Coming of Age in Sonoma

‘Nursing is the practice of Anthropology’

By Melanie Dreher

From Dreher’s talk to students in the Sonoma State University course on Cannabis as a Sacrament, Jeffrey O’Shaughnessy, MD, May 2, 2018.

I had never thought about being an anthropologist, but I was a big fan of the work of Margaret Mead, and had an opportunity to work with her at Columbia University in the 1960s. Mead had asked, “Why are Americans having such a hard time with adolescents, when adolescence is just an easy time in other cultures?” She never got tenure at Columbia University. She had left the traditional path of academia, and was writing for Parent Magazine and for the public. Margaret Mead took anthropology to the public. And the anthropologists at Columbia — stuffy, old, white men — hated that. So they would never grant her tenure. But she was head of the natural history museum in the world. She had an enormously important position. I think when she was much older, and they thought they should offer her tenure, she shrugged and said, “Mm, I don’t really need or want it.”

Sometimes you can’t take just the academic route. Margaret Mead published in academic journals, too, but she felt that if Americans need to know more about how to handle adolescent behavior, they’re not going to read those articles. She needed to put it in Parent, for women who are raising children to read, and not to worry about tenure, or progression from assistant professor to full professor. I certainly have done the tenure thing, and was Dean of Nursing at four different universities. I was at Columbia for the last 15 to 20 years, has been really to inform the public of the truth. Margaret Mead’s example taught me that I’d get along fine without promotion and tenure. She was an excellent role model, teacher, and person.

I don’t even know if they assign her in anthropology courses anymore, but if you ever have the opportunity to read “Growing Up in New Guinea,” and “Coming of Age in Samoa,” you should.

Margaret Mead taught me how to do field work and I tried to use my approach when I had the opportunity to study cannabis use in Jamaica.

I was a first-year doctoral student at Columbia University and my major professor was essentially a disciple of Margaret Mead. I went to the National Institute for Drug Abuse. There was a very enlightened person at NIDA that we discussed “What’s going on with marijuana in the US?”

In the 1960s marijuana was being used by college students and NIDA became interested in chronic and not just what happens to you immediately after ingesting marijuana, but what happens when you use this substance all the time for many years. The proposed study examined three cul- tures in which marijuana was used consistently: Costa Rica, Greece (in the form of hashish), and in Jamaica, where it was called ganja, a term you’ve probably heard. So, after a year of taking courses in an- thropology, my professor said, “Let’s see if you can cut it. Go to a country or village where you’ve never lived in before and find out everything that you can about...” a substance that carried a two-year mandatory prison sentence for possession.

I said, “Oh, no problem, I’m on my way.”

So in 1969 — the same summer as Woodstock and the first landing on the moon — I found myself on a mountain top using just two electricity, no plumbing, no running water, no telephone, or transportation. I did not know a lot about Jamaica, and I actually knew nothing about cannabis or marijuana because I had never smoked anything. And I didn’t actually know all that much about anthropology.

I got to this mountain top, and started thinking. “Wow, an illegal substance — no one is going to talk to me about this.” But in fact, people did talk to me. I attribute that to my being a nurse. I was used to asking about sensitive questions, and getting answers, and having conversations about intimate topics. So I think my nursing skills really helped me in that environment.

I managed to come back with a fair amount of information, about why it was used and in what kind of contexts. I discovered that it was exclusively men who smoked marijuana, and the women were in charge of the tea.

The most interesting substance that not only had recreational value for men, but was also a very powerful part of the folk pharmacopeia. It was used for just about everything, from early childhood — giving children who were teething an eyeproder full of tea or medicine — to mothers who wanted to make sure their children were smart and healthy and prepared cannabis tea for them three times a week.

You can imagine what would have happened to the mothers if they were in this culture. But in Jamaica, where folk remedies were rampant, people would say to me, “We’ve got good medic- ines, but ganja is the king of it.”

Ganja was not indigenous to Jamaica. It was brought from East India by indentured British workers. It was used in the factories and in the rum shops after work, or down at the river to have a smoke. They were a little odd, and in Jamaica at the time, and still, the belief was that in order to smoke mari- juana, you had to have the brains for it. They also imparted the information that that’s in fact why women couldn’t smoke marijuana. They didn’t have the brains to handle the psychoactive effects. I just sort of put that in my pocket and dealt with it. But you can imagine the tiny percentage of men who didn’t use it, they just weren’t part of normal male society. So we should not be surprised that they didn’t fare as well in the study.

So then I figured, “All right, I have to do a dissertation on this.”

At that time, there was a theory about the “Amotivational Syndrome” — that once you started smoking marijuana on a regular basis, you would lose your ambition, drop out, not care about succeeding, perhaps not finish college and not be able to get a job, etc. But I had found in that first summer something very interesting: people in Ja- maica were actually smoking marijuana to make them work harder. The sugar cane plantation managers — they called them “Bushers” — would come around to see how they were loading the cane and cutting the cane, and in order to make them work harder and faster, they would actually dis- pensing ganja for them to smoke. The bush- ers would come around on horseback and pull out a big thing of cannabis, and give it to them so they could roll it up and smoke it and work harder.

Student: Was there a language barrier at all?

MD: Jamaicans, especially rural area Ja-

micans, speak something called Patois, which a combination of Elizabethan Eng- lish — 15th century English — and West Af- rican. But you can pick it up after a while. They do understand and speak the King’s English, and that was what was taught in the schools... Anyway, that became my dissertation: “Is there really an amotivational syndrome that occurs universally for anyone who uses marijuana?”

I studied men who were rural farmwork- ers and cane workers in three communities, and discovered that actually their use of marijuana had no impact on their work whatsoever. Even though they would claim that it would make them work harder. I discovered this by actually measuring the tons of cane they cut, which was not hard for me to do, because the factories, in which they cut the cane and bring it to the factories, had a measure for each man and how much cane they cut.

I found that there was no impact. But while I was there I noticed that women rou- tinely gave their families morning teas of ganja two or three times a week to keep them healthy and to make them more pro- ductive. They believed it made them stron- ger, they ate more. For children especially, many of them believed that it helped them con- centrate in school.

So I finished the two-year study, and got a job after I graduated, and I had a couple of babies, and decided I needed to continue this work. I went back to see if this was true: If children drink marijuana tea, do they actually perform better in school?

I went to a rural community, a different one than I had been in before. I asked one
They saw it as part of their religion, and part of Rastafarian culture. So we had a number of women and mothers who were smoking, and I saw it as an interesting phenomenon that I should take a look at.

I was able to get funding from the March of Dimes. The Thalidomide crisis was still on everyone's mind. [A drug taken by thousands of pregnant women to counter nausea and morning sickness turned out to cause deformity and death]. People were very, very interested in the teratogenic effects of any substance being used through pregnancy, and what the outcome would be neonate.

Cannabis was the third most commonly used substance among women in the US. So there was a particularly keen interest in looking at women who were users, and then when they got pregnant, what impact it had on their own prenatal experience, and what their neonatal experience of the newborn.

We followed the women from the third trimester all the way through their pregnancy, then we examined their neonates at one day, three days, and one month.

We used the same model that we used in the earlier study. We took 30 women who were cannabis users and we matched them according to parity — the number of children they already had, socioeconomic status, and age. We selected a very small sample from a rural parish in Jamaica, and we followed the women from the third trimester all the way through their pregnancy, then we examined their neonates at one day, three days, and one month.

The environmental factors, familial factors, economic factors were much more powerful than whether they had been exposed prenatally.

We wanted to look at their readiness for school, and to see if their prenatal exposure had any impact on their beginning to be ready for school. We found that there was no impact of the cannabis at all. The real issues had to do with children who had better environment for neonatal development than other children. The environmental factors, familial factors, economic factors were much more powerful than whether they had been exposed prenatally.

That is what we said about the earlier study. We just assumed there would be differences. We looked at their readiness for school, had lunch at school, and so forth. And I found that it was actually just the opposite. The children who were drinking cannabis tea, as the parents had predicted, were in fact performing at a higher level in school. They were also the children who came to school most often. And they were also the children who had clean uniforms and notebooks to write in, and so forth.

So one of the things that I had discovered was that preparation of cannabis tea for children was part of what I call the "Good Mother Syndrome." If you wanted your children to do well in school, you made sure that they had whatever was necessary, including shoes that made their long walk of two-and-a-half miles to school. Had a proper breakfast, had lunch at school, and so forth.

So once I looked at the results of this study and thought, "Hmm, another correlation between really strong behavior, good behavior, positive behavior, and cannabis use." But was it really the cannabis use? The best we can say about a study like that is what we said about the earlier study. We know it doesn't disadvantage them.

While I was doing that study, I noticed that increasing numbers of women were starting to smoke cannabis in a manner not unlike the way men smoke it. It was the early 1980s. The women were smoking with their friends, they were smoking alone if they had a hard task to do. If they were going to the field to pick crops, or even at home doing laundry, it was not uncommon for many of the women—not all of the women—to have a ganja cigarette, a spliff. And I thought, well this is a change. Things are happening.

The Rastafarian men really felt that their Rastas Queens had their right to smoke.

The Rastafarian movement had given women a special place in that culture. They called the women who were Rastafarian the Rasta Queens. The men who were not Rastafarian, who criticized women when they smoked (unless it was in a pre-sexual context with them) didn't like it at all when women smoked with friends or in a social manner.

But the Rastafarian men really felt that their Rastas Queens had their right to smoke.

There was a culture for marijuana. When there is a culture, rules are developed by people about who should smoke it, when, where, at what age. All these things just emerge from the culture, and that's how you control a phenomenon culturally. They didn't need laws, they didn't need a two-year mandatory sentence.

And said, you know, "these are the data. I'm going to terms of my NIH contract that did the study, I collected the data, analyzed it. Everything was done very carefully. And I can't change the data, these results.

At that point I said, "Okay, enough. I don't want to have to fight these battles with the federal government." So I discon tinned that work for a little bit and thought, "Maybe I've done all I can as an individual researcher, maybe someone else can take this up..."

Cocaine

It was the 1990s. I was still teaching, and was Dean of Nursing at the University of Massachusetts. I decided to keep taking nursing students to Jamaica where they could really learn a different kind of nursing practice.

That was a very good thing to do. The students came back incontrovertibly changed in their whole way of thinking about patient care. But while I was there, I noticed that in Jamaica, cocaine had entered the substance-abuse scene. And this was very sad.

There was a culture for marijuana. When there is a culture, rules are developed by people about who should smoke it, when, where, at what age. All these things just emerge from the culture, and that's how you control a phenomenon culturally. They didn't need laws, they didn't need a two-year mandatory sentence. The fishermen and transporters had never heard of crack or cocaine before. They had no idea what it was. But that's how they...
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In the US alcohol is allowed for pregnant mothers. We know the damaging effects of alcohol. We know them, yet we can’t find any for cannabis and it’s illegal.

And they said, “Yeah, we’re seeing that, but we didn’t prescribe it.”

And I said, “Listen to you: you don’t want to prescribe something that is very effective, pretty inexpensive compared to what else there is, and you would rather see the pharmaceutical companies come up with very expensive, synthetic products that only rich people will be able to afford, and that the taxpayers will pick up the bill for people who needed to have this antidote to opioid addiction.

And that’s sort of where we are right now on this whole issue.

So as I’ve shifted from saying, “I did the research, here are my findings, and it’s up to you policymakers, you clinicians, or you decide what to do,” I’ve been finding myself talking to everybody.

Now I’m saying that I have to be part of that group that is out there spreading the word and helping people understand what a profound substance this is. And if that it were discovered today, it would be considered a miracle drug.

But because it has this long history, in a fear-driven society, we are reluctant to use something.

Student: You talked about the farm workers and how they use ganja. What has happened to those occupations, like doctors and teachers?

MD: There was a wonderful physician in this village who was absolutely fine with cannabis. He didn’t use it himself, but he had no problem with his patients using it.

He had trained in England as a physician, and then he went to the University of Minne- sota where he got a degree in public health. He was well known and liked.

On one of the articles, he’s the second author. He found that it was a very helpful substance to people, and they should be encouraged to drink the tea, and saw nothing wrong with it at all.

A Jamaican doctor named Manley West observed that ganja smokers have no glaucoma. He and his colleagues developed a medication called Cannisol — eye drops for glaucoma — that never got to the US but sells very well in South America.

MD: I don’t know. I found that teachers were really struggling to move from what might have been the working class to middle class. And they were divesting themselves of anything that might speak to a working class behavior. Even though they might have ingested it themselves, been given it by their mothers, they just wanted to separate themselves from what was a working-class phenomenon.

One of the things about being an anthropologist, working in the community, living in the community with the people whom you’re studying, is that you go through several trials of trust. It was a nurse that helped a lot. I delivered a lot of babies when I was in Jamaica. Once someone de- cides you are a baby, you won’t do anything to it. I have a lot of godchildren who are now big adults, older than you. It was a useful skill set to have, to be able to treat peoples’ problems.

Studying behavior in context is really im- portant. The studies that have come out in the US on marijuana use during pregnancy, it’s been done by government-funded research search that people can respond to: “I do,” “I don’t,” “I sometimes” — this is how many times…

But to actually be in a place where you can observe people’s behavior makes a huge difference. You can relate it to other behaviors. I could understand which women were going to become the marijuana smokers, because they were usually wom- en who were independent of their men. They could take a chance, use when they wanted, and many women in our study whose children were exposed prenatally were not to smoking. So one of the things they could do that other mothers couldn’t was stay at home, have their home- based cottage industry, preparing and selling—

Then and we had the third group, who were pretty serious cannabis tea drinkers, and occasional smokers. It might have been two or three times a month. They had to be smokers, they had to smoke cannabis at home. As for children, I don’t think that we find a difference among the three groups, in terms of neonatal outcomes at all. Nor could we see any differences at age two, when the toddlers were at age five. There was just no evidence of any impact at all.

A number of the authors have written letters to the editor. One of the things that’s happened is that the taxpayers will pick up the bill for people who needed to have this antidote to opioid addiction.

Some of the NIH critics of the study would say, “Well you know, that works in Jamaica, but I don’t think the data would apply here in the US.” And in fact, you can’t do that study here in the US because it’s been much multi-drug use in the US. Pharmaceutical drugs are so widely used that to tease out the specific effects of can- nabis is very hard to do.

In the US, everybody, every culture, has its sub- stances that it approves, and its substances that it doesn’t approve. In the US, alcohol is allowed for pregnant women; We know the damaging effects of alcohol. We know them. We can’t find any damaging effects for cannabis and it’s illegal!...

...the state authorities have removed the baby and put the baby in foster care.”

I have made many court appearances in response to heartbreaking stories. I get a desperate letter from a family that says something like, “My wife was having her first baby, they did a hair-sample test dur- ing labor and delivery that was unauthor- ized, it wasn’t approved, which we didn’t contest, and in fact she was never using cannabis. And the state authorities have removed the baby and put the baby in foster care.

There are all these types of stories that have put me more into the activism role. Some are much worse, believe me, where they actually took the mother and put her in prison. Recently I called the Attorney General of a big mid- western state, and I didn’t speak to a staff person and said, “What is the problem? What problem are you trying to solve here?” I was very nice, I wasn’t trying to be confrontational, I just said, “Just explain to me.” And they said, “Well frankly, we do not believe that a child is safe in a house where there is cannabis. Where marijuana is pres- ence.

And I said, “Really? But your gun laws say that anybody can have a gun. You don’t take a baby out of a house where there’s a gun, if you don’t use it. And if you have aspirin, or any of the other things that can kill children and babies. Why are you so focused on this?”

“I don’t have an answer, but they really feel like they’re doing the right thing.” It’s astounding. But we have classic, “We’re going to do this the same way we’ve been imprisoned right after the birth of their child, without even the proper cloth- ing or services needed for a woman who’s just given birth. These letters keep coming. We really have a problem, and it’s not go- ing to go away unless we become activists with this issue.”

JYH: In the Jamaican study were all the pregnant women smoking or were some just drinking tea?

MD: No. Had women who smoked daily, several times a day. They were categorized as heavy users. And then we had women who were in the middle, who tend to just smoke recreationally or socially, on the weekends, and use cannabis tea during the week. And then we had the third group, who were pretty serious cannabis tea drink- ers, and occasional smokers. It might have been two or three times a month. They had to be smokers, they had to smoke cannabis at home. As for children, I don’t think that we find a difference among the three groups, in terms of neonatal outcomes at all. Nor could we see any differences at age two, when the toddlers were at age five. There was just no evidence of any impact at all.

MD: The dogma in America is that it...
Parents believe that the ganja tea helps them concentrate in that kind of environment. And they would go without ganja themselves, because, one, it showed what good parenting was about. These schools in Jamaica are likely to have 50 in a classroom, with four children squeezed into one desk. There are not enough tables and chairs, and a lot of children are sitting on the floor. Sometimes, children have to go around and on a chair in order to concentrate in that kind of environment is really difficult.

I never saw dementia in Jamaica. They live longer than we do, and I never saw a hint of dementia there. I'm not sure there were some, but in all the villages I lived in, in Kingston and wherever, it just wasn't there. So I think that's worth really examining the role of this substance in brain functioning in much older people.

Student: Do you have any idea how the ganja-using children turned out?

MD: In 2000 I got a tiny grant from the Ruth Landes Field Study Fund, Research Institute for the Study of Man and I went back to look at these kids, who were then between 18 and 20. We didn't have a lot of time, but we found 14 of them just by going from the village and asking where they were. It was so much fun! We’d pull up to the house, and look, “Miss Mel, it’s the student from the USA!”

We asked what they were doing now. Many of them had gone on to college — meaning high school in Kingston—and then went on to be nurses and other professions like counting, nursing, teaching, which I thought was pretty good. These were all the using children. But since I didn't have the full whole sample, and couldn’t do a comparison, I just didn’t think it was worthy of publication. But it was gratifying to see these kids, who were allegedly doomed by their cultures and the way they were raised, in fact succeeded quite nicely in a country in which it’s quite difficult to succeed.

V alcoholizing evidence

It’s very hard to understand any kind of human behavior when you take it out of the context in which it occurs and put it into a laboratory or test tube and try to figure out what’s going on. Even to do a questionnaire or a survey. But when you actually witness this behavior as it occurs, it’s intelligible, you can understand it. And that’s the real value of social science.

I think it’s really important that you’re considering a career in social science, but I would say we add an enormous amount. What we don’t do is do double-blind studies that have clearly formulated hypotheses. What we do do very well is record and compare human behavior. And that in itself can be extraordinarily enlightening, and enriching for people to help them understand their own culture as well.

What I’ve found is that nursing is the practice of anthropology.

Advice from medical professionals should be consistent: pregnant and lactating women should be advised to avoid cannabis use...

The authors cite numerous published allegations of harm and then express dismay that many clinicians do not consider these allegations conclusive. “...Despite these risks, it appears that marijuana use may also contribute to NVP, and that this trend is occurring frequently among women who report using marijuana.”

The War on Mothers

1. “Perinatal Marijuana Use and the Lactating Child” was published by JAMA June 17. Lead author Lauren Jansen is in the Department of Pediatrics at Johns Hopkins. Co-author Chloe Jordan, PhD, is with the National Institute on Drug Abuse. Their fear is that “Exponentially expanding can- nabis among pregnant and lactating women (as likely will occur with legalization) may lead to increased risk from fetal and child exposures if the teratogenic potential of cannabis remains underappreciated.”

2. “A review of the evidence” in The Journal of the American Medical Association, September 2009. The authors are with Kaiser Permanente’s Northern Cali- fornia Division of Research. In response to pregnant women using cannabis as an antiemetic, Kaiser records were analyzed to find a correlation between marijuana use and nausea and vomiting during pregnancy (NVP, also known as “morning sickness”). They found, unsurprisingly, that the more severe her nausea, the more likely it is that a woman will use marijuana.

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