



“We’re supposed to be a family here”: An ethnography of preserving, achieving, and performing normality within methamphetamine recovery

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ABSTRACT

The perception of being abnormal, and a visceral desire to ‘feel normal again’, is a common feature of the literature on drug use and recovery. Normality is constructed, however, in response to context-dependent values and priorities, thereby legitimating certain behaviours as normative and therefore the assumed goal of people in recovery. In this paper we draw on an ethnographic study with twelve people attempting to reduce harmful methamphetamine use to explore how they engaged with ‘normality’. Semi-structured interviews and ethnographic observations were conducted across a range of settings related to participants’ recovery, including private residences, withdrawal services, doctor’s offices, counselling rooms, and court houses. We used a relational lens to conduct thematic analysis on interview transcripts and fieldnotes collected over six months, following the steps of Iterative Categorisation. Our analysis explores the central organising theme of normality as something that can be ‘preserved’, ‘achieved’, or ‘performed’ by people using methamphetamine. Findings are understood through the original concept of ‘ambient paternalism’, where neoliberal norms and values shape recovery trajectories even outside of engagement with services. Exhibiting normality enabled participants to work against the stigmatisation and moralisation of methamphetamine use by demonstrating their socio-political acceptability. Methamphetamine use could also be strategically used to enable participants to keep up with neoliberal normative standards of independent self-management. Increasing awareness of these complex repertoires of normality, and a more critical understanding of how this ideal is constructed and can impact service interactions, can support a less homogenising or coercive approach towards treatment and policy for people in methamphetamine recovery.

1. Introduction

Drug related harm emerges from a complex interaction between pharmacological effects and their broader social and cultural context (Skewes & Gonzalez, 2013; Weinberg, 2011). Understanding drug related harm and recovery must therefore incorporate the cultural narratives, value systems, and social networks being navigated by people who use drugs (PWUD) (Becker, 1963; Hennessy, 2017). In this paper we explore the concept of ‘normality’ for people attempting to reduce their use of methamphetamine in Brisbane, Australia, to understand how ideals of normality can be relationally constructed to reflect their neoliberal context, and experienced by PWUD as aspirational, burdensome, a social resource, or a form of social control. Our analysis advances current research on drug use and recovery by differentiating multiple experiences of normality and exploring them in the specific

context of methamphetamine use.

1.1. Normality and recovery

The perception of being abnormal, and a visceral desire to ‘feel normal again’, is a common feature of the literature on drug use and recovery (Fraser & Treloar, 2006; Gibson, Acquah, & Robinson, 2004; Kellogg, 1993; McIntosh & McKeganey, 2002; Nettleton, Neale, & Pickering, 2013; Radcliffe & Stevens, 2008). The significance of normality has also been observed in the accounts of people who use methamphetamine (Duff & Moore, 2014; Gideonse, 2015), where it can play a particularly complex role given the prevalence with which psychostimulants are used to increase workplace performance and capacity for other domestic tasks, thereby supporting the appearance of ‘normal’ functioning (Lende, Leonard, Sterk, & Elifson, 2009; Pidd, Roche, &

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Buisman-Pijlman, 2011). Despite these frequent allusions to normality as a significant component of recovery experiences, there has been limited analysis of what PWUD mean by normality and the different ways this concept can be experienced or deployed.

Recovery in Australia has been constructed in policy as “a *voluntary self-determined process toward minimisation or cessation of drug-related harms*” (Anex, 2012, p. 1), a definition supported by many clinicians and advocacy groups (Mawson & Goodwin, 2020). Services have been dominated, however, by abstinence-based approaches that prioritise reducing drug use specifically, with minimal funding directed towards harm reduction approaches (Ritter, McLeod, & Shanahan, 2013). Methamphetamine use has received significant attention, with hyperbolic descriptions of Australia’s ‘ice epidemic’ driving increased research efforts and resources for law enforcement targeting this drug (Pisarski, 2021), and the development of methamphetamine specific treatment approaches (Black, Watson, & Black, 2018; Burgess, Parkhill, Wiggins, Ruth, & Stooove, 2018). Despite increasing momentum towards ‘recovery’ terminology in alcohol and other drug treatment policy in Australia, the term remains controversial due to its perceived focus on abstinence (Pillay, Best, & Lubman, 2014). By exploring how the concept of ‘normality’ can shape trajectories of methamphetamine recovery, we can understand further how recovery is experienced by some PWUD, and how they could be more effectively supported in a truly ‘voluntary, self-determined process’ (Anex, 2012, p. 1) of reducing drug related harm.

1.2. Normalising normality

Normality is significantly related to the concept of ‘deviance’ identified by Howard Becker (1963), in its capacity to label and delegitimise particular groups, behaviours, or beliefs (Keane, 2020). Rather than a stable category, ‘normal’ can be observed over time to be a shifting collection of social and cultural narratives and signifiers which coalesce around those behaviours engaged in by dominant groups within society (Link, 2004; Misztal, 2015). The description of ‘normal’ can therefore be applied by this dominant group to other in-group members, reinforcing the validity and social significance of the label. In this way ‘normality’ becomes invested with significant value for marginalised people, who may attempt to demonstrate this attribute in order to maintain their socio-political acceptability in the eyes of the general public (Harris, 2015; Misztal, 2015). Normality can therefore exert political and cultural effects when it is deployed in the context of recovery, by legitimating certain behaviours as normative and therefore the assumed goal of PWUD.

These processes of labelling and changing behaviour can be expressed towards PWUD in the form of coercive or paternalistic services and interventions (Janssens, Van Rooij, ten Have, Kortmann, & Van Wijmen, 2004; Lloyd-Jones, 2012). A neoliberal form of paternalism can also be expressed towards marginalised groups through the diffused reinforcement of certain behavioural expectations, whilst avoiding direct coercion (Woolford & Nelund, 2013). Throughout neoliberal modernity, the idealised behavioural norm has been increasingly built around ideas of autonomy, self-sufficiency, and rational self-control (Duff & Moore, 2015; Gideonse, 2015; Sakellariou & Rotarou, 2017). In healthcare this norm has given rise to the ‘*rational-moral consumer*’ of health services (Race, 2004, p. 36). This paradigm emphasises the value of the individual managing their own healthcare, thereby obscuring the relational, embedded aspects of how health and illness are enacted in practice (Wrenn & Waller, 2017). Instilling the desire for this form of normality promotes independent management of health and care by individuals, rather than by communities or the state, something which critical drug scholars have observed with opioid agonist therapy (Bourgeois, 2000; Harris, 2015) and needle and syringe programs (Fraser, 2004; Moore & Fraser, 2006). Idealising normality can therefore be a method by which the dominant values within a particular context, in this case neoliberal ideas of health and healthcare,

are inculcated or imposed on marginalised groups, facilitating the governing and self-governing of PWUD (Harris, 2015).

‘New Recovery’ first crystallised in the 1990s as a paradigm in which long term recovery was situated within broader neoliberal understandings of functional wellbeing (Fomiatti, Moore, & Fraser, 2018; UK Drug Policy Commission, 2008). In this model, addiction recovery was supported by increased social integration and engagement with work or study, offering the ‘*challenge of redemptive service*’ (White, 2000). New Recovery therefore had the double-edged effect of expanding the scope of drug use interventions, while also producing a more all-encompassing mould into which individuals could be required to fit, often based on neoliberal ideas of optimal functionality. In this framework abstinence from drugs could become associated with specific (more ‘normal’) forms of employment, civic engagement, social interaction, and even familial structure (Fomiatti, 2020; Schlosser, 2018).

The implicit goal of a ‘normal life’ within some approaches to recovery aims to disrupt the power of drug use cultures, and work to instil alternative narratives that facilitate the homogenising of PWUD into more dominant social and cultural identities. This process was observed by Dahl (2014) in their study of people trying to reduce cannabis use, finding that their behaviour change was inhibited by internal identity conflicts provoked by changes in drug use. Fomiatti (2020, p. 2) similarly draws attention to the ‘*normative fantasies*’ presented by New Recovery models, as an aspirational incentive that ‘normalises normality’ among people trying to change their drug use. People using methamphetamine can also experience the potential ‘normality’ of recovery as oppressive and unobtainable (Gideonse, 2015). In this context of neoliberal paternalism, addiction recovery can increasingly be a process of demonstrating normative attributes and desires, rather than strictly a process of health behaviour change. There is therefore a need to critically disrupt these ideas of aspirational or apolitical normality, to understand their implicit and explicit influence on drug use trajectories.

2. Theoretical approach

In their analysis of normality among people recovering from harmful heroin use, Nettleton et al. (2013) explored how participants utilised various cultural narratives to develop ‘discursive repertoires’ of normality. The authors used ‘repertoire’ to refer to a socially produced way of interpreting experiences which draws on a broader and more complex set of influences and cultural resources than a single narrative, or ‘story’ of events (Nettleton et al., 2013). These repertoires are not taken to originate within the individual, but to be an emergent property of the wider socio-cultural context in which they are being employed (Somers & Gibson, 1994). Nettleton et al. (2013, p. 179) identified themes related to various aspects of recovery such as the ‘*aspiration to everyday practise*’ in the form of normative family, home, and work life, or ‘*embodied normality*’, wherein PWUD experience their bodies as looking, feeling, or behaving abnormally.

These repertoires highlight the diverse aspects of how normality is experienced and also discursively constructed in dialogue with others embedded in the same value-laden social structures. With our analysis we extend Nettleton et al.’s (2013) exploration of this concept among people using heroin, by using relational theory to ethnographically explore other repertoires of normality enacted within the context of recovery from harmful methamphetamine use. Relationalism is an analytical stance which focuses on the emergent products of relations between individuals, groups, states of being, materialities, and other environmental factors (Desmond, 2014; Lamont, Beljean, & Clair, 2014). Rather than distilling the essentialist components of individuals or groups, it explores how processes of health and illness contingently develop in particular settings. Relationalist theory and its implications have been adapted into relational ethnography, primarily by sociologist Matthew Desmond (2014, p. 548), who describes the research methodology as one which addresses ‘*fields rather than places, boundaries rather than bounded groups, processes rather than processed people, and*

cultural conflict rather than group culture'. Relationalism steps outside of the conflict between individual actions and social structures by considering these factors inseparable and addressing a single continuous relational reality (Donati, 2015). Society is constituted by relations, rather than 'containing' relations between discrete relata (Gane, 2016).

Nettleton et al. (2013) emphasised the 'politically, socially and psychologically loaded' nature of normality as an aspiration, making it a complex and precarious personal attribute to navigate. Their analysis explored the discursive invocation of 'normality' in the context of interviews, and how heroin use remained categorically beyond the realm of normal or acceptable behaviour. We aim to build on this concept by ethnographically following the operation of normality across multiple social and clinical contexts, and the ways methamphetamine use specifically can both inhibit and support the pursuit of demonstrating normality. Our analysis therefore positions normality as a relationally dynamic social resource, incentivised by a broader context of neoliberal paternalism, which enabled people in recovery to navigate particular social or institutional contexts.

3. Method

3.1. Recruitment

Recruitment was conducted via an outpatient withdrawal service and a brief intervention team at a tertiary emergency department in Brisbane, Australia. Twelve participants consented to the project, with nine participating for the full six months of ethnographic data collection. Two participants were lost to follow up some weeks into the project, and another participant withdrew after the first interview and period of observation. Participant information is detailed in Table 1. The study received ethical approval from both the Royal Brisbane & Women's Hospital and University of Queensland human research ethics committees. The project was also supported by a Community Advisory Group comprising advocates and representatives of the local population of PWUD. This group met five times during the project to advise on the practicalities of data collection, ensure the research was focused on the local priorities of PWUD, and guide data interpretation and analysis.

3.2. Data collection

Data collection included participant observation and in-depth interviews. Three interviews were conducted with each participant, at the beginning of the project, and then at three and six months. It was important to conduct longitudinal interviews and observations to observe the influence of different factors on participants' trajectories over time. The first interview included life history questions, with later interviews focused on events that had occurred during participant observation. The principal researcher (S.B.) conducted all data collection. Participants were compensated with a \$50 supermarket voucher

Table 1
Participant characteristics.

Participants	Trajectory during data collection	Age Range	Accessing Recovery Services	Approx. Duration of Methamphetamine Use
Jane	Long term abstinence	40s	Yes	20 years
Ian	with lapses	30s	No	3 years
Stephen		30s	Yes	10 years
Simon		50s	Yes	20 years
Carl	Controlled/reduced use	30s	No	14 years
Kim		30s	No	12 years
Bridget	Continued frequent use	40s	Yes	15 years (intermittent)
Kira		30s	No	15 years
Claire		40s	Yes	20 years (intermittent)
Oliver	Withdrew	20s	Yes	2 years
Jack	Lost to follow-up	40s	Yes	5 years
Michael		40s	Yes	15 years (intermittent)

for each interview. Interviews were about 1 hour in length, based on an interview guide, audio recorded, and transcribed verbatim using a professional transcription service. All data were deidentified and researcher-generated pseudonyms were used for all participants. Some minor details have been changed to protect confidentiality.

Ethnographic fieldwork was conducted by S.B. who spent time with participants at their homes, interacting with their families, and accompanying them to medical appointments, withdrawal services, counseling sessions, court dates, seeing parole officers, meeting drug dealers, and engaging with Child Safety Services (CSS). These interactions included multiple ethnographic conversations either audio recorded with consent or documented as field notes. S.B. spent approximately 160 hours in the field, spending time with each of the participants about once every 1–2 weeks. The aim of fieldwork was to provide essential context for interview data by observing the unstructured and 'messy' reality of participant's lives (Plows, 2018), allowing follow up interviews to discuss events that occurred during fieldwork in more detail. During fieldwork S.B. focused on the relational components of social settings, observing how drug use and recovery experiences were relationally constructed through the participant's movement between different social contexts and using different forms of language and behaviour in relationships with family, clinicians, and others (Desmond, 2014).

3.3. Data analysis

Iterative Categorisation is a systematic, stepwise method of qualitative analysis developed in the addiction sciences (Neale, 2016), which we used to structure our thematic analysis of interview transcripts and fieldnotes (Braun, Clarke, Hayfield, & Terry, 2019). Coding was inductive and deductive, based on the interview guide and additional subjects raised by participants such as their new plans for recovery, preoccupying conflict with a partner, or the experiences of friends they considered relevant to the subject. Both interview transcripts and ethnographic fieldnotes were interwoven throughout analysis and comprised equally essential aspects of the data, with themes being constructed from excerpts of both. Normality emerged as a significant component of how participants navigated recovery, both explicitly in their statements during interviews, and implicitly through their interactions with family members and services during ethnographic observation. Drawing on Nettleton et al.'s (2013) 'discursive repertoires of normality', and in alignment with the relationalist framing of the data collection, our analysis organised the data around three different 'relational repertoires', focusing on how normality was relationally constructed through participant's interactions with others and processes of drug use.

4. Analysis

Participants experienced and expressed the concept of 'normality' in a variety of complex ways that significantly shaped their trajectories of recovery. The central organising theme of 'normality as a resource in methamphetamine recovery' was prevalent across the dataset, and was differentiated into *preserving*, *achieving*, and *performing* normality as exemplified by three subsets of participants.

4.1. Preserving normality

For some participants normality could be preserved in the context of home and family by limiting the practical and financial privations or disruptions related to drug use. These participants experienced normality as an important set of requirements to be managed alongside their drug use, with recovery becoming more necessary as the conflict between these competing requirements became more acute. In contrast to other repertoires, methamphetamine use was sometimes cited as helping participants to preserve normality, by using it to help them complete tasks whilst trying to limit its impact on their life.

This process of integration was observed with Bridget, a woman in her early forties who was living with her three children and injecting methamphetamine a few times each week throughout most of the data collection period. For Bridget, normality was an important feature of her home life to preserve, however it did not entail abstinence from drugs. S. B. visited Bridget many times at her house, and went with her to visit her doctor, opioid substitution therapy clinic, and methamphetamine dealer. She was energetic, sociable, and spoke frequently about how proud she was to have maintained her house and custody of her children over the years, especially given how many of her friends' families had broken down. The 'normality' of her home was foregrounded throughout her conversations with S.B. and some clinicians, acting to protect her from stigmatisation and demonstrate her awareness and attempted compliance with the behavioural standards of wider society.

In her final interview Bridget discussed how aspects of her romantic relationship had started to threaten the 'normality' she constructed at home. During the project Bridget developed a relationship with a man she met through friends and was initially supporting while he underwent an inpatient mental health admission. Some months after being discharged and moving in with Bridget, he was given a second-hand car by his mother, and started dealing methamphetamine.

Bridget: It must have been two months now or something, or a bit more. ... I told him he had to go and that I will be leaving – because it is dangerous, it's dangerous to our future, it's dangerous to him, it's dangerous – he is changed as a person ... I requested that he has normal hours, like he's just not fucking off and every like four in the morning, go and see someone, drop something off, or, constantly all day. He doesn't do that. He's more – to keep in mind that we're supposed to be a family here, you know.

– Bridget, Interview 3.

Bridget was very attached to the sometimes precarious normality she worked to exhibit within her home, and the idea that they were '*supposed to be a family*'. While she was using methamphetamine frequently, regularly going all night without sleep, Bridget also prided herself on ensuring her children were washed and fed each night, often emphasising what a priority this was. She would also walk the kilometre to the supermarket a few times a week to get groceries, struggling to carry it all back on her own in the intense summer heat, and sometimes using methamphetamine to enable her to carry out these tasks. For Bridget, maintaining a normal home life and managing the behaviour of her partner co-existed alongside the more unconventional aspects of her own day to day existence related to drug use. This experience challenges the binary distinction between normal, healthy behaviour, and harmful drug use, as Bridget integrated these two modes of being to manage the competing demands of her family, her own mental health, and the cultural expectations of her as a single mother.

The socially visible consequences of drug use were also an issue for Jack, who used methamphetamine frequently throughout his engagement with the project and had become estranged from his family and recently homeless. He was unable to preserve the 'normality' of abstinence and standard work hours in his life without stable employment, accommodation, or social connections. When discussing what was motivating him to change, he discussed experiences of social discomfort about things he '*shouldn't be doing*' such as being seen '*riding around on a push bike*' or being seen by his daughter's friends stealing food from the supermarket.

In addition to the discomforts of methamphetamine's side effects, Jack was particularly distressed by what he considered to be visual signs of abnormality that he might display. Walking with him to the hospital one day he was pointing out porches that some people who were homeless might sleep in but emphasised how he always found somewhere out of sight. People sleeping in full view were different, he argued, saying '*they eat out of bins and shit. They're the real ones ...*'. Jack differentiated himself from what he perceived as the more abject state of

other people that were homeless, alluding to his own less visible and therefore more acceptable form of disadvantage and poverty. This was complicated by the observation that times when Jack was able to initiate efforts to access recovery services, or get new copies of identification documents, or access his social security payments, were also days when he had been able to use methamphetamine. Stimulant use could therefore paradoxically be a situationally necessary tool for Jack to preserve this differentiation from other people experiencing homeless or using drugs.

Several participants similarly differentiated between standards of behaviour among PWUD, implicitly demonstrating their own normality and therefore acceptability. Kim was in her thirties and also used methamphetamine frequently throughout data collection, while struggling with court appearances and trying to regain custody of her one-year-old daughter. One day S.B. accompanied Kim to a shopping centre in the outer suburbs of Brisbane. At the shopping centre Kim said, '*it's good here, but there's a lot of gronks*', which she explained meant '*a putrid person, who steals from people*'. She explained that a gronk is someone who looks drug affected, and that '*you know a gronk when you see one*'. Despite ongoing drug use, Kim preserved normality for herself and her appearance by avoiding these behaviours, ensuring she was visibly distinct from the class of 'putrid' people whose abnormality and unacceptability she considered more explicit.

For Bridget, meanwhile, maintaining normality required money from drug dealing. The income from dealing enabled the purchase of jewellery, furniture, and gifts, all of which Bridget stated had brought a greater sense of normality and stability to their lives, despite the multiple risks that dealing exposed them to. Bridget also valued her partner's role in their family structure.

S.B.: Do you think it's had an effect or made any difference for [youngest daughter]?

Bridget: I think [youngest daughter] is very happy because he's very, very good with her, you know. And he's been here a while now. And [youngest daughter]'s never had a man, male influence in her life. No – we really work hard to keep her away. Nobody comes here, you know. It won't – this is normality here. And he goes off to whatever he has to do – a lot of the time I'm with him. But I don't want to do this forever ... It's just I guess, uh, he doesn't want to get a proper job. You know, he has his issues too. I don't know if he could do a proper job, you know. He is very smart guy. And I found –

S.B.: What would be a proper job?

Bridget: Well, as in, you know like, I don't know a banker or fucking working at the servo [service station].

– Bridget, Interview 3.

In the above quotation Bridget describes the preservation of normality through her partner's parenting activities and keeping her daughter's life separate from drug use. However, she also acknowledges that her partner's income from drug dealing might be considered 'abnormal' by others, presenting her life in the wider context of normality or '*proper jobs*'. These aspects of Bridget's experience are always defined in relation to what she sees as proper or normal, despite the ways they may bring more normality to other parts of her life.

The way these participants held a dual understanding of their drug use, as abnormal but within certain bounds of propriety, could have an ambivalent effect on their behaviour. The idealised norm could work to restrict some potentially harmful drug related behaviour, whilst this idealisation could also fuel stigmatisation. Participants would work to avoid certain extents of drug related harm, in part due to its socially visible abnormality. They also discriminated against other people struggling with drug use, homelessness, or poverty, potentially exacerbating their own internalised stigma, and reinforcing prescriptive or paternalistic norms. The repertoire of preserving normality therefore

had a complex and uneven effect on different participants' trajectories of recovery.

4.2. Achieving normality

For several male participants, normality was a difficult aspirational state which they had to consciously work to achieve to avoid greater degrees of social marginalisation. For these participants, normality was a categorically different state from their episodes of drug use, which required maintenance and discipline, and was also a source of pride and pleasure when acquired. This anticipation of discrimination, the subtle contours of what they constructed as normal, and the validation of feeling normal were continuously shaped by the norms of their social context. Simon and Oliver both discussed the pleasure of doing what they called 'normal' activities, which they could often only do while in recovery. Simon was a single white-collar worker who struggled with social isolation, therefore he described having to make the effort to foster social relationships that facilitated these 'normal' activities.

Simon described a friend of his coming around and taking him out to lunch in the middle of his binge. His friend was a recreational user who had decided to stop for some time. He remarked it was nice to spend time with someone he could be honest with. They had lunch and did some Christmas shopping. He said it was nice to do 'normal' things, and also to do them with someone. If he had had to do those things alone, it would have been playing on his mind the whole time how alone he was.

– Simon, Fieldnote.

Alternately for Oliver, a young man undergoing one of his first prolonged attempts at abstinence, this normality was predicated on avoiding previous social contacts. In the interview at the start of the project he described the way normality also felt 'clean'.

S.B.: How does it feel doing normal things?

Oliver: Great, really great. ...

S.B.: What is it that feels good about all those things?

Oliver: It just feels clean. I'm not talking just- everything just feels clean, fresh, like I can see. It's almost like a haze was lifted, and that I can see things around me, and that people aren't judging me for being a piece of shit. Like, I don't feel like a piece of shit, and I think I don't feel that way because I don't have all the paranoia in my head.

S.B.: You feel like people were judging you before?

Oliver: Yeah, always.

S.B.: Which people?

Oliver: Everyone. Like, everyone around me, like walking through here to [the supermarket] would freak me out. I don't even have to be on anything, and I just felt that way; that people were looking at me like I was fucking scum walking past the police station.

– Oliver, Interview 1.

Carl also characterised normality as carefully avoiding certain environments and people, which he achieved by restricting his schedule and activities in order to stay out of 'trouble'. He was working as a bartender and felt this inhibited his ability to recover. Carl expressed his desire for a more regular schedule which would require him changing occupations and social networks.

I'm thinking something through the day hours and out of hospitality really because it's just, the industry is full of drugs and alcohol really. It just makes it harder to try and stop. ... I'd rather go out and work nine hours during the day and then be buggered by four-o'clock and

come home and just read a book and make dinner and then go to sleep. That's more the routine I'm looking for.

– Carl Interview 1.

Over the months of ethnographic observation Carl struggled to make this transition, finding limited other employment opportunities that he could maintain with his ongoing methamphetamine use and continuing to desire a more 'normal' work schedule. Each of these participants expressed a motivation to acquire and demonstrate normality in their lives as an indicator that they were reducing the harms of methamphetamine use and engaging in recovery. The material impact of these changes was not always that significant, but they enabled participants to demonstrate greater conformity with an ideal communicated to them by their environment and constructed by broader recovery discourse. Carl, Oliver, and Simon constructed their recovery, and the associated changes in personal identity, social identity, routines, social networks, and coping strategies, as a sometimes precarious and socially defined progression towards normality, as well as working towards abstinence.

For Stephen, living in the suburbs of Brisbane with his parents, efforts to achieve normality were framed by his relationships with his family. He tried to maintain abstinence during the project and lapsed several times for periods of up to a week. Outside of those times, he focused on doing casual building work for friends, and maintaining stability in his life.

S.B.: How are you doing? What's going on?

Stephen: In general?

S.B.: Yeah.

Stephen: Nah, fuck all, just been doing a bit of working, and not really very much. Trying to be a bit more normal, I guess.

S.B.: Trying to be a bit more normal?

Stephen: Yeah.

S.B.: What does that mean?

Stephen: Trying to stay out of trouble. Yeah. So, that's about it.

– Stephen, Interview 3.

Stephen also discussed how the post-binge period could be the easiest time to not use, whereas over the following weeks his abstinence and experience of normality could be increasingly challenged by cravings. A life in accordance with 'normality' in which he was abstinent, working, and spending time with friends and family, gradually became more difficult to maintain over time, which Stephen ascribed more to changes in his psychology than in his environment. When Stephen did use again, he was focused on limiting use and reducing harms, and he explained how his ability to do this was making him feel positively about his most recent lapses.

Stephen: Probably my biggest achievement really is not just fucking going- like keeping a conscious effort to not just go back and use. Because it is very easy to just go and use all the time. [Pause] Definitely doesn't require much life effort to, like, use all the time. Being an actual- life is harder, like, living in a normal society and working and all that is more than just, get money, go and get drugs, you know what I mean, like ... In society you've got more than one thing you've got to focus on really. But when you're on drugs all the time, it's easier, you might have something else to do, so you go and do it, but once you've got your drugs, once you've got your drugs you know that's your- kind of your focus, so it makes it easier. [Pause] Much more to care about in normal life [laugh].

– Stephen, Interview 2.

Stephen constructs normality as more complex, diverse, and harder

to handle than a life of drug use. Methamphetamine created a space where life was 'easier', not only by providing pleasure, but also making life simpler. The experience of methamphetamine use is constructed in part through the obligations and relationships Stephen is entangled with in his 'normal' life, and what he views as 'society'. The broader norms of that society, and the way these are expressed through services and institutions, therefore form part of these entanglements, helping to produce his use and motivate his abstinence. For each of these participants normality was constructed as a valuable achievement and therefore a social resource, whilst also being a sometimes burdensome aspiration. The potential achievement of normality could therefore both incentivise or complicate recovery trajectories, producing the prospect of social acceptance and the possibility of perceived failure.

4.3. Performing normality

A third repertoire of performing normality was enacted by several female participants each of whom was the primary carer for multiple children. This repertoire was utilised by Kira, Claire, Jane, and Kim, wherein behaviours were exhibited, and opinions ascribed to in a way that produced an image of normality for certain audiences, particularly with regard to strongly gendered roles of motherhood and parenting. This performance mobilised normality as a way to consistently anticipate and respond to the paternalistic requirements of services, and thereby protect them from social exclusion or rejection. For these participants with children, normality was a key part of how they managed relationships with services that could intervene on issues of child custody. Rather than an internalised value, normality was therefore identified as a valuable resource, the demonstration of which through service interactions became a high priority.

The outward performance of normality was incorporated into how Jane engaged with various support services, whilst managing her complex homelife with her partner Ian and their six children from previous relationships. They both had a history of methamphetamine use, but during the period of data collection were mostly abstinent with several brief lapses. Jane was very engaged in recovery and enjoyed the 'normality' of abstinence and spending time with her children. Like other female participants, she was also subject to gendered expectations of normal behaviour, such as doing most housework and childcare, while managing her own recovery. A couple of months into data collection, however, they experienced a lapse of methamphetamine use and were referred to a family support service. A staff member from this service visited Jane in the afternoon when the children had arrived home from school. The house had been tidied and Jane was dressed in a clean white dress. Ian did not participate. She spoke with the young social worker for about an hour about her relationship with Ian, her triggers for using, how she planned to manage those triggers, her aspirations, and what she struggled with when caring for her children.

The session felt like an opportunity for Jane to demonstrate her alignment with the values and behaviours that society wanted to see from her. Even though there was nothing coercive or dominating about the process, behind the social worker was CSS, and behind them was the government, and wider society. Therefore, this conversation could be seen as a normalisation process, ensuring the individual is operating within the bounds that society will tolerate, in terms of mental health, child safety, productivity, honesty, and therefore moral value. ... After the social worker left Jane lit a cigarette and took off her sandals. ... I saw a change take place as she kept talking to me. More tired, drained of energy. Talking about her recent fights with Ian she started to look sourer, angrier, her face scrunching up in the way I'd seen before. Perhaps this was not the person she had wanted to be for the session.

– Jane, Fieldnote 5.

There is not necessarily anything particularly unusual about was

Jane is doing in the fieldnote above. Most people when being visited by a professional in their home will perform normality, maybe looking, sounding, and acting differently. It is worth noting however that in this context, while it was not explicitly coercive, Jane was still monitored and shaped by the discourse of normality. The session was partly the social worker providing support, but also partly Jane demonstrating the capacities, intentions, and values that were required. These had to be performed through dialogue for the process of the session to be undergone, for Jane to access freedom from further supervision, and for the best support services to be put in place.

Other female participants had to undergo similar processes in the context of family support services. Kira was a mother of four whose family had broken down a few years previously when her husband was incarcerated, and she lost custody of her children. In her first interview Kira was frequently tearful about her ongoing drug use, family estrangement, and current relationships, all of which she framed with an appeal to normality. She described the normality her family had experienced in the past despite methamphetamine use.

S.B.: You had used somewhat from quite a young age?

Kira: From a young age but it was controlled, and more recreation like on weekends. We still functioned as a normal family during the week. We still both – I'd work doing jobs and stuff in school hours and the kids would go to day care and they'd go to after-school care. And their dad, he worked. We ran like a normal – like we nearly had a white picket fence out the front.

– Kira, Interview 1.

These memories describe a process of 'preserving normality', however the last few years had seen a breakdown of this repertoire, transitioning instead towards performing normality when necessary for engaging with services. Kira was required to access domestic violence counselling as a part of her process with CSS, which she underwent in an often resentful and perfunctory way. One day S.B. had picked Kira up from her house and she started talking about the experience of behaving the way required by CSS to regain custody of her children.

Kira: Everyone goes on their merry way and I'm here picking up the pieces that I didn't really just do on my own either, because they're my kids, I guess.'

S.B.: It feels like you bear all the consequences?'

Kira: Yeah, because anyone- I might have a relationship, I have to make sure that person looks okay in safety's eyes [CSS], and will they be okay having their record looked at? It's like now my path has to be written into a straighter different path, because if I don't it's going to be taken from me again'.

– Kira, Fieldnote.

Kira describes the pressure to demonstrate to CSS that her future relationships would not be dysfunctional, by having attended counselling, and evaluating potential partners as whether they would be 'okay in safety's eyes.' This constant evaluation of her personal life in this broader normative context demonstrated the diffuse effects of paternalistic approaches outside of actual service interactions. Kira's unease regarding what behaviours and relationships would impact the custody of her children was demonstrated more explicitly one morning a few weeks later when a CSS officer visited Kira and her mother at her home. The officer was an affable woman in her thirties who perched on the edge of one of their large recliner armchairs as they spoke for about an hour. At one point they started discussing Kira's past relationships, and the importance of having different relationships in the future.

The CSS officer spoke about guiding Kira towards different relationships, asking her what would be 'different about your next relationship' so that things 'don't repeat themselves'. She appeared

anxious to say that Kira was 'entitled to have relationships', but they wanted to help ensure they didn't take Kira 'down the same path that your previous ones have'.

– Kira, Fieldnote.

These statements about Kira's past and future relationships appear to be cautious in establishing Kira's autonomy, while also demarcating its limits, thereby exerting a subtle but consistent form of paternalism. The officer may have been attempting to avoid being controlling of Kira's behaviour, while promoting a 'healthier' model for her relationships, instituted through mechanisms such as domestic violence counselling and other classes provided by CSS. The ambiguity of the expectations placed on Kira by CSS, however, particularly in the form of gendered norms regarding personal relationships, made the performance of normality a necessary and persistent requirement of her engagement with these services without necessarily translating into a helpful change in her personal life or behaviour.

The paternalism of various support services, which participants implicitly understood and responded to, meant that their recovery was partly shaped around these performative requirements, rather than their individual needs or aspirations. The recovery trajectory was therefore produced through a relationship between neoliberal normality and the particular goals and interests of the people subjected to the systems that expressed it. This could mean that the messy world of incentives that Jane or Kira lived in was less visible to the standardised, structured processes they moved through within CSS and other services. With this disconnect between idealised, homogenous normality and the real world of PWUD, the ability of services to support people to recover, or otherwise change their drug use, could be limited in scope and based around increasingly performative and perfunctory interactions.

5. Discussion

Participants demonstrated three distinct repertoires of preserving, achieving, and performing normality. These repertoires describe different ways participants responded to the neoliberal ideals implicit in their social and clinical environments, and attempted to integrate them with their methamphetamine use and recovery. Repertoires of normality emerged from the relations between participants, clinicians, support organisation staff, family members, researchers, and the wider cultural context structured around ideas of acceptable motherhood, family dynamics, and work ethics. Nettleton et al. (2013) address how normality was discursively invoked by people using heroin in the context of neoliberal expectations that people return to a pre-existing, acceptable, 'recovered' state. Our findings extend this analysis to explore how contemporary normality is constructed in direct response to the implicit neoliberal paternalism present across multiple environments that participants moved through, and also identifying the specific aspects of methamphetamine use which could enable participants to alternately undermine or aspire to this pervasive value system.

5.1. Ambient paternalism

Whilst the social and institutional environment participants were embedded in rarely exercised explicitly paternalistic control over them, the diffuse and implicit regime of normality could be observed throughout their experiences. This regime was derived from neoliberal ideals of rationality, autonomy, and independent self-management of health, pleasure, and risk, which have been critiqued as a prescriptive and limiting framework for understanding or reimagining drug related behaviours (Duff, 2015; Fraser, Moore, & Keane, 2014; Keane, 2020). The reduction of human systems within neoliberalism to individuals interacting with market forces (Chapman, 2016) necessitates a constant paternalistic effort by structures of authority to deny the contingency and complexity of human relationships and experience (Soss, Fording, &

Schram, 2011). These authorities must also work to continually legitimise the autonomous rational actor as the achievable and natural goal of all citizens, particularly those perceived to be most deficient with regard to these qualities such as people experiencing addiction (Bourgeois, 2011; Seddon, 2011). In an analysis of buprenorphine treatment for example, Harris (2015, p. 516) argues that the '*therapeutics of buprenorphine*' inculcates and reinforces a desire in PWUD for particular forms of 'freedom' and 'normality'. Definitions of normality are thereby constructed through these relationships between PWUD, clinicians, and society.

In the context of neoliberal normality, recovery therefore becomes a complex transition towards particular social, cultural, and economic norms, rather than simply a reduction in drug related harms. What Bridget saw as the indignities of her poverty also motivated her to support her partner's drug dealing, exposing her to greater risk while also enabling her to demonstrate more signifiers of normality. Jane subtly altered her behaviour and speech to conform to the perceived expectations of her support service officer. These effects were multiple, interactive, and also demonstrated in private moments between family members or when away from systems of power such as recovery or social services, or law enforcement.

This homogenising or 'normalising' effect was evident in how participants discussed their own behaviour, and how they responded to the perceived expectations of people and institutions they engaged with. If direct coercion or regulation is considered hard paternalism, and soft paternalism is when individuals are guided towards a more palatable form of citizenship through policy (Fateh-Moghadam & Gutmann, 2014), then these participants seemed to be experiencing a form of 'ambient paternalism', where the value system embedded in policies, services, and models of intervention indirectly and persistently shaped the behaviour of people participating in them. Rather than representing a direct approach to power and control exercised by regulatory bodies in terms of positive reinforcement, or towards predefined populations like PWUD (Moore & Fraser, 2006; Rose, O'Malley, & Valverde, 2006), these ambient expressions of hegemonic norms and ideas were ostensibly emerging organically from this target population outside of interactions with figures of authority. Whilst not tangibly produced by the exertion of power in the moment, participant responses demonstrated this ambient paternalism as an assimilated feature of how they interpreted their world, a feature persistently working to condense and legitimise narratives upon which the more coercive manifestations of paternalism may rely.

5.2. A new normal

In recent decades the requirements of health have been increasingly embedded in wider behavioural repertoires that are collectively seen to constitute good citizenship, expressed in addiction treatment discourse as New Recovery (Fomiatti, Moore, Fraser, & Farrugia, 2021). This version of recovery can be critiqued as an example of neoliberal normalisation, which constructs people in recovery as deficient individual subjects which can be indirectly moulded into ideal participants in neoliberal society. Our findings, however, identify multiple ways participants could both reinforce and destabilise this approach. Bridget's trajectory undermines a New Recovery model as she independently worked to preserve her normal homelife in the presence of intermittently functional methamphetamine use. Kim and Jack similarly constructed their own distinctions of acceptable behaviour, distinguishing themselves from people more visibly experiencing poverty, addiction, or homelessness, further complicating the association of neoliberal normality with abstinence.

The complex effects of New Recovery were also observed through Kira's interactions with support organisations that subtly, and perhaps benignly, attempted to steer her towards a different '*path*', rather than focusing specifically on the presence or absence of drugs. Normative expectations were imposed on Kira by CSS in response to her current

relationships, history of abusive partners, drug use, and lack of stable accommodation. She had to mould her life into something approximating the normal image required by CSS, to gain access to her children and re-entry to the normal life she described living previously with her ex-husband. The active retention of 'normal' status was demonstrated most explicitly by Kim, when she distinguished between her own behaviour and that of 'gronks', who represented a more abject state than her own history and personal experience of drug use. Drawing these kinds of distinctions is frequently observed among PWUD as a form of moral calibration, social cohesion, and in response to the wider norms of their community (Boeri, 2004; Copes, 2016).

Similar performances of normality were observed by Thurang and Bengtsson Tops (2013) when interviewing women with alcohol dependence, especially in relation to gendered expectations of how women and mothers should behave. Their participants generated feelings of belonging and acceptable normality through prioritising housework and caring for those around them. These activities thereby reduced the threat of marginalisation, or reduced the significance of stigmatised behaviours such as drug dependence (Thurang & Bengtsson Tops, 2013). Significant parts of life for PWUD can therefore be a response to the ambient effect of paternalistic expectations, and a desire to be seen to be the right kind of normal.

Critiques of neoliberalism within healthcare are longstanding, and extend to all of modern medicine as a framework for motivating individuals to self-govern, rather than imposing external rules of behaviour (Farmer & Keshavjee, 2014; Mol, 2002). These more diffuse systems of social control can be considered a development within pre-existing systems of governmentality. Foucault explored how:

"judges of normality are everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the social worker-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he [sic] may find himself, subjects to it his body, his gestures, his behaviour, his aptitudes, his achievements" (Foucault & Sheridan, 1975, p. 304).

While some of these judges were clearly present in dialogues with participants, an internal judge also joined the chorus. Stephen lightly berates his behaviour as ignoring things that he should be caring about. Bridget defends herself, unprompted, against the insinuation of abnormality, by carving out a version of her life which met its standards. Kira assumed the roles expected of her, even while resenting or resisting them. Significantly for Bridget, methamphetamine was also explicitly used to enable her to preserve normality, stating that she could not keep up with her domestic work without it in her current situation. Jack similarly was able to meet the perceived expectations of neoliberal normality more effectively when engaging in drug use. This 'strategic' use of methamphetamine to increase normality has been observed previously with people using methamphetamine (Duff & Moore, 2014). These are important instances of how methamphetamine use can be enlisted in the performance of neoliberal normality in ways that other substances such as opiates may not.

The moral discourse underlying normality requires PWUD to justify their experiences, aspirations, and judgements as always in relationship to contemporary neoliberal standards, highlighting how the discourse of normality can promote wellbeing or stability, such as by ensuring child safety standards, but also restrain and shape people's lives by prioritising the appearance of normality over real change. This is the complex and subtle way in which an ambient form of paternalism could colour private moments as well as public interactions and played a significant role in shaping trajectories of methamphetamine recovery.

6. Conclusion

These findings add to current knowledge regarding methamphetamine use and recovery by articulating the way broader social and

cultural narratives translate into private lives and are intermittently enacted across trajectories of drug use. Rather than a goal in and of itself, normality for these participants was a repertoire of relational behaviours and values in which they engaged to manage the consequences of their drug use and acquire social and practical resources. This develops the work on repertoires of normality (Nettleton et al., 2013) by exploring the multiple effects of this concept for people using methamphetamine across multiple social and clinical contexts.

Given the ongoing and widespread stigma and discrimination towards PWUD within Australian healthcare services (Fraser et al., 2017; Fraser, Moore, Farrugia, Edwards, & Madden, 2020), increasing awareness of these complex and dynamic repertoires of normality may promote a less homogenising or coercive approach towards treatment and policy. A more flexible and responsive perspective on what can constitute 'normal', and a critical awareness of how this ideal is constructed and can impact service interactions may reduce the risk of delegitimising some people's experiences and prompting disengagement from services. Future research could further explore the role of normality within clinical services, and how the concept can be either used or critiqued to support people experiencing drug related harm.

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Ethics approval

This research project received Human Research Ethics Committee approval through the University of Queensland (2017001579) and the Royal Brisbane and Women's Hospital (HREC/18/QRBW/172).

Declaration of competing interest

None.

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