Marginal groups, marginal minds

Reflections on ethnographic drug research and other traumatic experiences

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In this article I seek to explore the connection between personal life and research by examining my own background growing up in a religious cult and the manner in which this has contributed to the generation of analytical insights regarding methadone assisted rehabilitation and the politics of consciousness in contemporary society based on ethnographic fieldwork in Trondheim, Norway. Although altered states are a highly situationally contingent and primarily subjective experience, drug and addiction research is largely dominated by epidemiological methods relying on objective observation, quantifiable data and verifiable truths. Consequently, many professionals choose to approach the field by employing disengaged scientific methodologies that minimize investigator involvement and subjectivity, while maximizing separation and objectivity. This approach to a highly complex field leaves little space for inter-subjectivity or reflexivity. On the other hand, by explicitly examining our own native constructs, the dominant climate within which drug research is conducted and the experiential basis of knowledge production, anthropology is in a unique position to provide a much needed critical analysis of this process and the manner in which it implicates the autobiography of the researcher. In this article I will therefore investigate the manner in which the dialectic between my personal life and research generates epistemological points of access to knowledge about the field and serves as a portal for self-exploration. In so doing, I hope to transcend the Self/Other divide that currently permeates most drug research today and arrive at a deeper understanding of illicit drug use dynamics in contemporary society.

[reflexivity, subjectivity, auto-anthropology, addiction, rehabilitation, drug use, altered states, intoxication, methadone, native anthropology, drug policy, cults]

All science is based on perception, and since perception is mediated by our sense organs, neural pathways and previous experiences in the world, there is always an element of subjectivity involved in any scientific endeavor, to a greater or lesser degree.

Unfortunately, the holy grail of 'objectivity' still reigns strongly in our society, and civilization is to a large extent still "deeply based on this illusion" (Bateson 1979). In the social sciences, and ethnography in particular, the positive outcome of any investigation frequently depends on the ability to connect and establish a relationship of mutual trust with people. This connection involves an on-going dialectic between self and other, based both on who and how you are as well as how 'they' allow you to be in any given context.

My first fieldwork at a methadone clinic was a powerful and unsettling experience on many levels. One thing that became increasingly clear was the extent to which my experiences in the field were strongly influenced by my personality and somewhat atypical background in particular, far more than my academic training as an anthropologist. As Crick has pointed out, anthropological knowledge is inherently autobiographical. It arises first and foremost from a state of mind not a set of procedures or from anything actually 'done' in the field (Crick 1982: 16). Although this is frequently acknowledged among anthropologists, the actual process through which this occurs is seldom made explicit in the final text. There are probably several reasons for why this is so. A lack of time and space for instance, or perhaps a fear of exposure and vulnerability, appearing too self-obsessed, self-indulgent and not 'objective' enough prevents one from exploring this shadowy terrain. Whatever the reason, since any social interaction will inevitably involve a strong symbolic, inter-subjective and inter-cultural dimension, the 'craft' of social science goes way beyond descriptions of events, and collecting facts to be registered, analyzed and later stored away.

Knowledge of others is to a large extent based on indwelling, which means "to exist as an interactive spirit, force or principle. It literally means to live between, and within" (Maykut & Morehouse 1994: 25). This involves an inquisitive yet empathetic ability to connect and embrace another person's being in the world. Knowing, in other words, arises both as a product of our intentional (and sometimes not so intentional) interactions with the world at large, our ability to empathize and connect, while at the same time reflexively changing, and modifying our very being. Some say that this posture of human-as-instrument approach may be the only method flexible enough to truly be able to capture the "complexity, subtlety, and constantly changing situation which is the human experience" (Lincoln & Guba 1985, in Maykut & Morehouse 1994: 26). Seen in this light, reflexivity may then become a strength and valuable analytical tool. It is based on the dual characteristics of equality and distinction which both permits and demands that the researcher becomes part of the research experience based on one's own personality and self-consciousness as well as the ability to establish trust and create rapport with other participants (in Aaslid 2007).

One field where reflexivity is practically non-existent, yet desperately needed, is in drug research. As we know, a neutral, value-free science does not exist, and the field of illicit drug use is so emotionally and politically loaded that this in itself, more often than not, blinds us to our very own prejudice. What we today regard as dangerous 'illicit substances' have undergone a long process of cultural and historical transformation. Symbols and values are connected with substances that are ordered in a structure of subsequent meanings serving as a paradigm for the consumption of other

materials (Klein 2008). Public perceptions of illicit drugs in society generally reflect two opposing discourses. Where the dominant official discourse reflects a 'pathology paradigm' which emphasizes danger and risk that must be strictly regulated and controlled, the marginalized 'subjugated knowledge's' of users themselves tend to focus on agency, context and pleasure (Moore 2007). Although it is commonly agreed that understanding subjective motivation among drug users "is an essential part of any coherent response" (ibid.) a similar dichotomy can also be found in contemporary drug research. As Hunt et al. have shown with regards to contemporary ecstasy and club drug research, the approaches of epidemiology versus cultural studies "reflect dichotomous views of young people based in part on different underlying theoretical paradigms of positivism and phenomenology" (Hunt et al. 2009: 2). Here epidemiological drug research portrays club drug use as "particularly dangerous, and young people as especially vulnerable and in need of protection, [whereas] researchers trained in cultural studies begin from the position that young people are 'active and creative negotiators of the relationship between structure and agency" (Ettorre & Miles 2002: 173, in Hunt et al. 2009).

In this regard, the cultural studies approach represents a "much-needed corrective or supplement to the epidemiological research through its introduction of a focus on pleasure, subjectivity, and social context" (Hunt et al. 2009) and provides several significant vantage points from which to examine the mechanisms by which culture and politics determine which states are encouraged, tolerated or forbidden. Regrettably, for predominantly political and ideological reasons, the comparative study of psychoactive substances has not attracted the scholarly attention that it deserves. Contemporary issues reflect the agenda set by pharmacologists, psychologists, sociologists and policy makers which primarily address "the problem of addiction and 'abuse' rather than use and context" (Goodman et al. 2007: xiv). According to Sherratt, "It is one of the paradoxes of Western, twentieth-century life that, although we have access to more information than ever before, the nature of our industrial society makes it harder to perceive other cultures except through categories which are largely inappropriate. This, in turn, makes it harder to see our own culture in comparative perspective" (ibid. 2007: 1).

To this day, with very few exceptions, there is almost a complete lack of presence, voice and reflexivity within drug research literature. This is somewhat predictable considering the general political climate of the past few decades. As Lenson (1995) has pointed out in *On Drugs*:

> Never has 'the death of the author' been more desirable – and more advisable. The 'Just Say No' campaign of the Reagan years was designed to preclude exactly this kind of talk. Drugs are the Unspeakable, and yet this is what I have to speak about. A properly dead author could endow this project with respectable necrography and uphold what Alan S. Weiss calls the "prohibition against the use of the word 'I' in the critical text or theoretical text." By at least playing possum, if not actually dying, I could create an 'invisible image' of myself as disinterested and disembodied philosopher taking up an unpleasant matter against my will, doing a dirty job that someone has to do, my self-effacement

> necessitated by an ongoing social crisis that must enlist everyone, even reluctant metaphysicians (ibid. xviii).

Consequently, one of the greatest challenges for me during all my years as an anthropologist and drug researcher has been finding a place for myself – my voice, experiences, and subjectivity (see also Aaslid 2007). Situating myself as author has proved to be an almost impossible task, both because the perspective I was attempting to portray conflicted so radically with the dominant paradigm, the academic jargon used often distorted that perspective, and also because being in the field itself revived some rather unfriendly ghosts from my past, which as it turned out, has had major implications for the analytical results and development of my research. Previously, I have mostly relied on the voices of the Other, both my respondents and other 'experts' in order to express much of what I wanted to say, but couldn't. This paper is an attempt to remedy this situation for several reasons. For one thing, I strongly feel that situating myself more explicitly and reflecting over why I found my first fieldwork experience so disturbing may provide new and important analytical insights. Secondly it will help me, the author, gain some desperately needed light and clarity by becoming more conscious of the process by which these insights were generated in the first place. And last but not least, it is just one of those stories that needs to be told. I am writing this for my own peace of mind. It has taken me a very long time to collect all the pieces, gain some perspective, and create a coherent framework of interpretation that might explain my reactive responses in the field and perhaps serve some useful analytical purpose at the same time.

Entering the field

It's been over ten years now since I first set foot in the world of illegal drugs as an aspiring and idealistic Master's student trying to capture 'the native's point of view' at a methadone clinic for heroin addicts in Trondheim, Norway. It was an experience which taught me a lot more than I wanted to know, both about myself as a person, my role (or lack of a role in many cases) as an anthropologist, and the drug field in general. The first thing I learned upon timidly entering the clinic was that I seemed to have much more in common with the 'natives' than most of the staff at the clinic. While in any other ethnographic setting this might be a reassuring discovery, at the methadone clinic it complicated matters, to say the least. Although not a complete stranger to altered states, this still came as something of a surprise seeing that I, unlike the 'natives', had not exactly developed the habit of regularly injecting opiates into my veins. As I was soon to discover however, what we had in common was based primarily on perspectives, not what flows in and out of our blood streams. It revolved around a similar way of viewing the world, relating to it, and expressing ourselves in it.

I grew up in what social scientists like to refer to as a 'new religious movement', a pleasant understatement for what most people call a fanatical cult, and spent most of my formative years segregated in a bizarre, clumsily fabricated, ideological cocoon.

This additionally involved drifting about from country to country, and place to place, always the stranger in a strange land, often stigmatized and traumatized through a long grueling process of shoddy socialization, lack of bonding and a general sense of failed programming within the sociocultural matrix. I looked normal enough but felt like a misplaced alien in most settings. In addition to moving about a lot, I was also stigmatized within the movement since I was born out of wedlock, which made me impure and 'unblessed' compared to the other children. So not unlike the addicts at the clinic, I knew what it felt like to be an outsider. Since my circle of friends at the time also included many outcasts and several addicts, I also knew the lingo, general codes of conduct, and had for some reason also developed the same kind of twisted sense of humor. Great point of departure for a career as a drug researcher and anthropologist perhaps, but not so good for self-esteem. I wasn't supposed to be the 'other' and in this case in particular, being a misfit anthropologist with no concrete role at the clinic made matters worse. As I drifted anxiously through the corridors, in and out of meetings, feeling like the big fat fly on the wall with only my notepad and pen to cling to for protection and a sense of purpose, I felt more and more like a vulnerable, pre-habilitated, liminal native for every passing day.

I guess I discovered experientially what Becker (1963) and Goffman (1963) had revealed decades ago, that being an outsider is more of a viewpoint than anything else, a way of seeing the world. Most anthropologists are well-acquainted with the Outsider perspective; it is in many respects the trademark of our craft. 'Fieldwork' and 'participant observation' more often than not, involve starting out as the freak in the group, immersing oneself among an assembly of Others, hopefully gaining their trust, and learning their ways. This is rather like starting the socialization process all over again, only in this instance we are not drooling toddlers but anxious anthropologists hoping to gain academic credentials, and perhaps even some original empirical insights during the process. In my case, the clients quickly picked up on my mounting anxiety and insecurity, and before long, sensing that we had something in common, took me under their wing. The boundaries dissolved and very quickly I began to feel more and more like 'one of them', the only thing missing was methadone and weekly urine tests. Although this had a positive effect on fieldwork (which was all about the clients perspective, after all), this made it exceedingly difficult for me to relate to the staff, many of whom seemed to view my 'mingling with the clients' with plain distaste. Not only did I strongly identify with the clients on many levels, but I also had a very difficult time swallowing the official public health perspective on 'drugs' and 'addiction'. It struck a strangely familiar cord and reminded me far too much of my own puritan extremist cult upbringing, which was packed with warnings of doom and damnation if one strayed too far from the straight and narrow path into the 'outside world'.

Within the context of methadone assisted rehabilitation there were many similarities, only in this case the impure clients had already strayed from the path and were being cleansed or 'rehabilitated' from their evil ways. Intoxication was 'the enemy', according to the director of the clinic, and methadone was the cure, or at least an acceptable substitute. The problem was that methadone was also highly (if not more) addictive than heroin, it could also cause intoxication, not to mention overdose, and it

had, as I later learned, a whole range of unpleasant side-effects which heroin did not. It lasted longer than heroin though, and could be administered orally, and was thereby easier to administer, regulate and control (or made the clients easier to control). The boundaries were set but seemed a bit fuzzy at the outset; I called this the "methadone muddle" (Aaslid 2003a) and quickly learned that it's not what happens to be floating through your blood stream at any given time which necessarily sets you apart from the flock, but how others react to and define the act of messing about with your bloodstream, and this is the difference that makes all the difference.

As it happened, I discovered a few years later that all of my informants (not counting three who died) had eventually been thrown out of the project, often several times, due mostly to recurring relapses. This involved primarily barbiturates, amphetamine and/or cannabis; despite being on exceptionally high doses of methadone (I think the average back then was about 120 mg a day). Relapse was a recurring theme at the time of my fieldwork also, and it became more and more obvious that addiction involved a lot more than brain chemistry. It was a way of life, an identity, a way of being in the world, and one small bottle of methadone, no matter how high the dosage, could not 'cure' the addict without taking that into account. While the staff seemed to acknowledge this, on paper and in public anyway, the focus at the clinic was primarily on keeping the clients 'clean', not necessarily improving the quality of their life. Relapse was seen as a failure to comply, or as a lack of motivation, and no matter how much things had improved in their lives (which they did, often dramatically) as long as there was illicit drug use on the side (even taking one valium tablet would be considered a relapse if it showed up in the weekly urine tests), this 'drug episode' would become the primary focus in meetings and clients were made to feel like losers. If relapses continued, they were then put on a three month 'absolute plan', meaning that one more relapse during that time and they were thrown out of the program all together.

This agenda strongly reflected a moralistic zero tolerance approach and created a clearly discernible, unhealthy imbalance of power between the staff and the clients. Instead of being open and honest about their drug problems for example, they would often say whatever they thought was necessary to keep the methadone supply flowing smoothly. This in turn was regarded as being deceitful and manipulative by the staff, who encouraged honesty and openness yet punished clients who continued to maintain old patterns of drug using behavior (which were, after all, the reason they were at the clinic to begin with). Effectively then, this form of treatment trapped the clients into a typical Batesonian 'double bind' (Bateson 1972), damned if you do, and damned if you don't. "We're here to help you" translates as "we're here to control and punish you" if clients don't comply with the rules and display any signs of addictive behavior. Although officially addiction is defined as a disease, in practice, any addictive behavior is condemned and punished as criminal. Clients obviously had developed 'native' perspectives of their own drug use, but most of their experiences and insights did not reflect the accepted public discourse or belong to the realm of legitimate knowledge. Consequently, this created a distinct division between 'us', the clients and 'them', the staff, and a marked contrast between frontstage interactions and dialogue, compared to what went on backstage.

Personal life and ethnography

As a child and adolescent I had experienced a similar dilemma growing up in a strict religious community which was based on an ideology and belief system that I had great trouble relating to and identifying with. There was a sort of caste system which segregated children based on whether or not their parents had been matched and married by 'True Parents' (the leaders of the church). Most of them had, and were consequently referred to as 'blessed children', born pure without original sin. As an 'unblessed' child however, I soon found that the dominant church ideology was not very constructive for my self-image, and therefore constructed my own version of reality independently of the environment in which I found myself, and more in tune with the 'outside world' (that is the rest of society, which we were taught was both very dangerous, evil and satanic). I knew how to 'walk the walk and talk the talk' (Skoll 1992) within the movement but for my own sanity, I ended up rejecting and rebelling against the orthodoxy of church ideology, fully aware of the fact that this would (and did) make me impure and 'satanic' in their eyes. I spent most of my childhood in limbo, not really belonging to either world, 'outside' or 'inside'. That's probably why anthropology appealed so much to me in the first place; it finally gave my liminal fate some legitimacy, positive value.

Needless to say, I sympathized with 'my tribe' at the clinic. I intuitively understood their predicament on a very deep level, and saw their occasional relapses as a form of self-medication and temporary refuge when the strains of being suspended in limbo as a methadone client (neither junky nor 'straight') was too much to bear. I was in my own hellish limbo at the clinic and had been forced to confront similar identity issues long before I entered the field, so I could definitely relate to their plight. As one client put it, "It's better to have an identity as a junky than no identity at all." That made sense to me, and often made me wonder why I never became a junky in the first place, it sort of 'lay in the cards' I had been dealt. The more I learned about addiction and vulnerability the more I realized that I was definitely in the risk zone. Social exclusion, instability growing up, abuse, trauma and victimization were all factors that increased the likelihood of substance abuse.

One thing is certain; there are not many drug researchers who ask the question "why didn't I become an addict" as opposed to "why did THEY become addicts." Fieldwork, however, pretty much forced me to reflect along those lines. I guess I approached it from a slightly different, more 'indigenous' perspective. Seeking temporary refuge in chemical highs when the world just became too painful and there seemed to be no way out made perfect sense to me. After all, I had my booze, but I also had my identity as an 'anthropologist studying junkies' which perhaps kept me from becoming a heroin addict like so many other traumatized misfits in the end. That's one theory anyway. Maybe I'll write a book about that one day and call it "How anthropology saved me from heroin hell."

All in all, my ethnographic exploration at the methadone clinic was no picnic, and I sometimes thought to myself that if growing up stigmatized and ostracized in an intimidating cult didn't push me over the edge, then this certainly could. My way

of thinking about drugs and addiction was highly inappropriate, as I soon learned, so I eventually stopped going to the clinic all together, and continued doing fieldwork pretty much everywhere else. I did manage a few interviews with some of the staff, just to have that point of view. These interviews went surprisingly well, and also helped me realize that it was not so much the staff members as individuals that I had problems with, but the presuppositions on which the rehabilitation of the clients was based, their belief system so to speak. This was more on a tacit level though, not something that I was all that conscious of intellectually at the time, I just felt extremely uncomfortable at the clinic. There is something quite unsettling about realizing that your own insights, experiences and perceptions are illegitimate and irrelevant, they don't count, and that voicing them will most likely lead to stigmatization and ridicule. I grew up in that kind of environment and the clinic seemed to replicate that experience for me and many (if not all) of the clients. Consequently, most of the time I just sat there, quietly, feeling very ill at ease, but doing my best to at least look intelligent and good-natured.

My first fieldwork experience brought up so many issues from my past that I vowed never again to do fieldwork in any kind of drug rehabilitation centre. It just got too personal. It was all about demons and angels and hell and damnation all over again, but on a far more subtle level. It all just 'felt' wrong, it was embodied, illegitimate, tacit knowledge that I wasn't supposed to know but did. However, I was too young, inexperienced and timid to consciously deal with what was going on, it never really became an object for reflection. It didn't seem 'appropriate' and in any case, to what extent are we anthropologists (or any other social scientists) "ready to suffer the anthropological gaze?" particularly when that gaze reflects a rather unflattering image, highlights the blemishes and freezes the smile (Depelchin 2005: 103). I wasn't ready, but at the same time I had no choice, fieldwork transformed me into the stigmatized Other, and at some point I had to deal with it, 'anthropologically'. So to sum up so far, my 'cult-kid' traumas, in addition to my liminal status at the clinic, enabled me to both strongly identify with and relate to the experiences of the clients at the clinic, yet paradoxically, these factors also made articulating those experiences exceedingly difficult, unless it was through the medium of someone else's voice. I knew that being an anthropologist involved my whole being, 'you are the instrument', etc. but this was way over my head. It was a trauma trigger and creepy flashback to stuff I thought I had grown out of and put behind me years ago, although it took me years to figure out why.

Michael Agar once pointed out that high-quality ethnography is all about pursuing shocking discoveries, things that don't really make sense or seem rational at first sight, not testing a trendy theory or proving a given hypothesis, but creating something new out of something slightly amiss in the field (Agar 2006a). That's all very well and good as long as it mostly involves the Other, but when it intimately engages the anthropologist him or herself that's easier said than done. In my case, it was not the right time; I didn't have the guts nor the insights necessary to explore my cult-kid flashbacks at the clinic in the actual text. Not explicitly anyway, I scarcely scraped the surface and just managed to send out a few subliminal messages in between the lines. At the same time however, it gradually dawned on me that staking out new territory,

exploring new perspectives and challenging established assumptions was actually part of my job as both anthropologist and drug researcher. On the one hand this came more or less naturally to me, while on the other it also tended to made me feel like an insecure, demoralized infidel, at least when confronted with the guardians of the dominant drug discourse.

This feeling continued to haunt me over the years and was revived on many occasions, especially at conferences and other public events where there was always a great assembly of 'guardians' and I had to present my work. There was obviously a 'right' and a 'wrong' way to think about drugs; conventional established views were correct, while anything challenging those views was immoral and wrong. Once again, I just couldn't bring myself to relate to the dominant discourse, in this case the decontextualized dogma on illegal drugs. Consequently, I was frequently left with an uneasy feeling of either being fundamentally flawed or trapped within the midst of a congregation of well educated idiots. Even when it was nicely wrapped in impressive, high-tech medical lingo, topped with statistics and incomprehensible graphs, it still basically seemed to boiled down to an almost childish, simplistic dualism between the 'good' drugs and the 'bad' drugs, mostly based on whether the dealer is a pharmacy or the freak next door. Fortunately, as I have discovered more and more, this wasn't just about me and my messed up childhood. The number of texts which openly criticized this simplistic, dualistic paradigm seemed to be growing exponentially year by year and also included many groundbreaking ethnographic classics like Zindberg's *Drug, set and setting* (1984), Rubin's and Lambros, *Ganja in Jamaica* (1975), Agars, *Ripping and running* (1973), Bourgois *In search of respect* (1995), just to name a few.

Essentially, what these findings implied is that the disturbing incongruity and cognitive dissonance that I and the 'natives' were experiencing on a very personal level actually reflected dynamics on a much larger scale, embedded in the system as a whole. What has become more and more obvious regarding the problem with the dominant paradigm of established drug discourse is that there is no space for cultural or historical context (the main point of departure for indigenous perspectives). As soon as these perspectives are included, conventional 'drug speak' just stops making sense. It was a classic case of purity and danger (Douglas 1984), sanctified 'inside world' perspectives were reflected in the established drug ideology while anything (or anyone) threatening them became polluted and marginalized. This applies to no less to 'drug experts', in particular regarding their own user experiences, as Agar notes:

> Once I became a genuine drug expert, I learned the drug expert rule. I could no longer talk about my own drug use, past or present. God forbid a drug expert should actually have any real experience with illegal drugs. Unless of course he or she had lost it completely and recovered, thereby demonstrating through biography the truth of the drug warrior vision. Repenting and abstaining and returning to the church to heal sinners like him or herself was acceptable. But doing just fine and adding a little illegal chemical to the life mix was not. Official drug experts could only be virgins or ex-whores (Agar 2006: 171).

This in turn produces a bizarre and peculiar field where "the experts can only be terrified of or resentful towards the subject of their expertise" (ibid.). There are interesting parallels between the general atmosphere surrounding illicit drug use and the highly charged and somewhat paranoid political climate rampant, particularly in the US, during the Cold War. By employing a politics of fear, 'drugs' have now become as much of an undifferentiated enemy as Communism once was (Walton 2001: 15) and conformity of consciousness, which was the hallmark of the Cold War, "became the foundation for the War on Drugs" (Lenson 1995: 9). In this landscape drug users, and especially addicts, have been transformed into key metaphors; folk devils (Cohen 1972), contemporary witches and demons, who must be carefully monitored and controlled at all times.

Lately, it has become more and more clear to me that the problem in the drug field today is not so much a lack of knowledge as an inability, or unwillingness, to integrate new perspectives and insights into policy and discourse. It would be nice to think that I could come riding along on my little white horse and anthropologically save the world from its drug delusions. Regrettably, there have been many before me, with sharper tongues and quicker minds, who have tried and failed. To cite Michael Agar once again, one of the most gifted among them:

> The topic carries so much freight, everywhere I have worked, that legitimate research questions can get stomped on like fire ants. You can ask and answer them anyway – most of us have and continue to do so – but the results will not enter into the policy flow, and you will become a persona non euphoria. This contradiction has frustrated me for years, in the US and everywhere else I have worked, and unfortunately I do not see any end in sight (Agar 2006: 257).

The 'Therapeutic State' ensures that social order is maintained through a collaboration between science and medicine (Klein 2008; Szasz 1985). This in turn provides legitimacy to the divisions created by the state and which category a particular mind altering substance falls into. A "straight forward scientific issue" is subsequently established out of what might otherwise be regarded as an "irrational and unpredictable enterprise driven by the historically contingent forces of culture and commerce" (DeGrandpre 2006: viii). In this respect, myth was not replaced by modern science. "Instead, a cult of pharmacology emerged as pharmacological essences replaced magical ones," and the innate power of chemistry could bypass all social conditioning, and directly transform thought and action. DeGrandpre is quick to point out that this process was not a deliberately orchestrated conspiracy but involved "various networks of understandings within which drug-related phenomena, both praised and condemned, were interpreted, and how these understandings caused social and historical determinants of 'drug effects' to be overlooked" (ibid.).

> The pharmacological industry, the tobacco industry, modern biological psychiatry, the biomedical sciences, the drug enforcement agencies, and the American judicial system – all these institutions were quick to embrace and promote a cult of pharmacology not as a

> conspiracy but as a belief system that served their own interests, albeit in varying ways… America became the world's most troubled drug culture not because the government conspired to allow access to drugs to some while denying access to others, but because more than any other nation, it was a full member of the cult – it truly believed (ibid.).

Adler (1972) referred to this process as the "pharmacological fallacy," where the chemical properties of a drug alone are seen as the sole determinants for its potential harm, subsequently ignoring completely the entire "matrix of psychological, cultural, and social values" within which every substance, whether it is beverages, pills, injections or smoke, is embedded. In other words, "There are no good or bad drugs; there are only good and bad relationships with drugs" (Weil 1983). However, during the past century, drugs in society have been consistently loaded with "extraneous meaning – with myth," this meaning then "joins the drug ritual itself, animating outcomes… As 'soul' was reinterpreted as 'mind,' and 'spirit' was reinterpreted as 'biochemistry,' magical explanations of drug action fell out of use. Indeed, psychobabble and biobabble had taken their place" (DeGrandpre 2006: viii). Seen in this light, the effects, uses and users of drugs are also affected and thus transformed by the social meanings drugs acquire. Had these insights been acknowledged, or gained the same level of legitimacy among the public at large as the 'pseudoscience' that developed later during the course of the twentieth century, they might have "undermined the modern mythologizing of drugs as angels and demons" (ibid.).

The politics of consciousness, in other words, are always contextual, but this cannot be explained or understood without explicitly revealing some uncomfortable truths. Several authors (Cohen 2009; Agar 2006) have used the analogy of HC Andersen's 'The Emperor's New Suit' to describe the subsequent lack of critical discourse within the drug field. Here, a false message, for instance 'drugs are evil', is conveyed to the general public combined with a meta-message that insures the delusion continues even in the face of obvious contradictions. There is often a significant correlation between "social, economic and political blemishes" and a "disproportionate number of people taking the chemical high road" (Agar 2006: 21).

> You can't understand and explain an intoxicated corner of a society without a critique of the larger society that produced the historical conditions that make that corner the place it is. That, needless to say, isn't what the politicians wanted to hear. So they turn to *medicine*. Medicine doesn't talk about society; it talks about sick brains (ibid.).

However, in this case the emperor is not any one person, the naked emperor of the War on Drugs is a distorted way of seeing backed by power. "It is a framework built over time, a framework that uses science and medicine to serve political ends … The swindler is a historical demon that the powerful call up to delude their public" (Agar 2006: 15) and in many cases, anyone contradicting the dominant 'pathology paradigm', is seen as dangerous, incompetent, or both.

Georges Canguilhem's (1991) ground-breaking work in medical anthropology strongly challenged the process of reductionism and mechanistic tendencies of bio-

medicine by providing a strong biological and philosophical basis for the significance of individual feeling and context rather than biochemical abnormalities expressed quantitatively. This qualitative notion of normality strongly emphasizes the manner in which the environment defines health or disease by way of adaptability. "An inability to tolerate and adapt to one's environment produces disease. The total environment now becomes an equal partner with the whole individual in understanding the genesis of illness" (Horton 1995: 318). The types of respondents included in a research project, the questions asked and the attitude taken towards them in terms of defining their behaviour as pathological and uncontrolled, as opposed to seeing it as a strategic, often temporary, adaptation to circumstances (as even rat studies have suggested; see Alexander et al. 1980 and Schenk et al. 1987), will profoundly affect the findings and results. Most drug research in the past decade has been within the field of psychiatry, clinical psychology and biomedical disciplines, with a strong problem focus that often disregards subjective motives, symbolic import and sociocultural factors. For example, an internet search on the Web of Science for the term 'cannabis' in the period 1997-2007 revealed that only 10 out of 3,500 articles were within the discipline of sociology while 1,200 records were within psychiatry (Pedersen 2009: 135).

Today, epidemiological approaches within the social sciences and medical professions still largely dominate the debate leading to a re-enforcement of current ideologies with a total disregard for evidence showing that the current system of classification is both irrational and misleading (Nutt et al. 2007, Van Amsterdam et al. 2010). In many respects, criminalization and the war on drugs have had far more catastrophic consequences, both on an individual and global level, than the illicit substances in themselves ever could (Mena & Hobbs 2010). Drug harms are in many instances a direct consequence of criminalization, but instead these human tragedies are used as a further argument and support for the current system. Agar once stated that the drug field should be one of the most "exciting transdisciplinary cutting-edge" and "challenging fields on the intellectual landscape" (Agar 2002: 255, 257). This, however, is not the case due to a complex dynamic of power and knowledge that is all-pervasive, institutionally, academically, and internationally. Up until now, the experience of most ethnographers and other drug war 'dissenters' has been a long and frustrating struggle of trying to "speak truth to power and finding out that power doesn't give a damn" (Agar 2006). Ultimately, real change depends on whether or not those in power; the professionals, politicians and other 'experts' in the field, "can accept that humanity can only be seen and salvaged if, and only if, they are willing to see it through the prism of all the wretched of the earth" (Depelchin 2005: 21).

Concluding remarks

I started out this discussion by reflecting on my own personal experiences in the field over ten years ago. I felt that before embarking on yet another ethnographic exploration in the underworld, I needed to gain some clarity and perspective by reflecting over what really happened and explicitly situate myself with regards to the dominant

drug discourse. Obviously epidemiological science and medicine have much to offer in their own way, but human beings are far more than wandering biochemical brains on sticks. We are embodied beings, immersed in dynamic, sociocultural landscapes, shaped and maintained through inter-subjective interactions, and this is precisely what is left out of the picture in the essentialized drug discourse. Consequently, a huge gap is created between silenced 'folk models' and legitimate 'professional models', which results in the perpetuation of overly simplistic almost simple-minded policies and treatment agendas that are far removed from the daily reality of those closest to the drugs and their use (Agar 1985). Therefore, drug users and addicts are repeatedly forced to stifle and deny their own ethic of truth and adopt the dominant belief system, which is based on a grossly decontextualized pharmacological fallacy.

Rehabilitation in this context implies far more than giving up a chemical substance, it means negating a fundamental part of who you are, doubting your own way of perceiving the world, and converting into a cult that seems to totally negate your own experiential reality. Not surprisingly, relapse rates are high and many never return from the other side. As an ex-cult kid entering the scene 'anthropologically', I was almost instantly confronted with an eerie feeling of *déjà vu*. Being 'un-blessed' as a child also forced me to choose between two models of reality. Either I 'converted', that is to say denied my own phenomenological reality and adopted a pre-packaged set of simplistic, dualistic and stigmatizing beliefs, or I resisted, and was banished into the evil 'outside' world of sin and damnation; sort of an existential catch-22. I somehow sensed an uncanny similarity at the methadone clinic, albeit on a very subconscious, primarily tacit level, which made the experience all the more unpleasant.

We all adhere to a set of beliefs, and are continually constructing and re-constructing reality based on a complex system of categorization and socialization. This process is in most cases taken for granted, and happens largely on an unconscious level until something forces us to reflect over our perceptions. Finding oneself stuck in-between two very conflicting models of reality has a rather unsettling effect on the psyche in terms of re-affirming the fluidity and fragility of our own little life-worlds, and becoming uncomfortably aware of the many layers of illusions that must be perpetuated in order to keep them intact. Due to my own background, I have always had a deep-seated mistrust of any model of reality based on a dualistic world view and grounded in fear. I know from personal experience that nothing is ever fundamentally good or evil, there are far too many grey zones and a whole spectrum of colours to add to that, and in the final analysis, it all depends on where you stand in the total scheme of things.

The war on drugs, as in any other war for that matter, can only be waged by way of decontextualizing the Other. To the extent that the whole field of anthropology is based upon contextualisation, reflexivity and cultural critique, it has much to offer by way of approaching the issue "not from the premise that drugs are a problem to be eliminated, but a social phenomenon to be understood beyond a simple moral division into good abstinence and bad consumption" (Klein 2008: 33). After all, we have a long tradition of studying social phenomena which "at first sight seem evil and strange… to make the strange familiar and the familiar strange is to generate critical thinking and explore alternatives" (ibid.: 36). This is one of the key principles in our

discipline, yet this approach by its very nature, threatens the dominant paradigm, and the potential of this kind of research has had little significant impact on public policy so far. Seen from the perspective of drug prohibition, exploring the meanings people attach to their drug use is simply regarded as yet another way of "justifying and legitimizing that use" (Buxton 2006, in Klein 2008: 35).

My background has given me a unique opportunity to reflect over the process of Othering from a more or less indigenous perspective, as a cult-kid, sociocultural misfit and adult anthropologist. On the one hand, this has made gaining access and rapport with addicts and drug users largely unproblematic, while on the other, it has made finding a voice and place for myself an extremely challenging task. It is a voice from the outside, a dissident, infidel 'non-believer', and that means facing my own demons from the past in a re-embodied collective form. Anthropology ceases to be a purely intellectual pursuit but becomes highly subjective, emotional and existential. Growing up misplaced amidst a peculiar group of devout totalitarian teetotallers has evidently had a lasting impact on my own perceptions and the fact that I identify so strongly with the 'wretched'. Boundaries become blurred and things tend to get personal. At least I have been fortunate enough to stumble upon a profession where my freakish being in the world can perhaps be put to some good use. In any case, writing my way through this mess has enabled me to create enough distance and objectivity so that I can start to see the terrain without getting totally lost among the trees. Hopefully these insights will contribute something by way of expanding our understanding of what addicts and drug users are up against today and perhaps give their voices far more legitimacy than they have had up until now. I have my doubts but it's worth a try anyway. The American poet and philosopher Ralph Waldo Emerson once said that to be yourself in a world that is constantly trying to make you something else is the greatest accomplishment. I agree and will leave it at that for now.

Notes

Flore Singer Aaslid completed her doctoral studies in January 2007 at the Norwegian University of Science and Technology (NTNU), with a primary focus on anthropological approaches to substance use and abuse in contemporary society. Her dissertation was entitled "Facing the Dragon: Exploring a conscious phenomenology of intoxication" and can be regarded as a continuation of her previous work which explored rehabilitation from a user's perspective based on fieldwork at a methadone clinic in Trondheim, Norway. The main objective has been to use the discipline as a reflexive cultural critique in developing and applying traditional anthropological theory and methods to contemporary social problems such as illicit drug use and addiction. She is currently engaged in postdoctoral research at the Department of Social Anthropology at NTNU with a project entitled "Cannabis: An ethnographic exploration of individual trends and socio-cultural context." The project is funded by the Research Council of Norway (NFR). E-mail: flore.aaslid@svt.ntnu.no.

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