are used to explain why individuals neglect other social aspects of their lives for heroin. As a result, much of the focus centers upon the physical addiction as demonstrated by the use of methadone treatments. Medical workers treat heroin users as sick patients in need of chemical treatments and, in some cases, psychological counseling. Their addiction is what drives them to engage in criminal activities; the need for heroin is so overpowering that they go to extreme lengths to have their kick. Heroin is regarded as the most dangerous drug because of its notorious and well-known addictive qualities.

Yet, how heroin users themselves speak about their heroin use may differ from those in the public health service. There is little room to discuss the positive effects of heroin when so much of the focus is on the physical dependence aspects of heroin. It is not the heroin that causes one to become a 'junkie' but rather that heroin is part and parcel of a larger framework of legal, social, and cultural factors. Once heroin is taken out of its cultural context, it simply becomes a naked drug stripped of everything but its molecular structure. This research questions the biomedical understanding of heroin and its detrimental effects on people who use heroin. I conducted eight in-depth interviews, five of which were with long-term heroin users who could speak about their ability to live inside a lifestyle that contained heroin use, and the remaining three with advocates for drug users, in hopes of improving our understanding of 'harms' caused by heroin and the biomedical focus on addiction.

### **The Dutch health care system**

The Amsterdam GG&GD took the lead in providing health services for drug users in the Netherlands, because of their attention paid to preventative medicine and environmental and occupational hygiene. Drug addiction was viewed as a sickness and was treated as a medical problem (Korf et al. 1999: 2). The medical community assisted drug users since drug policies dating as early as 1920 made a distinction between those who trafficked, produced, or dealt drugs from people who simply used drugs. In the case of heroin users specifically, the GG&GD based their programs on 'harm reduction' after abstinence measures failed: "that if it is impossible to cure a drug addict one should at least try to create a situation that greatly reduces the risk that the addict harms himself or his environment" (Buning et al. 1986: 1435). They adopted this pragmatic and less moralistic approach after drug-free treatments failed. Needle exchange was one instance in which the GG&GD conformed to practices that originated outside of the public health community. It was the hard drug users union in Amsterdam who first provided free needles and syringes to injection drug users in 1983 to prevent a potential hepatitis B outbreak when pharmacies stopped selling injection equipment (Coutinho 1995: 1490). Due to parallel fears of blood borne diseases such as hepatitis, tuberculosis and HIV transmission, the Drug department of the Municipal Health Service took

over the needle exchange in 1985 as the need grew beyond the capabilities of the hard drug users union (Coutinho 1995: 1490).

Needle exchange, however, was not the only strategy to 'cure' heroin users. Methadone has been available widely to heroin users since 1981 (Van Brussell 1995: 1). For drug use and addiction, there is a three-tier system provided by the GG&GD. Heroin users who seek low threshold treatment most frequently visit a general practitioner who oversees methadone treatment for regular, stabilized users. The more 'difficult' cases are handled by the GG&GD, which has several drug programs.<sup>1</sup> The third option is for heroin users who are abstinence motivated and involves the Jellinek Center. Since the GP system is premised on the fact that they mostly serve 'healthy' people, there are basic social regulations expected of heroin using patients: medical insurance, housing, stable income situation through work or welfare payments, the ability to attend appointments, the ability to manage with weekly provision of methadone, and minimal use of other drugs (Van Brussell 1995: 4). Other preventative strategies employed by public health services for injection drug users included stabilization of drug use through methadone and medical check-ups and urging drug users to maintain attention toward social circumstances, such as "housing, money, and social relationships" (Buning 1986: 1435).

Amsterdam's public health community garnered attention both nationally and internationally for their pragmatic innovations (Coutinho 2000: 1387; Korf et al. 1999: 1).

Services geared toward heroin users are considered to be successful because the population of heroin users has stabilized. It was not only the goal for the public health community to reach as many drug users as possible, but there were large amounts of research conducted on heroin users. Throughout the 1980s, most qualitative drug studies focused on heroin or poly-drug users (Korf & Blanken 2001: 4). There were several national surveys about the public support for mandatory treatment for heroin users as well as medical prescription of heroin that was comparable to other European cities (Korf et al. 1999: 6).<sup>2</sup> More than the medical beliefs of harm and physical dependence of heroin, the general public and policy officials were concerned with how heroin addiction causes social problems like nuisance and criminality (Korf et al. 1999: 6). Although heroin users were not the biggest drug-using population, there was a lot of attention paid toward them because of their highly visible deviance and concerns that heroin users would eventually resort to criminal activities to get their kick. Today there is less focus on heroin users since the heroin using population did not regenerate itself with new users, but stayed the same, only growing older (Van Brussell 1995: 1). The remaining concerns of the public health community are now more directed toward the fact that as the heroin users age, the more susceptible they are to infirmity and illness (Van Brussell 1995: 2).

### **Two guiding theories on drug use and addiction**

One of the most often cited authors in drug policy research is Norman Zinberg, because he not only considers the pharmacological aspects of drugs, but also the mindset of the

person and the physical and social setting within which the drug use occurs. All three concepts of 'drug, set, and setting' configure into how researchers construct their drug studies. Zinberg challenges the notion of heroin as a highly addictive drug that causes physical and psychological dependency to the extent that the drug user no longer possesses control. Instead he argues that drug use is a form of social learning and can be done with control, consciousness, and regularity. Individuals make choices in deciding whether or not to use, when, with whom, and how much (Zinberg 1984: 7). Furthermore, Zinberg opposes the word 'abuse' in reference to drugs because it implies that anything but abstinence is morally wrong. In fact, he argues that drug policies ignore those who responsibly use drugs: "Since it is the moderate, occasional users who develop controlling sanctions and rituals, the policy whose goal is to minimize the number of dysfunctional users may actually be leading to a relative increase in the number of such users" (Zinberg 1984: 159). The segment of users that the public is more often exposed to contains chronic users, while the drug users who put forth a 'functioning' face to society are less visible. As a result, the image of drug users is primarily based upon the sector of dysfunctional users rather than one of functional users.

Drug debates are usually strictly dichotomous; one is either for or against. Suggesting that drugs can be used in moderation or have benefits is considered to be a vacuity of liberal thinking. This moralistic stance has made it difficult to see heroin as anything other than a highly addictive drug that ends in destructive behavior. In Western cultures, illegal drugs are symbols of moral failings. In an ideal world drugs would not exist, because the biological effects of drugs cause societal problems. Peter Cohen questions this line of reasoning by reminding us about the social construction of drugs: "We are so conditioned by medicine to think in terms of the pharmacological effects of a substance that drug use related behaviors are automatically associated with the substance" (Cohen 1990: 4). Cohen believes that it is not a drug that determines the type of person or 'junkie' but that the environment forces individuals who use drugs regularly to adapt to social exclusion and labels of 'deviancy.' Placing both of these authors as the theoretical grounding for this research is paramount to establishing the importance of social, cultural, and political economic factors surrounding drug use.

### **Broadening the population of heroin users**

Contrary to popular beliefs, these individuals who have been interviewed do not have an affinity toward each other simply because all of them use heroin. There are several movements in the United States to mobilize injection drug users into a political group where the harm reduction movement is akin to a social movement (Friedman 1998: 101). A vision of a specific kind of drug users forming a vanguard assumes that all heroin users are in the same social, economic, and political position. As long as a person is able to function in public, they are accepted members of society, provided that their illegal activities are kept private. These individuals are not represented because they have no incentive to publicize their drug use due to stigmas. Those with financial means to support their heroin use are also the ones who probably do not use public

health services should they need medical attention. Those who are able to quit heroin on their own are not recorded in clinical studies or seen by the medical community. As a result, ideas of heroin addiction are based upon one sector of heroin users. In *Mind Matters*, Michael Gazzaniga, a professor of psychiatry at Dartmouth Medical School, highlights Columbia University's Professor Stanley Schacter's study on why it was so difficult for some people to stop smoking. Schacter observed rehabilitation centers and a community of smokers and non-smokers in Long Island, New York and discovered that the ability to quit was not based on nicotine. Gazzaniga argues that specific populations of drug users skew our ideas of addiction:

They don't need treatment programs, support groups, therapeutic drugs – nothing. People who have been smoking for years on a daily basis abruptly quit. This suggested that the rehab centers were attracting only those people who were unable to stop. As a consequence, the rehab patients are not a random sampling of the population with an addiction. They are a subculture that cannot easily give up their addictions. Yet it is the patients from these centers who make up most of the studies about addiction and how hard it is to kick the drug habit (Gazzaniga 1988: 140).

The interviewees in this research were not filtered from rehabilitation centers, but were accessed through two key informants, Hanneke Oberman of Basisberaad GGZ and Job Arnold of the Hard Drug Users Union. Although it is not random, it is also not contrived in the sense that I chose them to present a particular view of heroin use. The only requirement was a history of long-term heroin use and to be at least 50 years of age. Each interviewee challenged stereotypes of heroin users, because all of them have homes, work experience, and social contacts. Even though some of the interviewees knew each other, they did not necessarily form a community. I spent time socializing and informally interviewing about 20 'hard drug users' (heroin, cocaine), but only used five in-depth interviews as the basis of this research paper. These five were chosen simply for their desire to speak with me and because of their age. (Clearly those who died from heroin use were not able to inform me why they were not able to live and whether or not it was caused by heroin or lack of access to food, housing, and health care.) These interviews lasted approximately an entire day with some additional socializing in informal settings (riding bikes, walking around the city, and drinking coffee).

All of the interviews were conducted in English, since all of the participants were fluent in at least two languages. For the most part, they are directly quoted verbatim from the interviews, but minor grammatical changes were made, and Dutch words translated into English. Their narratives and perspectives toward heroin use will be compared to the conventional biomedical ideas of heroin. Yet, these five individuals certainly do not provide a coherent 'discourse,' nor could any number of heroin users. Without unity, it is difficult to establish a coherent discourse.

### **What is ‘addiction’?**

The type of ‘addiction’ discussed in this research is the one typically attributed to heroin, a biological or chemical imbalance in which the individual is forced to maintain a constant drug intake, lest he/she suffer from intense withdrawal. I am defining addiction in the way people speak about repetitive behaviors, while revealing that addiction associated with heroin departs from the traditional definition as a consequence of its stigmas. Heroin addiction is distinguished, arbitrarily, from other types of ‘addictive’ behavior. The type of addiction politicians and doctors refer to is one based on physical dependence. The de-contextualization of heroin takes away the individual actor and leaves only the chemical properties that act upon the individual. Set routines are ubiquitous; it is considered normal, and even healthy, when people establish a sense of regularity. When we spend most of our entire life with one other person, drink a cup of coffee every morning for several years, or attend the same fitness class every week, we do not necessarily consider them as ‘addictions’ even though they are examples of repeated behavior that would lead to conflict if they are suddenly disrupted. The main difference between these types of addictions and heroin addiction is that one is socially approved while the other is medicalized.

There is an implicit understanding that ‘normal’ addictions are easier to quit than heroin, because they do not cause heavy withdrawal symptoms. The degree to which a person suffers, however, depends upon whether or not the person had a choice, who they are surrounded by, and the context in which the change takes place. A person who willingly decides to quit an activity among family and friends will face a different withdrawal period than someone who is forced to quit and socially ostracized. In addition, there is more tolerance given toward coffee drinkers than to heroin users. A person struggling to cut down on caffeine is given more sympathy than someone who starts using heroin again. The social objections to heroin use make it difficult to conceive why certain individuals would actively choose to use heroin. Thus, we turn to a physiological or biomedical explanation that focuses on the addiction and withdrawal process.

### **The role of biology**

The biological underpinnings of heroin are the main crux of anti-drug arguments. By emphasizing the physical or clinical effects of heroin, biomedicine effectively overrides the individual preference for heroin. The physical addiction no longer makes it a choice, because the chemical is seen to have more power than the mind. Yet, heroin users are the only ones who can make the decision to enroll in a methadone program and stop using, not methadone. The heroin users themselves and people working on behalf of drug users recognize the biological process and withdrawal phenomena. While this may seem contradictory, it is actually consistent with how cultural conceptions shape the way we approach heroin. For instance, Hanneke argues against the complete social construction of heroin use because she does not believe it is a decision to be a drug user: “It’s not a decision to be a drop out of society. It isn’t a decision to have no food, to have



no social contacts, to be lonely... Most drug users are lonely and not happy. And that's no choice." Currently heroin users are regarded as sick patients; heroin causes individuals to lose things because of their addiction. Hanneke criticizes the conditions in which some heroin users live, but she does not necessarily blame the drug as much as she does the lack of housing, insurance, and social respect. Arriving at the stereotypical junkie state may have more to do with social interaction than with the chemical:

By forcing heavy users of heroin in severely ostracized and asocial situations, their ways of relating to the social world around them will change. One of the consequences of ostracism is that many users are no longer seen as normal persons towards whom normal behavior is required. In their turn, heavy users will experience that if they behave normally this has little effect on the way they are treated. Their behavior is met with enormous mistrust. Ergo, users will say goodbye to the old rules of behavior because these rules are not productive for them. Abiding or not abiding to basic social rules will make little difference on their being seen as outcasts (Cohen 1992: 8).

Biomedical explanations of heroin and the construction of addiction are a way of evading the fact that individuals choose to use heroin and take on lifestyles and behaviors that are a combination of their own free will which results in them being ostracized. For if we are to argue that these individuals are making an active choice, it becomes difficult for those who cannot balance their life with heroin to seek social services and even more difficult for people to accept a way of life that is antithetical to their own sets of morals and values.

### **Mind/set/setting**

"To admit the 'as-ifness' of our ethno-epistemology is to court a Cartesian anxiety – the fear that in the absence of a sure, objective foundation for knowledge we would fall into the void, into the chaos of absolute relativism and subjectivity" (Geertz in Scheper-Hughes & Lock 1998: 368). Arguing that heroin use is a choice and that addiction is a tool for medical people to exert control immediately draws rebuttals, because of the need to distinguish what is 'right' or 'wrong' and 'healthy' or 'unhealthy,' etc. Opponents would point toward heroin users who want to quit, but cannot, or heroin users who are obviously struggling to make ends meet, hardly rendering their drug use as an appealing choice to continue their lifestyle.

This is not an attempt to deny the biological aspects, but to analyze how the biological process is interpreted to fit certain social values. Rather, I put forth once again Zinberg's theory of mind, set, and setting. All three of these elements determine a person's ability to both use and not use. Not every individual reacts to heroin in the same emotional, physical, or mental manner. The interviewees present a perspective that departs from traditional notions of 'heroin addiction':

I can imagine that different people have different reasons but the common factor is that they want to express a certain respect for their habit, for what is the conscience of their



habit... I used to think that I may have a more intimate relationship with nature by way of taking opium than by smelling roses because I make marriage with my body and the dope, and in fact you do that with a rose and that is also intimate and I don't think you can consider that as nothing because it means a lot. You do not only choose to use it because you get sick after not using it, I use it by way of preference. I prefer to feel under the influence and that is not a strong influence but it is an accent that makes my life easier. And it probably has to do with the fact that many aspects of life are not enjoyable and you try to dampen a little the input of the world (Adam).

I used (heroin) for 20 years and never tried stop using because everything went fine. I was satisfied with the way I was living. It sounds incredible but I was... But at the moment I thought I wanted to do something else, I was already 44, after 6 weeks, I was clean... (Jonah).

I do not have to go to the clinic to stop with the dope. If I want to stop with the dope, I do it for myself. When I go to the clinic or talk to a GP, I am scared that they can tell me on or off something, and I have to fight all my life for what I want to do with my life. Nobody always listens to me, because I was a fucking boy from the children's house and was always in trouble (Bastian).

The individual's motivation for using is different, as well as their motivation to stop. It is not just a person's willpower, however much Alcoholics Anonymous wants to tell us. This discussion of drug use in different cultures returns to this triangular facet of heroin use.

The 'set' or group/population of the people using affects their ability to lead a lifestyle of drug use. A mother with children who uses heroin will not only face different social circumstances, but also social responses from outsiders than a father who uses heroin would. Three of the interviewees used to be strongly connected to the artistic/music scene and all traveled to Paris (separately) to pursue their writing, music and photography. Within this scene it is acceptable to use, because it can either enable their art or because it is a social norm within their cultural standards.

The scene is what you made of people who stopped using who died from AIDS and some people who became successful and are famous in Rotterdam, famous in Holland in fact. There's a creative segment... I was part of the segment which was always playing around... making music, making drawings, writing things, writing poems, year after year... There were people who did everything wrong and had to make money through criminal acts and took their shots by using water from the streets... Then there were the people who were very ambitious and made it in poetry and in writing and in painting, and are accepted in Dutch society. People know they are shooting dope but it is expected because you become a success. There is a scene like Jules Deelder and Cornelius Bastiaan Vaandrager and Herman Brood... (Adam).

My friends, they're all musicians or painters. Mostly painters. We came back from Paris. We came here but we had no room. So we hang around the same neighborhood here. You

know, the red light district... We started to see these American militaries who came from Germany. They had a couple of weeks staying over here in Amsterdam and they brought the coke. Because there was no coke in Amsterdam, there was grass and pills, of course. Coke was for the rich people and heroin was for the poor people. But people who want to get stoned don't want to get heroin because it's the most powerful kick. You can never get off. If you have taken it, stoned on heroin then you cannot stop it. It's finished. You have to die on this kind of trip. It don't work because you're too high out. Even if you drink a bottle of black label, you don't have a high. So, if you cannot find your dealer you drink two bottles and you die. And the conditions were the most nasty, they were struggling, and HIV also... And they want to find cheap dope, so they want to go to another country. Turkey, so I followed them because first of all they were my friends, and secondly, we had nothing in common, only to be friends. They were on heroin – needle. And I was just traveling and making pictures. I used heroin, but I was never hooked (Syd).

Really, if you cannot put your creativity into art or into music, then you just don't belong to society. If you are doing something weird in the art world, then people think it's cool. You are able to do weird if you're an artist because it's normal, or, well, accepted. But if you're not living as a musician or an artist, then it's going to be a problem (John).

But it is not just within the artistic scene where heroin use is accepted. Bastian talks about the normality of heroin use within the context of growing up in a children's home and working on a ship:

I think there are two reasons. The first reason is that a lot of people working on ships were growing up in children's houses, broken families, you know? Of these guys it was too hard to handle. And then children houses you learn a lot about dope. You know that is a lot of the reason for why we were taking dope before being a sailor. Two, a lot of sailors were traveling and getting drugs in Malaysia, Indonesia, Turkey. When you're in the position then you get it. Why does so many people work on the ship and taking dope? That is the same with children houses, a lot of people taking dope they are sitting always in children's houses. They want to see the world. Some people want a house, wife, and kids, and others want something alternative (Bastian).

The particular kinds of social groups in which these individuals spent their time probably enabled them to use drugs as its use was social acceptable within that social circle. The unity of people is not just based on drugs but on personal interests, which makes the 'set' a relevant factor in understanding the varying experiences of leading a lifestyle with heroin.

The third determinant of pattern use and consequence is 'setting,' or the context in which individuals use drugs. During the Vietnam War, many U.S. soldiers used heroin and President Nixon took the accusation that all returning soldiers were junkies seriously. In 1971, Nixon commissioned Lee Robins to conduct a study on the returning soldiers' drug use (Robins 1974: 99). Robins' research findings proved to be surprising since 92% of those who were confirmed drug users through urine tests were also the

same ones who tested negative for drug use six to eight months after their return home (Gazzaniga 1988: 140). There were several reasons for their discontinued use. Lee Robins describes how the context in which one took heroin was different in the U.S. from Vietnam, and that this difference influenced the soldiers' decision to quit: "One said heroin in the U.S. was terrible. The heroin in Vietnam was 95 percent pure, and in the U.S., not more than 8 to 10 percent. And they said it was much too expensive. In Vietnam you could be an addict on \$6 a day. And finally, they said their girlfriends and their parents didn't like it, so they quit" (American Radio Work URL July 14, 2003). Another reason could be that once removed from the violent war scene, they no longer needed to use heroin. The solution of removing soldiers from war zones, however, was probably not in the best interest for the U.S. military. A heroin user who is homeless, socially ostracized, and hungry seeking to quit heroin but cannot is not a sign of severe addiction, but rather a consequence of his/her surrounding context. If that individual were placed in a new environment that includes respect, then the chances of not using would probably be quite different. Syd says that he was able to stop using heroin because of his experience meeting a guru in India, as well as having grandchildren. Both of these factors changed the context he was living in.

I went from Amsterdam to India and there was a guru. And he said, "You know heroin is like a gate opener, like when you do meditation but it is the wrong way. Heroin is the gate opener, but when the heroin wears off, the gate closes again. And you fall back again, but deeper and deeper. Because you come back deeper and deeper and you don't look after your environment. When you come back you find yourself in a hell. I just don't use it.

Syd recognizes that his ability to travel and immerse himself in an entirely new environment enabled him to quit using heroin, whereas others who face dismal social conditions find it extremely difficult to find a replacement for the comforts provided by heroin.

If your friends aren't coming anymore, then you go search for them. You go hang on the bell. You go walk the streets. You go to the places where they used to be before. And then you go kind of down. Heroin does that. And then you lose your cause and it is not possible anymore. And then you become real on the streets, sleeping on the streets. And if all that is not effective, your conscious, the, you know, you get more into heroin because you say, "If I don't use heroin, I cannot survive living on the street and eating out of the trash can." I mean that becomes natural. So, you need more heroin, day and night. You don't sleep anymore. You only drink coffee and what you can claw at the supermarket. So you become a problem and then they put you in jail and they give you methadone. You become a psych. If I swallow industrial alcohol, I become very sick and go to the hospital. But if you take an overdose or a high dose of heroin, no one is going to help you come off. I mean they put you in the hospital for a couple of weeks, and then they throw you back on the streets.

The contradictions of the heroin causing the damage and the lifestyle are resolved by blaming the drug, because it is the only way in which individuals can seek help. Heroin users themselves use that language because they are still part of a culture that views

drugs in certain ways and cultures teach people how to view the world. The language is limited to how science speaks about heroin, just as it is difficult for me to write without making a distinction between the mind and the body.

The interactions between mind, set, and setting are what enable some individuals to engage in long-term heroin use. When asked about the difference between them and people who were not successful living a lifestyle with heroin use, they did not discuss the biological or chemical aspects of the drug, but rather the mental attitude, social contacts, and living situation.

There's a psychedelic aspect of taking dope... And there is something fascinating in this world of fantasy. And the people who go crazy are the ones who cannot live without this fantasy. They cling to their fantasy and it also makes them crazy because they refuse to make a difference between reality and fantasy because fantasy is bringing the joy and adventure in their life. So that was especially with my girlfriend Cornell; she was not able to let it loose, because then she would lose everything that was interesting, because it was frightening... Maybe some people, I suppose are more lucky and they find alliterations and the charming aspects of spiritual life more easily... (Adam).

Because they have no children or grandchildren. I stopped because of my children and grandchildren. I could not face them when I was stoned. I knew that my son with his – my grandchildren would receive me and he would have me spend time with them. So I kicked... Junkies are in a high atmosphere – spiritual or mental, and they have to come back to our world and I stand on the backside of the lower world. And then when they come back to the lower world, there is nothing for them. There is nothing – no food, there is no dope... You can knock on the door of ashram, of the holy spiritual thing. Or they can knock on the door of the church, but you have to follow the church – you have to go to their meetings but not everybody accept that though... If I come home to my wife and children I feel warmth and everything I need in life. When these people come back from their trip, their heroin trip, they come back to nobody. He goes to Hell. There are negative influences. People think that they are all thieves and criminals – no, they are not. Because we alienate them from the real world, they become like that (Syd).

Well, I think it's really because of my family... I have always had good contacts with my parents. And, they're still alive 80 and 83. And they are really happy that I am working now. And I'm really repaying them for the way they treated me. I just brought them a television for my mother and a car for my father... But also I see people shooting up and really going over the edge. That's something I never did. Although I did it for 25 years now. I never went so far as I see from other people. Maybe I don't have to because it's easier. Because it's hard to find your veins, the technique... I don't want to say I'm a clever user, but you just don't go on. You stop (Jonah).

These statements support Cohen's interpretation of Zinberg's theory that junkie behavior is not caused by pathological traits, but rather from "stimuli deprivation" or "strong environmental forces which exclude people from standard forms of social relations by labeling them as extremely deviant or dangerous" (Cohen 1990: 5). Adam is clear in his articulation of bordering the fine line between reality and fantasy – an act also com-

mon to non-drug users, and the pursuit of fulfillment and happiness. Syd's desire to hold onto his family ties is an example of environmental forces impacting his decision to stop using heroin. As is the case with Jonah as well, who is extremely close to his immediate family, but hides his heroin use from them. His success in hiding his heroin use from his family and friends is attributed to his moderate and controlled use of it. In addition, none of his co-workers are aware of his drug use. Perhaps the psychological and biological explanations for continued use or disuse overlook the more compelling reasons that motivate heroin users.

### **Conflict of values**

In Western industrial society, values of youth, productivity, individualism, autonomy, and self-control prevail and give way to social status (Helman 2000: 7). Heroin users are deplored because of their public image – one that disregards these societal values. Although one can argue that drug users are enacting the ultimate forms of individualism and autonomy, heroin addiction as it is currently conceived describes heroin as a drug that denies both of these values. Their flagrant opposition to societal values causes a rift in how people should behave and act according to cultural morals. Hanneke and John speak about the separation of two worldviews:

There are two different worlds. There's the world where the people are homeless, drug users, illegal, whatever. There is a whole world of people that are not living like those in the other world. I was talking about living in society but on the sideline – there are people who are not even part of society. That's the way institutions speak about it. They always talk about going back into society. So now you are not part of society (John).

And they make it very clear to you, that you are not a part. Even if you are not feeling alienated yet, they will make it very clear to you that you are not part of society, and that society has different rules, and that you have to live according to those rules (Hanneke).

Even as harm reduction seeks to accept that drug users will not stop, they are not in full acceptance of the drug use.

They (public health/doctors) will change their angle for the acceptance of drug use; it's very fashionable as such. But there's a difference between coming to understand intellectually and really facing the consequences of accepting users and their drug use... We do not promote drug use but we do enjoy an individual's right to make a choice for themselves. To have control over your own brain and explore the many ways in which your brain functions. The many ways you can explore the state of consciousness. I think this is a right that we do not compromise on something – an inalienable right (Job).

The public health community in Amsterdam avoids debating whose morals and which morals are subject to scrutiny. Their approach is more 'pragmatic' which translates into having a heavier focus on the drug, rather than the person. Although I would admit

that the 'pragmatic' approach creates a better environment for drug users than the moralistic approach in the U.S. because more drug users have access to health care and can legally use heroin, there is still a battle of morals at play.

What shadows the conflict of morals is the fact that it is not a dialect between the mainstream and the subculture, but that the nuances of social relations and rules bend and change. Not every public health official or social worker disapproves of heroin users, and not every heroin user objects to societal values. Yet, the public opposition to these values is what is contested. There are some heroin users that are accepted in society – those who work. Earlier Adam spoke about which artists were accepted in society and which were not. Those who did not become famous were seen as junkies, whereas the famous artists became not only well-known, but excused from their drug use. There is a wide range of different types of people who use heroin. The ones who are accepted are the ones whose drug use are not publicly known and are able to present a productive face and conform to 'normal' social interactions.

I was looking to get crazy. I was really looking for it. What is the frontier of where do you get crazy and where not? And I told you I had the feeling of invincibility, and remained invincible, and maybe people will tell you that I became crazy, but I am still able to behave like a normal person when I am with normal people... I use one day of the week to going to into a café and meet people who are completely different than me and I have no problem with nobody (Adam).

We have somebody who used to work here as a volunteer after mainly being a mother for her child for 10 or 11 years. And it was time for her to start working again, so she started here as a volunteer and then moved on to a full time job with an organization that is looking after drug users called Rainbow. And she's concerned with the women for that organization. After they noticed her activities here they said that they would like to fulfill the vacancy. Unknown to her employer and most of the people around her is her daily consumption of heroin. And her past, before having her child, which is not as normal or stabilized as after her birth of her son (Job).

The ones who are ostracized are the ones who live on the streets and are most likely the same ones who use the public health services. Thus, the majority of heroin users the public health community sees are the dispossessed. Although Adam, Syd, and Jonah are clear examples of people who are able to function despite long periods of heroin use, they are considered to be anomalies. Whereas Bastian and Gabe edge more toward stereotypical images of heroin users, because of Bastian's troubled background and Gabe's heavy presence on the streets. Yet, all five of them contradict in some form current ideas of heroin users since they all have worked or continue to work, traveled extensively, and defended their life decisions. Among the five of them, they have held jobs in writing, photography, government, social services, shipping, and other service sector jobs.

For these five individuals, heroin was used for different reasons – whether to counteract the effects of amphetamines or as a way of seeking a new experience.

I had a lot of trouble with my boss who worked for the political party VVD. She gave me an order to go on the street and check all the people who sleep on street, try to take people who were using drugs their names and everything, and bring it to her, who will bring it to the register. But you know politics is very dirty. If you see politicians stray, they will put you in the mouth. I left and began taking drugs at 31 or 32 to understand them. I do nothing, how do you fight them? I know I can't win because I'll get mad. Everything when I stand up I try to make something of mine. Because nobody going to do that for you (Gabe).

I think it has something to do with concentration. You know people who have ADHD? Because I am still interested, I can still sit and read with much pleasure. But to sit down and writing something takes a lot of energy... I published some things in magazines, wrote poetry and stories. In my magazine, I published his (Allen Ginsberg's) things (Jonah).

Life is a drag. There were no opportunities. And on the top, there are always people imposing on you, what you should do. It's like small children want to grow up and you grow up. So most people on the corner go to the cinema or the bar. And then you find some other people say, "Oh, we know of a way to get out of here." They can get it. So then people start heroin. I mean not all begin this way... My start was in the army for three months... They also have photography service but they didn't put me there. They put me to dig holes and throw bombs in there... So, then I quit. I said, "No I don't want to serve." There is no future in throwing bombs in holes. They said, "No, you have to serve, every boy your age has to serve." So, then I quit, I stopped moving out of bed and I dropped pills... (Syd).

The scene I was living all used amphetamines and used heroin to dampen the exaggerated excitement. I started living the moment I took amphetamine. Like I was not really alive. I always experienced it this way. When I think about my period of youth, it was dull, music coming out of the box, there were only 4 stations, and having parents who were always behind a newspaper in the kitchen and stones in the street. And nothing. I bored myself to death until I started taking amphetamines (Adam).

I shoot heroin, coke, and amphetamine. But the best is cocaine. You know the heroin giving you body flash and when you take it longer the sickness is away. And the amphetamine gave no flash. It is more running on time and when you have to do something that take a long time of the same thing. If you have to do one hour to put something in box, and take some amphetamine and you can do it. With coke you think nice books, and dreaming more. When you take heroin one time in a couple of weeks so your body do not need, it can be nice and give you a lot of experience and a lot of visions, if you want it. But you have to put yourself inside. Lie on your bed and put some music on and that is easy... I wanted to know what it did to you (Bastian).

It is also crucial to point out that their interests and values are not entirely based around heroin. For instance, speaking about Syd's favorite subjects in photography (shadows) and admiring the photographs taken during his career as photographer illustrated



where his primary interests lied. Jonah's enduring collaboration with poet Allen Ginsberg and numerous publications, including a magazine, demonstrated his established and dedicated writing career. Adam's papier-mâché models of polymers and ruminations on 20th century history highlight his intellectual curiosity. Bastian's redecorating jobs in his home, including wallpapering and refurnishing, prove his aspirations in "making his house into a palace and finding a nice girl." I witnessed Gabe's emphasis on 'health and friends' through his interactions with people and lack of physical damages despite his absence of medical interactions for the past 20 years. Although interviewees are always in a sense performing or presenting their life in a particular point of view, their credibility is lent by their ability to produce facts from their past and confirmations made by the key informants and peers.

### **The real problem**

The physiological or pharmacological effects of heroin are real, but are not emphasized by the interviewees to the same degree as science or medicine would present. If the problems attributed to using heroin, such as unkempt appearance, thefts, and prostitution, are caused by a need for more heroin, then making the drug "more available on a regular basis supervised by responsible people" would in effect lower these social offenses (Cohen 1992: 3). Some of the interviewees also saw this as the key factor in disabling them from living an optimal lifestyle:

It is easier to do it the right way when you have an authority to trust and it has never been like that. So when you use clean stuff in a clean environment, and also not all your money – when all of your money is going into dope, nothing remains for your health or for your status, you cannot go to a café for a drink and have contact – you're social status, you're outlawed for your use. And that has an incredible impact on your health, on you life, it makes or breaks you, this difference... It's not cheap for everybody. There are people who cannot get it. Well, it depends. If you do not want in from the street, in the street you are at risk of having a bad deal. So there is people who prefer to stay with a house dealer with someone they know and you always have to pay twice as more than in the street. Then I do the same because I am sure of the quality. There is a big difference in quality. As soon as you are dependent on the street, you lose quality because there is always people who want to make money out of it. They buy something and they cut into it and add something that is not working and make some money... (Adam).

Heroin is bad. They cut it up too much. And you become weak and weak. And they manipulate you. You become a slave of the dealer. And the dealer makes out if you get good or not good stuff. Giving out junkies chemicals... There are some people who could have distanced themselves from bad dope. Rather than have good dope than be impatient and get bad dope (Syd).

The stress on quality of heroin is notable because "in its pure form, heroin is relatively non-toxic to the body, causing little damage to body tissue and other organs (Australian

Drug Association URL July 12, 2003). According to the Harm Reduction Coalition, heroin “does not cause serious, long-term health problems for the generally healthy person,” but it is the “practice of injecting and the fact that people don’t know what they’re getting when they buy street drugs that present significant short and long term health risks” (Australian Drug Association URL July 12, 2003). Thus, individuals are able to lead long lives free of any major health problems if they have access to a non-diluted or cut heroin. The distribution and cost of drugs is key to creating an environment in which individuals are able to use heroin in a regular and moderate manner:

Doing drugs did not make me unhealthy, but the way I was forced to use it, the quality I got, the way of life that was forced upon me because I preferred to spend my money on dope, and that is what I blame the government for, that I was not able to get my dope at the price that nature would demand of me. Because it is available, it cost nothing, it does not cost anything to anybody to have me have my dope, then I could become a useful member of society, when I wouldn’t have to give everything I got to get to this state... I don’t want to say that I am disappointed, but in fact I should say that I learn in a soft way because I had a lot of fun and interesting time in my life. But it brought about a lot of damage and that is what I am sorry about. But I want to say especially that the damage is from the repressive policies, from the authorities (Adam).

The affordability of heroin remains a central issue for individuals to support a lifestyle that they choose. While traditionally critics of heroin argue that the inaccessibility is attributed to drug users’ insatiable appetite to score another rush, these people would argue that the social structure, rules, and unauthorized distribution of high quality of heroin are the reasons for lowered standards of living.

Although Amsterdam has a reputation for having the least repressive approach to drug users (Prinz 1997: 379), one of the legal practices enacts a cycle of poverty. The use of bans destabilizes drug users’ environments:

There’s has been more focus on public order and new residents...It is what they called the emergency area which is the inner city of Amsterdam, around the red light district and the quarters around it like the central station. Parts of the subway system and the south-east are designated as state of emergency areas. It means that considering the events the drugs and dealers there are special authorities and police to attack this situation. When this started in 1986 and 1987 there was really a pretty bizarre situation of herds of a lot of injecting drug users at the time because there were a lot of foreigners because Amsterdam had a reputation. The mayor said this is a state of emergency and the police will be given the right to disperse any crowd more than 4 when it is drug related to remove people from the area for 8 hours when caught red handed with user items visibly at hand, or smoking, or dealing, or drinking or a knife. It started with having a knife in this area, which all users have knives to cut up their dope. So we banned the knives we ban the users. Then we ban any sharp items... Today you get an 8 hour ban for minor things such as trespassing, two lighters, a nail clipper... You are banned from the area that is very high in all sorts of drug services. So you are banned from these services like needle exchange, shelters, night shelters, your social workers, city hall is even there, the church.

All of these facilities, you are banned. Persona Non Grata for 8 hours. They have to make their money, sell their dope, see so and so, see their social worker, but a lot of people will ignore and usually they get another one, and if you get 4 within 6 months or year... and every ban is a subpoena. It is a court order. So you are not only banned but you are also to appear before the judge and hear the prosecutor who asks for a fine. It depends on whether you show up in court or not and it costs from 90 to 120-190 Euros. Sometimes it's even higher... Most of these people don't pay these fines and end up doing jail time... So if you don't show up in court, it's 120 Euros fine, and end up doing 3 days in jail. You get 4 of these 8 hour ban then you get an extra warning saying that another one would not be 8 hours but 14 days. And 14 days ban you better not show up or else if you are caught you are arrested and get either 6 weeks to 3 months (Job).

When a drug user enters jail, a series of setbacks are released that cause a person to lose his or her stable living circumstances. When an individual is put into jail for a period of three months, he or she will lose their home, because of a residency law requiring people to occupy a house without being absent for longer than three months. When a person loses a house, it is difficult to receive mail from institutions that individuals must be in contact with, since all individuals must re-register for social services including health care and insurance when they get out of prison. The bureaucratic process of gaining back housing and other provisions is a primary factor in poor living conditions for drug users:

So, they have no money, no insurance, no rights, because you have never subscribed to assistance for looking for a house. You lose everything – if you had a house, and get maybe even a job, when you are in jail because you start to steal, and then you lose your house again, because in 3 months you lose your house. Most of the people who die, they come out of jail and they take the same dose as when they went into jail, and they take the same dose when they come out and it's an overdose. And so they say, "Oh, it's an overdose." (Syd).

You need that address from one institution. You need that address to have somewhere to sleep or you can do things during the daytime. But you have to have an address of some kind of helping institution. But that means if you have a problem then you cannot function with that institution. Then you will be kicked out and normally they suspend (imprisoned) you for a period of time. If that is longer than three months then you are suspended, then you lose your address, that means that you lose your social security money, actually you lose everything. When you have no money, then you have nothing anymore. So, you are back on the street, you don't have shelter anymore, you lose your money. So that's the way they cope with people who really need help because they can't cope with the way institutions work, instead they are looking for another way, they don't want to deal with it, they put them on the street. So most of the people who are suspended for aggression, you take away everything and wait until he explodes (John).

It is not necessarily that the drug is overpoweringly addictive, but if the setting, or the context, does not change, it is difficult to maintain a healthy lifestyle. Hanneke helps

the section of heroin users who are trying to stop using heroin, mostly ones who are in the position as described above. While people who have secure housing, family contacts, and a job are able to use heroin in a regulated way, others who are using heroin heavily because they have little else, the cycle of poverty and chronic drug use can be detrimental without health and social services that take into account the surrounding factors and not just the right amount of methadone.

They are only focused on the abstinence, but that is not what is important to you. You have your debts, you have trouble with housing, I mean you don't have no place or enormous debts for rent, your social life is broken, you don't have a job usually. They don't pay attention to those things – I mean why did I finally succeed? Well, that has to do with a lot of things, but also I had a filling for my day, because I had a working project straight to the moment I was clean, so I had filling of the day through circumstances that was the end of the tunnel at the moment because of help from other people, and not the care of the institutions. But those kind of things are important. That there is a perspective to a better life. That is something they don't pay attention to. Because what is the use of being clean if you're life is one mess and you cannot see a way out? (Hanneke).

How we construct ideas of addiction influences the types of assistance strategies made toward heroin users (Cohen 1992: 4). There are methadone or heroin administering, and behavioral therapies with supervised consumption for heroin users to bring them as close as possible to abstinence. Yet, the real problem lies in the social position of a heroin user. People are more opposed to crime and public nuisance than the actual heroin use, or else people would be hounding down those who use in clandestine ways. Trying to change a person's desire to use heroin is a way of medical and political authorities regulating social norms: "For, is psychotherapy here not the quasi-scientific treatment of the suffering from social prejudice, a prejudice the addict himself has not been able to escape...?" (Cohen 1990: 8).

### **Changing how we see heroin**

Heroin was not always conceived in the way it is today in Amsterdam, since there was less visibility of heroin use prior to the Vietnam era. The individuals themselves discuss heroin in contradictory terms, acknowledging the dangers yet defending its use.

You can have delirious moments – like with music, literature, enjoying moments. It's hard to explain, but [if I had another chance] I would put it in second place. For me it was always first place. I would like to travel too, you know. Although there are many other things. But when I grew up, I think at least, it was different... Drugs were really hot. It was a hype thing to do (Jonah).

I can imagine that different people have different reasons but the common factor is that they want to express a certain respect for their habit, for what is the conscious of their habit. Kind of like in marriage – faithfulness and especially when it becomes suppressed,

when ideas become strong, you try to revolt against the repression. So, maybe your experience becomes more romantic than in reality and that's a kind of defense or unjust opinion by the people who are against it. A lot of people my age started using it in the time that the government or authority didn't make any difference between drugs. And we started using we experienced things that were completely different from what our parents said, from what our teachers on how it was, and so we had absolute no authority on what is meant to be using drugs. So we start to have much more confidence in yourself in what it is all about or how it is or how forbidden it should be. You start relying on your opinion and the problem with heroin, of course, is that it is addictive (Adam).

The social conditions in which heroin users with low socioeconomic means were forced into put them in a position where they had to accept the conditions the public health community established in order to survive. The dominance of medical knowledge has influenced how drug users discuss and understand heroin. If people become social outcasts for their drug use, one way of 'elevating' their social status is by becoming a sick patient. As more became known about heroin from a biomedical perspective, the pharmacological aspects were used to explain the repeated use of heroin. The ability for the biomedical community to forge a new explanation of heroin use is time and culture specific. The treatment of heroin users as addicts with a pathological disease was a way for the medical community to justify their treatments and services for drug users. As sick patients, heroin users could not be blamed for their 'addictive' behavior, because it was not a fault of them personally, but a chemical imbalance.

If we are to acknowledge that heroin users are not victims of a chemical but are autonomous beings making a conscious choice to use, however, it is much more difficult to create support for a deviant group, because it would implicitly improve their lifestyle. In addition, social workers, doctors, public health workers, and even drug users, would ask in exasperation: "What about the people who have tried to quit but can't?" Before addressing these counterarguments, it is essential to reiterate the diversity of the different types of people who use heroin. The people who are able to use while maintaining their health and socioeconomic circumstances are not included in the image of helpless heroin addicts. Those who are able to stop using heroin without institutional help are not the people doctors and GG&GD see in their offices. These people are able to live with heroin use without problems or quit without tortuous withdrawals, because of various factors including the individual's size, health, mood, how the drug was taken and how much, the environment in which the person used heroin (Australian Drug Foundation URL July 12, 2003). Our ideas of addiction are based upon a particular segment of heroin users: those who are not able to configure the 'mind, set, and setting' to help them stop using or use with a balanced lifestyle. Ideas of heroin addiction are formulated with those who were not able to sustain an otherwise 'normal' lifestyle. Just as some people are able to socially consume alcohol without disrupting their lives, so can people use heroin without falling into depths of despair. Just as there are alcoholics, there are people who chronically use heroin. It is not simply about the personality of a person or the drug, but also the people they socially interact with, where they live, their job, and the culture they live in.

Having established the fact that not all people who use heroin experience the same social problems, it is still of great import to help those who have trouble supporting a balanced lifestyle or stopping heroin use. "Some people can take it without much trouble, and a few people can't – and it's those people we need to protect" (Robins American Radio Works URL July 14, 2003). Again, the construction of addiction and concentration on the biological aspects of heroin impede efforts to help drug users. Even though there are relevant factors involving the pharmacological process of heroin, the behavioral or counseling should not revolve around a psychoanalytic analysis of child abuse, mental disease, or personal weaknesses, but rather on emotional and contextual factors that affect a 'normal' person.

The methadone or heroin administering treatments do not take into account the socioeconomic issues for the heroin users who are not able to cope with their living circumstances.

They can give chemicals but they get sick. Most of the people are old junkies, they have no money. So now they got chemical dope, they get really sick. You smoke too much, so they give them three lines of heroin the whole day. So, the junkie needs it every four hours. So in thirty-five minutes you take all three shots. So there is a lot of things to say against this kind of thing. They should put them into a kind of a big, empty flat or something and put social workers there. And give them heroin three times a day. Not in one time, no, three times a day – they do it for the old people here also. They give them their medicines. These are not health workers; they are social workers. But in a big flat they can give them all the care. If they are flipping out, they can press a bell. That is less costly than to have all of these police forces running behind the junkies, sitting in entries of doors or on ships... [I stayed healthy because of] way of life. I was living with my wife and we have a big house. And we were living in the nature. We had a river, garden, a big ground under the stars. You could live like that. If the outside world is living you or you are living in the outside world. I think the outside is in (Syd).

As activists working on behalf of drug users, Job, Hanneke, and John argue for better living conditions for drug users. Even though they would probably describe heroin as being addictive, their concerns are not centered on the best kind of chemical treatment, but rather on respect, insurance, housing, and health care.

You now used the word 'respect' and I think that is a very, very important thing, like I already told you before, the regaining of the self-respect, you lose it because first you lose other people's respect and you feel that, it makes you feel powerless, you lose your self-respect. And it's so weird because many people have problems with how the world is, so respect is important to them, and that is exactly what you lose – respect, where that was already a problem, people are so disrespectful towards one another. I think most drug users' have a view on how they think the world should be (Hanneke).

Living on the streets, it makes you become old real soon. It's so much tougher than living in the house. Living on the street, it's not only having a roof but also not eating okay. A lot of things are part of it (John).

There's a system of complaining, we don't have suing, we can take your complaints to the authority. Like the man I was talking to I have spent 10 hours already working on his homelessness for a special service for HIV positive people where 4 or 5 people live in a house with a lot of independence, and their daily shopping money, medication. They clean and do everything themselves. And he was thrown out and the rent was stopped for stupid reasons – abusive power for one, he was shut out from his room for 2 weeks and couldn't get access to his medication, and his HIV cure was stopped (Job).

Another important issue to keep in mind when trying to aid a heroin user to stop quitting is that it is not only the physical habit they are kicking, but also an entire way of life. Hanneke attests to the difficulty of 'rejoining society' after being a heroin and amphetamine user during the time she finished her studies at University of Amsterdam with high honors:

I think the effect of marginalization has so many bad effects. You get isolated and you get used to that culture. You don't just kick the habit, but also those years have become your family and your own culture... There are all sorts of rituals and rules, and you have to kick that as well. It creates its own rules, and indeed you do get a society that is standing apart from normal society and it makes it harder to come back because you're used to a different culture. And you start having a different definition on what is nice... I can talk about that. I don't want to be a part of the drug scene no more, but I am standing close to that, and I don't want to be – I never wanted to part of society as it is. I don't think I would be able to even because I've lived a different kind of life and seen things and lived things are not present, they are put away, they are not a visible presence in society (Hanneke).

Not all heroin users are alienated from society, but the ones who are not living a life interacting with 'normal' society are pushed to the fringes of society, where they have to create survival mechanisms that are different or opposed to the ideas of mainstream society. It is therefore more beneficial if doctor-patient conversations revolve around the patient's life circumstances, which may explain 'addictive behavior.'

### **Recommendations**

Acknowledging that long-term heroin use is a choice rather than just a chemical imbalance not only respects an individual's lifestyle, but it also highlights the fact that not every person who uses heroin faces severe problems in both health and living circumstances. The focus on addiction takes away from the social, cultural, political, and economic factors that affect an individual's ability to use drugs. The personality and the quality of heroin being used and to what degree all play a role clearly, but there should be greater efforts to see the fuller picture of drug, set, and setting. Thus, for people who are not able to successfully balance a steady life with heroin need help attaining basic assistance to escape poverty or to provide a context in which a person can stop using.



For those heroin users who do need help, there are two changes that are imperative to aiding the individual. Instead of blaming the physical addiction of heroin for repeated criminal or drug behaviors, the process in which drug users face in stabilizing their life should be taken into consideration, especially for those coming out jail.

Last December, a guy 26 years old came from jail for a number of years. This time he really wanted things to go okay, he was in a foster home when he was two years old. All of this time he lived with people like him and all of them are doing the same kind of things, you have to make yourself part of the group. If you are not part of the group then you will be alone, and everyone will shut you up or out. This person he came out of jail – two months before he came out he really started taking care of things, and he wanted this time not to fall back on things he did before, and this time it has to work out okay. So, two months before he came out of jail he had contact with the social service asking what he had to do to get all of those things done... Well, they told him when he got out of the jail that the next day that he could come and collect some money. Well, actually now we are more than four months, actually almost five months later, and social services have still not – he's living from 60 euros a week since December and he has nothing. When I met him he walked on shoes that were two sizes too short and only had the clothes he had on. This is what they do to people who have had a long term in jail. The moment they get out, they open the jail and throw them out. They have him in there for aggressive things, and then you give him nothing. You don't even give him money, you don't give him clothes, you don't tell him the way – he didn't have anything, he didn't even have identification when I met him (John).

While it may be frustrating for public health workers and doctors attempting to help patients stop using heroin, it is probably equally frustrating for the individual who is trying to put together his/her life while trying to quit a habit that provides him/her happiness, relief, or spirituality. Taking into account the context may help public health officials and doctors better understand what the individual really needs or their continued drug use.

While the shift from the biological to the more socioeconomic and political factors expands the viewpoint from the specific to the more macro level, the public health community's approach must move from the general to the individual. What is effective for the public health community is not always the most effective for the drug user. Many programs before the 1980s for drug users were abstinence oriented. The harm reduction approach was adopted later on when increasingly injecting drugs posed a threat of infectious diseases among drug users and more importantly to the surrounding population. Thus, the initiation of services sprang from concerns of the general community rather than of improving the life of drug users.

With needle exchange, it didn't start because we wanted drug users to have clean needles or *bot* (dull) needles that don't work anymore, but simply because at a certain point there was a risk with AIDS. For instance, if there was bad teeth among most drug users, if you could catch that – if that was contagious, then all of the sudden they would get dental health care... But also in the politics in addiction care – harm reduction, that's one of the

points in their programs in the things they write. For instance, they started to get ideas of housing, from the idea of harm reduction, to have less trouble on the streets. But it's a negative point that they start from (Hanneke).

The concentration was on the different types of infectious diseases that drug users could contract and pass on, as well as constructing 'high-risk' groups, such as 'IDUs.' The public health perspective is heavily influenced by epidemiology, where disease patterns are sought out with minimal bias or misclassification through their own constructed categories and labels (McCombie 1999: 28). If the public health perspective combines its epidemiology with a more anthropological view on the local level, then services can be better aimed and effective at achieving the results negotiated by both the public health workers and drug users. Including the drug user's perspective would lead to more effective results, because services would then address the needs of the individual, which can help individuals seeking assistance to quit.

### **Conclusion**

Viewing heroin users as 'sick patients' helps build support for drug treatment among the medical community, because doctors are able to treat drug users under the auspices of medical ethics. The biomedical focus, however, concentrates disproportionately on the pharmacology of heroin, removing it from its cultural context and enforcing the construction of physical addiction. The heroin users presented in this research contradict perceptions of harm and addiction caused by heroin. They were able to manage long-term drug use and did not suffer huge losses to heroin, because of their social contacts, housing, source of income, work experience, and hobbies. Without a stable environment and social networks, it is difficult for anyone to survive. People should quit using heroin if they carry the desire, not necessarily because others think they are leading an immoral lifestyle. Those who are not able to 'hide' their heroin use also face social stigmas and are pushed into the social role of 'junkies.' Heroin users themselves may speak about heroin addiction as it is presented in the medical community, because they, too, are part of the cultural context. They operate under the same culture of language and ideas of body, power, and politics. The public health community, medical workers, policy makers, and politicians dominate the cultural conceptions of heroin and enact their ideas through law enforcement and specific health treatments that are focused on the chemical aspects of heroin. A drug users' perspective on the type of institutional supports needed would not necessarily mirror those in positions of power. Throughout the interviews, there was no mention of requests for increased access to methadone treatments, but rather concerns about their living conditions caused by repressive laws and social stigmas. By ensuring high-quality heroin and regulating drug prices, individuals could spend their time and energy on other things and maintain a healthier body free from problems caused by impure heroin.

The connections made between the body, representations of the social body, and body politic by Scheper-Hughes and Lock are clearly observed in perceptions of

heroin and heroin users. Pathological explanations dominate the medical discussion of heroin, where medical people attribute the social downfall of heroin users to some form of mental pathology and heavy drug use (Cohen 1992: 2). The scientific explanatory model replaces a religious model in explaining morally reprehensible behavior. Heroin users are not perceived to be in control of their life, resulting in a clash of values and morals: "In our cultural environment of the world-view of the self-steering, independent and entrepreneurial individual, it is the 'loss of control' that is the supreme evil that has to be recognizable and exorcisable" (Cohen 2000: 1). More importantly, it is not only the value of 'self-control' that is defied, but also of productivity. Western societies are built upon capitalism where citizens must produce something of value. Everyone is expected to work in some form, whether it is being a factory worker or a professor. Although many individuals who use heroin also hold jobs, heroin users are conceived as dropouts of society who do nothing but seek out another hit. The government, medical, and public health community discourage heroin because its use undermines central morals and values in their culture. Heroin legalization gains little support because people fear a mass epidemic of heroin abuse where large numbers of people who innocently try heroin are hooked and condemned to a life on the streets. This fear is created by biomedical ideas of heroin addiction and harm.

Yet, heroin is not very different from other drugs. Regulate heroin, lower prices, and provide social spaces, and not only would crime decrease, but also the street mafia markets that dominate the drug prices. Just as prohibition failed in the U.S., outlawing heroin only increases the black market. The common argument used against heroin is addiction. Unlike alcohol and cigarettes, heroin is regarded as being the most addictive drug, preventing people from functioning or being productive. Challenging the addiction theory not only means that it is a choice, but it also makes it difficult for the government to take responsibility for the segment of users who are economically and socially disenfranchised. By blaming the drug, they are able to blame the person for his or her socioeconomic circumstances. Change the ostracization practices, however, and many problems facing heroin users would probably lessen. If people agree that the lifestyle factor is what determines a person's health, then every member of society – drug user or not should have access to basic living circumstances. Improving the living conditions for heroin users would produce three positive effects.

First, for those wishing to quit heroin, they would be better able to fit the requirements to meet with a general practitioner. As stated earlier, clients must be able to have medical insurance, housing, stable income, and the ability to attend appointments and manage methadone. If a heroin user is in jail for three months or more, they face the risk of losing their home and job, making their process in registering for insurance more difficult and in financially supporting themselves. Their ability to regularly attend appointments depends on their ability to get their immediate concerns under control, such as where they are going to sleep and what they are going to eat for their next meal. Being able to see a GP is important because it increases an individual's ability to have privacy, to be treated as a regular client among other patients, and to speak with a doctor on his or her personal issues that is more common in clinical practice than in public health services. Having normalized services makes heroin users more likely to

use them. Reinforcing current services such as dispensing methadone through the pharmacy rather than methadone clinics, for example, improves the overall experience for the individual:

The GG&GD, the health services in Rotterdam, they helped me. They made me able to go the pharmacy to get my methadone instead of going to a methadone program. And now once a week, I go as a normal customer of the pharmacy and they say, "Hello, sir," and "Goodbye, sir." And I am a perfectly normal customer and nobody notices anything of my use. I take 6 pills in the morning and nobody sees it. So they have made life more easy in that way (Adam).

Increasing participation in GP offices, however, also assumes that the GP is willing to transcend the same negative images as the general public carries toward heroin users. Since medical workers also navigate similar cultural waves, there would need to be a reshaping of attitudes toward drug users in clinical medicine.

Second, it improves the social position of heroin users. Cohen argues that 'Junky Elend' or 'junkie misery' is less in the Netherlands compared to other European countries because of more availability of higher purity heroin, methadone, clean injection equipment, basic economic assistance, and social services that support social integration (Cohen 1992). This is not to say that public attitude toward heroin and heroin users are positive, because the stigmas faced by heroin users continue to be a real obstacle in their daily lives (Cohen 1992: 9, Korf et al. 1999: 5). By continuing the positive steps toward normalizing heroin and heroin use as much as possible through social acceptance and attitudes, the negative effects that lead to isolation will lessen, and in effect increase the number of heroin users who lead stable lives. The number of people who are able to use heroin in moderate and regulated ways would increase among the wide range of different heroin users. Thus, the ones who are currently integrated into society but keep their heroin use a secret would become not only more populous, but they would also be able to lead a lifestyle that is not inhibited by fears of being social ostracized.

Third, the focus on social assistance rather than psychological and chemical treatments and legal enforcement is actually more economical and practical. It is already accepted that eliminating drug use is unrealistic. Moreover, there will always be people who choose to use irresponsibly and does who do not. Providing for people who cannot is not a waste of tax payer's money, because in fact it is a way of neutralizing the cultural forces that cause marginalization. If there is money already allocated for the drug sector, allocating the funds into housing, insurance, medical service rather than prisons would both improve the conditions for individuals using heroin, as well as give incentives for people seeking abstinence to stop using heroin. If methadone treatments are not enough to stop a person to quit because of the context in which that person is in, then measures need to be taken to incorporate a more holistic approach to treatment.

Arguing to improve the living conditions of heroin users is not unique to the Netherlands but is better developed there, and it is only appropriate to recognize the pragmatic/progressive nature of the Amsterdam public health community in providing an extensive array of services to drug users, and their continuance in working with drug users. The initiatives and services of the GG&GD are even more impressive when

compared to the U.S.' 'war against drugs.' The political climate makes it almost impossible for drug users to enjoy a social status close to those in Amsterdam, since they are imprisoned for using drugs. Thus, the ability for me to critique the biomedical perspective is one that is enabled by the current situation of drug users created by Amsterdam's public health community's work to integrate drug users into society. Yet, the construction of heroin addiction affects not only the Dutch, but also other cultures that focus almost primarily on the chemical aspects of heroin. By broadening our vision of heroin beyond its pharmacological qualities, we are also able to become more honest as to why there is so much opposition to heroin use.

## Notes

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- 1 GPs refer clients to the GG&GD usually for one of the following reasons: "coming too early for a prescription, with vague, often creative excuses, asking for benzodiazepines with a high abuse potential, unkempt appearance, complaints of family members and significant others, and a police report of selling methadone on the street" (Van Brussell 1995: 4).
- 2 In 1992, 75% supported mandatory treatment and about 56-64% of the Amsterdam population supported heroin prescription (Korf et al. 1999: 6).

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