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Women on the Edge: Opioids, Benzodiazepines, and the Social Anxieties Surrounding Women’s Reproduction in the U.S. “Opioid Epidemic”

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Abstract

The current “opioid epidemic” provides an opportunity to identify age-old social anxieties about drug use while opening up new lines of inquiry about how and why drug use epidemics become gendered. This paper reflects on the intertwined phenomena of opioid and benzodiazepine prescribing to U.S. women to examine how gender, race, and class inform social anxieties about reproduction and parenting. Multiple discourses abound about the relationship between women and the “opioid epidemic.” Epidemiological reports attribute premature death among White women to the deadly combination of opioids and antianxiety medications. The National Institute on Drug Abuse reports that “every 25 minutes a baby is born suffering from opioid withdrawal,” leading to costly hospital stays for infants and the potential for mother–child separation and other forms of family adjudication postpartum. Primary care providers are reluctant to distinguish diagnoses of chronic noncancer pain from anxiety among their female patients. Taken together, these discourses beg the question: What exactly are we worried about? I compare and contrast the narratives of two anxious women on opioids to raise larger structural questions about pregnancy, parenting, and drug use and to interrogate the public narrative that women on opioids threaten the American family and thwart the American Dream.

Keywords

opioids; benzodiazepines; women; anxiety; reproduction; racialization

Introduction

In recent years, there has been a tremendous upsurge in the amount of scientific research, media, and political discourse surrounding opioids, and the “opioid epidemic,” in the United States (Dowell, Haegerich, & Chou, 2016; Newkirk, 2016; The White House, 2016). This upsurge is a result of epidemiological data showing the concurrent rise in opioid prescribing

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among physicians and accidental, opioid-associated mortality (overdose), as well as the media coverage of numerous high-profile celebrity deaths in which opioid use was implicated (American Medical Association [AMA], 2016; Cahoon, Cox, & Chitale, 2008; Centers for Disease Control and Prevention, 2011; LaMotte, 2017). While the U.S. opioid epidemic is frequently presented as a singular narrative of pharmaceutical greed, clinical negligence, and/or patient malingering (Coffin & Banta-Green, 2014; Quinones, 2015; Turk, Swanson, & Gatchel, 2008), the role of anxiety is often ignored or diminished. Opioid prescriptions frequently have a silent clinical companion: benzodiazepines (J. D. Jones, Mogali, & Comer, 2012; Larochelle et al., 2015; U.S. Food and Drug Administration, 2016). Statistics show that the co-prescription of benzodiazepines and opioids accounts for a significant proportion of overdose deaths (C. M. Jones & McAninch, 2015; McCarthy, 2016; Park, Saitz, Ganoczy, Ilgen, & Bohnert, 2015; Saunders et al., 2012). Increased risks that result from opioid and benzodiazepine co-prescription emerge in clinical settings in which medically complex patient populations can be diagnostic puzzles to their primary care clinicians (Becker, Sullivan, Tetrault, Desai, & Fiellin, 2008; Colasanti, Rabiner, Lingford-Hughes, & Nutt, 2010; Fels, 2016). Clinicians ask themselves: “Am I treating pain? Anxiety? Addiction? All three? None of them?” The majority of patients receive care for pain and the majority of opioids are prescribed in the U.S. health-care safety net (Institute of Medicine, 2011). Thus, comorbid chronic noncancer pain and anxiety, and its associated pharmaceutical responses, are enacted within a broader context of poverty, disability, and disparity.

When the “opioid epidemic” is unpacked—its monolithic narratives complicated through an examination of everyday clinical and social practices—it becomes apparent that there is much to worry about here. In this paper, I argue that the role of anxiety needs to be excavated as a central component of the U.S. opioid epidemic, particularly for women of reproductive age. National Health Statistics indicate that a disproportionate number of American women are dying as a result of the use of opioids and benzodiazepines in combination (Kindy & Keating, 2016; Mack, Jones, & Paulozzi, 2013). Neonatal intensive care units, where infants’ prenatal opioid exposure is medically managed, have seen yearly increases in neonatal abstinence syndrome since 2006 (Patrick et al., 2012). The National Institute on Drug Abuse (NIDA, n.d.) reports that “every 25 minutes a baby is born suffering from opioid withdrawal,” leading to costly hospital stays for infants and the potential for mother–child separation and other forms of family adjudication postpartum. Opioid-dependent women are more likely than their male counterparts to report higher levels of psychiatric morbidity (e.g., depression and anxiety), to use opioids in response to interpersonal stress, and to use opioids because of affective distress (Back, Lawson, Singleton, & Brady, 2011; Jamison, Butler, Budman, Edwards, & Wasan, 2010; Manubay et al., 2015; Munce & Stewart, 2007). Women with comorbid opioid dependence and anxiety have become a critical group to examine when seeking to explain the role of the opioid epidemic in the U.S. social imagination of the family and the American Dream.

In the United States, pregnant and parenting women with ongoing substance use (prescription and/or illicit) have been specific, targeted recipients of racialized health and health-care discrimination from both reproductive health and addiction medicine (Flavin, 2009; Knight, 2015; Roberts, 1997; Sufrin, 2017). I will chart the historically divergent

experiences of women of color and White women in larger media and policy narratives about drug use and present an analysis of the narratives of two anxious women managing the dual challenges of opioid dependence and anxiety. First, though, the complexity of comorbid chronic noncancer pain, addiction, and anxiety requires some foregrounding to understand how women get enlisted into the opioid epidemic.

Biopsychosocial Approaches

Multiple scientific experiments conducted to compare sensitivity to and endurance of pain unequivocally report differences between males and females. These studies have been conducted using a variety of pain stimuli, under varying conditions of administration, with rat and human subjects, for many decades (Fillingim, King, Ribeiro-Dasilva, Rahim-Williams, & Riley, 2009). According to these scientific studies, females have a greater sensitivity to pain and lower endurance. A range of theories have been forwarded to explain these differences, but experts have not settled on a uniform explanation. Feminist social scientific scholarship has provided robust critiques of the taken-for-granted reification of differences based on sex in a wide range of experimental contexts to reveal how social constructions of gender get read into basic science in ways that are both productive and reinforcing (Martin, 1991; Richardson, 2013; Spanier, 1995). A science studies–informed orientation helps promote a healthy skepticism about claims of difference based on sex or gender. Yet, it is crucial to recognize that the assumption of differences in pain experience by biological sex is scientifically recognized, but often clinically ignored (Edwards, 2013; Fassler, 2015).

An extensive literature documents racialized health and health-care disparities among pain patients, particularly with regard to access to opioids (Green et al., 2003; Singhal, Tien, & Hsia, 2016). Physiological differences in pain perception among racially, ethnically, and culturally diverse patient populations have been extensively studied in clinical and laboratory settings (C. M. Campbell & Edwards, 2012). In addition to biological explanations, causal mechanisms relating to sociocultural context, provider bias, and system-level factors have been offered as explanations for racialized health and health-care disparities in pain care (C. M. Campbell & Edwards, 2012; Cintron & Morrison, 2006; Green et al., 2003; Klonoff, 2009; Shavers, Bakos, & Sheppard, 2010). In Pryma's (2017) recent analysis, African American fibromyalgia patients report engaging in "moral boundary work" to demonstrate their worthiness for health-care and disability benefits. African American women "consistently understood the reception of their boundary work as explicitly related to their race and gender, illustrating a racialized 'intersectional stigma' absent from white respondents' stories" (Pryma, 2017, p. 69). Findings from research conducted with medical students indicate that many students and residents hold "false beliefs about biological differences between blacks and whites" which impact pain assessment and treatment (Hoffman, Trawalter, Axt, & Oliver, 2016, p. 4296). Journalists have reported that racism in the health-care system may partially explain the differential rates of overdose mortality burden among Whites, compared to African Americans and Latinos (Kolata & Cohen, 2016; Singal, 2016). Hansen and her colleagues have contributed a robust scholarship demonstrating differential treatment options for opioid dependency by race, ethnicity, and class (Hansen, Siegel, Wanderling, & DiRocco, 2016; Hansen et al.,

2013) and, along with others (Hart, 2017; Savali, 2015), have called into question the empathetic depiction of opioid dependency among White men and women in media representations as markedly different from previous public responses to addiction (Hansen & Netherland, 2016).

The social and clinical sciences have long grappled with the seemingly indeterminable etiologies and uncertain treatment pathways for chronic noncancer pain (Buchbinder, 2015; Crowley-Matoka & True, 2012; Good, Brodwin, Good, & Kleinman, 1992; Greenhalgh, 2001; Knight et al., 2017). If pain lasts for more than 3 months and is not associated with cancer or end of life, it is defined as chronic noncancer pain (Trescot et al., 2008); and we don't know quite what to do about it. What we do know is that 21 million Americans suffer from chronic noncancer pain and we now have an "epidemic" of personal and community harm due to the widespread prescription of opioid medications to treat chronic noncancer pain (Chou et al., 2009). It is well understood that chronic noncancer pain is a complex biopsychosocial condition. It is also a condition that is structurally situated, as one primary care clinician whom I interviewed described:

I would define [chronic non-cancer pain in this community] as a physical pain, which is often compounded by social and psychologic comorbidities. So if you took a patient with exactly the same arthritis and moved them to an intact family with plenty of financial resources and gainful employment and flourishing community maybe it wouldn't be nearly as debilitating.

In primary care settings, where the majority of Americans with chronic noncancer pain receive treatment, clinicians are often reluctant to name what is exactly being treated by opioids—pain or anxiety/depression—when these conditions are known to be bidirectional (Bair, Robinson, Katon, & Kroenke, 2003; Brown, 1990; Gureje, Von Korff, Simon, & Gater, 1998). In clinical settings, both diagnosis (of pain, anxiety, addiction) and difference (in gender, race, and class) are muddled (Green et al., 2003; Hernandez-Avila, Rounsaville, & Kranzler, 2004; Rouse, 2009; Todd, Deaton, D'Adamo, & Goe, 2000; Wailoo, 2015). This muddle is the often unspoken background—an invisible subtext—that belies uncertainty about both diseases and treatment. This uncertainty, in turn, permeates structural differences in how pregnant and parenting women, who are identified as opioid dependent, are then treated (Pollack, 2016). The biopsychosocial complexity of the current opioid epidemic opens up a space to interrogate racialized and gendered anxiety. In the next section, I will describe the rise of opioid and benzodiazepine co-prescription and the structural and social explanations for its widespread occurrence.

Women Feeling Terrible

Women are 1.5–2 times more likely to receive anxiety disorder diagnoses, according to large national survey data, with the greatest difference occurring in diagnoses of post-traumatic stress disorder (PTSD), generalized anxiety disorder, and panic disorder (McLean, Asnaani, Litz, & Hofmann, 2011; Olfson, King, & Schoenbaum, 2015). Dramatic increases in the prescription of benzodiazepines have been concurrent to the rises in opioid prescriptions in the United States (Bachhuber, Hennessy, Cunningham, & Starrels, 2016). Premature death

among White women has been attributed to the deadly combination of opioids and antianxiety medications (Kindy & Keating, 2016) (see Figures 1 and 2).

While the iatrogenic nature of the opioid epidemic has now been written about extensively in both the clinical and popular media, clinicians are also beginning to publicly discuss their role in the overprescription of benzodiazepines, a result of the temptation to manage the “high prevalence of anxiety symptoms” exclusively with pharmaceuticals. One clinician, who coauthored the epidemio-logical research, commented by saying:

This epidemic is almost entirely preventable, as the most common reason to use benzodiazepines is anxiety—which can be treated effectively and much more safely with talk therapy. Given the high prevalence of anxiety symptoms, we need a more constructive approach to the problem than popping pills.

(Dr. Sean Hennessy, MD, cited in Basu, 2016)

According to this clinician, care providers may be contributing to harm by ignoring psychoanalytically informed or cognitive-behavioral therapy treatments for the co-occurrence of chronic noncancer pain and anxiety.

When the aggregate statistics are presented and the clinical practices examined, it appears that the frequent recognition of symptoms and easy pharmaceutical fixes have intersected to put women at particular risk for co-prescription of opioids and benzodiazepines. The *Washington Post*'s investigative report on the subject described a “generation of women overwhelmed by modern life and undone by modern medicine” (Kindy & Keating, 2016). The article describes how a perfect storm of pharmaceutical availability, geographic isolation, and social failure have combined to create excess mortality. Kern County, California's Coroner Manager Dawn Ratliff, a care provider working to prevent suicide and overdose among dually prescribed women, was quoted in the article indicting social media: It creates “unrealistic expectations” that make lower income rural White women feel less than and left out. Harkening back to simpler times in rural America, she and her colleague Ellen Eggert portray a sense of life weariness in which women can no longer “be strong” and need opioids and benzodiazepines as a “way out”:

“They are worn down. And they can't rise above it,” said Ratliff, who puts the blame in part on the rise of social media, which can create unrealistic expectations about how life should go.

“Before, if you lived in a rural area, all you knew was your community. You just knew what people in your community looked like, what their lives were like. You didn't expect to look like a movie star—or live like one,” she said.

Ratliff, 60, works closely with Eggert, 58, who created an outreach team for surviving family members of suicides that has been lauded as a national model. Eggert said she, too, has noticed the weariness and the desire for a quick fix to life's problems.

“Women have had to be strong for so long. Opioids are a good way out. Benzos are a good way out,” Eggert said. Women “start depending on them to get through.

Then, after a while, it's not getting them through anymore. It's running their life ... and leading to their premature deaths.”

Presenting both local context and national statistics, the article points to a large swathe of American women of reproductive age who are structurally entrapped in economically depressed and isolating social environments. They seek relief from the biopsychosocial symptoms of pain and angst. They request and receive pharmaceuticals to help them “get through,” but those same medications might facilitate intentional or accidental suicide. In a paper that garnered a great deal of national attention, two Princeton University economists, Anne Case and Angus Deaton (2015), argued that mortality in midlife was rising among White Americans for the first time since the turn of the century and identified opioid overdose, suicide (accidental or intentional), and alcohol-related diseases as contributing factors. These diseases were categorized together and coined, by the authors, as the “deaths of despair” (Boddy, 2017).

Discourses of world weariness and anxious inadequacy, often embedded in structural vulnerability that drive women to the couch and then to the medicine cabinet, have been extensively documented in analyses that situate drug epidemics as social constructions of specific historical milieu (N. D. Campbell, 2000; Herzberg, 2009; Metz, 2003). Herzberg (2009), for example, describes the rise of the 1970s “Valium Panic” as a case of classed and racialized concerns about certain categories of people (middle- and upper-class White women) experiencing the ill effects of substance use that also offered opportunities for White-led feminist political movements to leverage sexist oppression as etiology for addictive behaviors. The panic and its politics reinforced entrenched American racial hierarchies that still work to construct worthy and unworthy addicted patients. Women swept up in the current opioid epidemic are emerging as a bracketed group: one suffering pain differently, perhaps as a result of biological difference; likely to be diagnosed with comorbid substance use and anxiety disorders; and appearing to be at pending risk for premature mortality. Examining the diverse economic and social contexts of pregnancy and parenting of women who are opioid dependent and benzo-prescribed might help to bring a needed critical eye to the “new” opioid epidemic writ large. The multiplicity of these experiences is equally historically rooted but also evolving within current racialized and classed discussions of what addiction and anxiety are for women.

The Adjudication of Addicted Motherhood

The NIDA reports rising prevalence of maternal opioid use and Neonatal Abstinence Syndrome (NIDA, n.d.). Official figures are partnered with the ascent of media reportage that asks the question: What if the women using opioids are mothers (Allen, 2016; Simon, 2016)? Mothering while opioid dependent is a pressing social discourse, one with a longer history that is beyond the scope of my discussion here (see N. D. Campbell, 2000; Courtwright, 2002; Acker, 2002; Murphy & Rosenbaum, 1999; Roberts, 1997). Currently, there are questions circulating about the influence of opioids on parenting abilities at a behavioral level (in terms of care and neglect) and at the level of neurocognition (in terms of brain changes). The stories of neglect are numerous and often highly disturbing in both their content and their rapid circulation. One story featured a photograph of parents overdosing in

the front seat of a car while their 4-year-old child sat strapped into his car seat in the back. Prior to the photograph and story circulating internationally, it was first posted on the Facebook page of an Ohio county police department as a cautionary tale (Farberov, 2016). This cautionary tale then became a tragic trope as additional stories went viral including a video of a 2-year-old nudging her mother to “wake up” after the mother overdosed in the middle of a supermarket aisle, and numerous other similar accounts (Allen, 2016; Seelye, 2016; Talbot, 2017). At the level of scientific research, one study examining opioid-dependent adults’ responses to photographs of infants reported that: “Compared with the brains of healthy people, the brains of people with opioid dependence didn’t produce strong responses to the cute baby pictures. But once the opioid-dependent people received a drug called naltrexone, which blocks the effects of opioids, their brains produced a more normal response” (De La Cruz, 2016). This scientific analysis of the impact of opioids on facial recognition contributes to an extensive American historic discourse about the ability of illicit substances to negatively alter women’s ability to mother (N. D. Campbell, 1999; Fitzgerald, Kaltenbach, & Finnegan, 1990; Knight, 2015; Okie, 2009; Premkumar, 2015; Roberts, 1997).

Beyond the mediated forms of public condemnation and concern and the psychological experiments, opioid-dependent parenting is also adjudicated at the intersection of criminality and clinical care. Fear over criminalization and loss of child custody leads a significant percentage of women who use prescription and illicit drugs to avoid prenatal care (American College of Obstetricians and Gynecologists [ACOG] Committee on Health Care for Underserved Women, 2014; AMA Board of Trustees, 1990). Having a previous baby born “dirty”—with a positive toxicology screen—can mark a woman with a residual biomedical trace that carries over into subsequent parenting custody negotiations; and poor women and women of color are disproportionately targeted for criminalization (Alexander, 2010; Knight, 2015; Roberts, 1997; Sufrin, 2017). Medical assessments and screening tests of women suspected of drug use can lead to multiple forms of adjudication—from immediate loss of child custody to the incarceration of drug-using women for fetal harm and child abuse. Every state in the United States has a surveillance system in place to identify prenatal substance use exposure: 24 states and the District of Columbia consider substance use during pregnancy to be child abuse; 3 states consider it grounds for civil commitment or incarceration (Flavin & Paltrow, 2010; Guttmacher Institute, 2017).

Earlier claims made by medical professionals that prenatal exposure to cocaine in utero—specifically, crack cocaine—would lead to severe physical and mental disabilities in children have been widely debunked and qualified (Okie, 2009). Medical associations and pregnancy rights groups now work actively to accurately study the short- and long-term effects of prenatal exposure to specific substances (ACOG, 2016). Scientific research about addicted pregnancy has become exceedingly more sophisticated in its ability to identify the multiple, environmental stressors that can produce poor pregnancy outcomes. These can include prenatal exposure to licit and illicit substances but can also include untreated mental illness, food insecurity and poor nutrition, housing instability, criminalization, and exposure to violence (Arria et al., 2006; Conradt, Measelle, & Ablow, 2013; Knight, 2015; Sufrin, 2017). Using these findings, advocates make demands for appropriate care and develop guidelines for the medical management of drug use during pregnancy (Newman et al.,

2013). Yet, stigma and fear often prevail, as women who use drugs during pregnancy remain intense targets of adjudication. Opioid use during pregnancy is problematic and potentially consequential, yet so too are poverty, discrimination, and shame.

The Tale of Two Anxious Moms on Opioids

It is within this context that *Slate* magazine (Copeland, 2014) ran an article making an indictment that the American public and its social and legal institutions were unlikely to learn from the past. Rather, *Slate* suggested we would choose to adjudicate the current generation of opioid-dependent mothers and their children much like the “welfare queens” and “crack babies” of years past. In presenting a broad comparison of two different experiences of parenting, opioids and anxiety, I hope to lend some needed specificity to this current debate. I attempt to compare and contrast two narrative constructions: the first is a conversation that takes place between myself and a long-term key informant (Lexi, see Knight, 2015); the second is an autobiographical op-ed piece published in the national media by a widely published author (Jen Simon, see <http://jensimonwriter.com/>). I recognize that these narrative constructions are just that—constructed stories created with specific audiences in mind and directed toward sensemaking and the communication of knowledge. I choose to analyze them together in order to argue for a close examination of the determining structural contexts within which each of the women experience anxiety, reproduction, parenting, and opioid dependence. I hope to reveal how social anxieties about mothering with ongoing drug use may adhere quite differently to different women, even as stereotypical “addict” behavior looks quite similar, at least on the surface. Examining their similarities and differences can help to bring specific clarity while also illuminating larger concerns about what might be “American” about the causes and consequences of this epidemic.

Lexi

I conducted 4 years of ethnographic research with pregnant women who use drugs and live and work in the privately owned daily-rent hotels in San Francisco’s Mission District, in which I documented 23 pregnancies among 19 women (Knight, 2015). Almost all of the women were opioid dependent; most were polysubstance users. One woman was Lexi, an African American woman who was diagnosed with PTSD, bipolar disorder, and substance use disorder. Lexi had a difficult family life growing up and a history of three suicide attempts prior to age 30. She used benzodiazepines and alcohol intermittently to manage her anxiety and methadone and heroin regularly to manage her opioid dependence. Lexi was street homeless, living in an emergency shelter, or paying daily in private-owned, single room occupancy hotels throughout the decade that we knew each other. Lexi came to drug dependency later in life having spent many years in the licit economy, working various jobs. Unlike many other women whom I encountered throughout my ethnographic work, Lexi was not someone who was initiated into drug use, or sex work, as a teenager or young adult. Lexi had three children, two of whom died as a result of inconsistent prenatal care and poor medical management.

As we sat in McDonald's one spring morning in 2009, Lexi and I discussed the multiple ways she "knew," and yet was perhaps still unsure about, the "fact" she was pregnant. We talked about her embodied expertise. Her initial mistrust gave way to ultimate acquiescence to the pregnancy testing technologies available to her. We discussed her family's religious background and how it weighed heavily on her decision not to terminate her pregnancy. She expressed concerns about the institutionalization of her pregnancy relative to her past forced detoxification from her methadone maintenance treatment slot when her daughter died at birth. She held fast to her decision not to disclose her pregnancy to Pano, the baby's father.

McDonald's, Mission District, San Francisco: March 2009.—Lexi and I are eating breakfast at McDonald's. About 10 a.m., it is crowded and loud. Young mothers from El Salvador attend to their children, fetching ketchups and straws. SF Muni bus drivers wait impatiently in line. Older Mexican men with coffee in the corner swapping stories. Drug dealers, sex workers, and other street folks move and out constantly, often stopping to chat with us or waving. Everyone knows Lexi. She has been staying in the hotels and on the streets down here for more than a decade.

The day before today I was contacted by an outreach worker, Tamika, who said Lexi wanted to talk to me because she thought she was pregnant. I go to see her in her hotel, and she has been up all-night turning tricks to pay for her rent. She was sick the week before and is several hundreds of dollars debt to the hotel manager. We talk for over an hour without her mentioning her pregnancy to me. After a long discussion about her going to the hospital for another woman's [Dylan's] delivery and subsequent "abandonment" of Dylan's son, I ask Lexi directly.

Kelly So what about you? Tamika told me that you were worried about being pregnant.

Lexi Oh yeah. I took that damn test thing and it came out positive. I'm shocked. I'm hoping it's just one of those—this was the third one I took.

Kelly And they're all three positive?

Lexi Um-hum.

Kelly Umm, what you gonna do?

Lexi The way I look at it ... I mean I don't believe in abortions. And I didn't went to a clinic yet because if I do that they're going to put me on PPMT [Prenatal and Postpartum Methadone Treatment, the methadone program specifically funded for pregnant women] again and I don't want to do that.

Kelly Why don't you want to be on PPMT?

Lexi Because I hate [the Director] ... That bitch.

Kelly Would you have to go on PPMT [to get methadone]?

Lexi Yes, I think so.

Kelly But then if you decide not to have the baby then you'll get knocked back off [the methadone program], right? So that's the—'cause that's what happened before.

Lexi Exactly, that's right. That was messed up. When I lost the baby [when her daughter died at birth] that was fucked up ... My locker got taken and they kicked me off the methadone. That was so bad. Ugh!

Kelly Did you talk to Pano about it?

Lexi You know what, we have never really still to this day actually really mourned that [the death of their daughter] and came to terms with it. I mean I have but it's something that ... I start to get emotional and then I try to blank it out. What made me feel a little better was when my mom told me—she said that she had one too [a baby die due to premature opening of the cervix]. I never knew that. She was pregnant and she was not on drugs ... So when she told me that I felt a little relieved. 'Cause I was doing my best to try to stay clean.

Kelly Yeah, you were.

Lexi And I was outside [homeless] too, living outside in a tent back here. It was devastating. And then when they explained it to me, see that nurse practitioner or so-called doctor ... 'Cause it was like she didn't want me to have a baby. She didn't, she was against me from the beginning. It was just weird. And then they told me another [white] woman's baby, that other junkie's baby, her baby lived, and she was like four months [pregnant]. She's [that baby's] fine.

Kelly I remember that. You felt like they [the hospital] didn't do everything they should have [to save your baby]?

Lexi No, they didn't. And I felt like it was like because I was black ... I just you know it's like every time I get even more stressed something else pops up. And I keep looking at—and there's no way I ... or anything else.

Kelly No way you what, hon?

Lexi Missed, you know that I'm misreading three different tests? I don't think so.

Kelly Do you want to have a blood test so you know?

Lexi Yeah, I think I should. Yeah, 'cause you can come with me. I would like you to. Whenever you can. That's fine. I have to do something [about the pregnancy] ... I pretty much know that I am [pregnant]. You know why?

Kelly Are you sick?

Lexi Throwing up every morning. I pretty much know I am [pregnant]. I can't drink liquor like I used to. It don't taste good. I throw up soon as I taste it. I mean I'm craving sugar I have to have it and it's all through the night. Like ice. I got the symptoms, I know. We're going to have to check this out for sure 'cause I pretty much know I am. I'm just trying to

face it. It ain't gonna go away, exactly. And you know what? It could be another sign like God gave me seven years ago when I had [my son] Lionel to get my butt out of here, be clean and stay gone. I mean I can look at it like that. Okay, now I have to go hit the streets [go back to sex work for her rent].

While Lexi experiences many of the biological “signs” of a new pregnancy, her traumatic pregnancy history, indebtedness, drug use, alcoholism, and structural vulnerability all exert contingencies upon her. During this conversation, she expresses fear, ambivalence, and hope that reflect the structured choices and limits framing her sense of potential optimism. She references a time when she was able to be abstinent and maintain custody of her son (Lionel), whom she later gave to a family member when she relapsed so he would not become a ward of the State in the foster care system. She describes the racialization of her pregnancy and pregnancy loss and the political–economic context of the medical management of her opioid dependence: her access to methadone being linked to her fetus, not to her.

The multitude of ways in which addicted, pregnant women in my ethnographic research came to interact with and avoid systems of care and control throughout their pregnancies is demonstrative of “stratified reproduction” at work in the United States. Stratified reproduction was first coined by Shellee Colen and applied broadly by Faye Ginsburg and Rayna Rapp as a concept used to “describe power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered” (1995, p. 3). Things often fall apart when poor, addicted pregnant women seek prenatal care and treatment for substance dependency. One clinician described her dilemma in seeking appropriate medically assisted support to stabilize the uterine environments of the unstably housed women that she treats and engage them in care. Emphasizing the added risks of alcohol and benzodiazepines in pregnancy, she said:

No one wants the liability for pregnant women. No one wants them. When they get picked up from jail, the jails want them out. They don't want a miscarriage or pre-term labor or birth on their hands. I can't even get a local treatment center to do a medical detox for pregnant women who need to be detoxified off alcohol. Now heroin, opiates, there are a lot of circulating rumors about detoxing too suddenly and its effects on pre-term labor and miscarriage. But the research seems to be that the uterine environment for women using those drugs is not that unstable. [In contrast] for alcohol or benzodiazepines [where] the research is clear. An unmedicated, rapid detox can kill you. These women need a medically supervised detox for alcohol. I have to use my background as a medical provider, because I know the language to get women admitted, to get them in to the hospital for an alcohol detox. I mention several health issues, I ask if the women can be “tucked away for a while”—that is the code. When I can establish that it is medically indicated then she can get a blood work-up, even get a psych evaluation while she is hospitalized. But it is a “social admit” [to the hospital] in the sense that the community-based treatment program should have taken her.

This clinician underscores the role of stigma against women identified as having ongoing drug use during pregnancy. A stigma that Lexi reported herself, remembering her

interactions with a clinician (“... it was like she [the clinician] didn’t want me to have a baby”) and the outcome of a previous pregnancy (her baby died as result of racialized health-care disparity, when “that other [white] junkie’s baby, her baby lived”). The interaction with the quoted clinician indicated that the community-based treatment program might be unwelcoming, and indeed, Lexi did eventually discover that she was pregnant but never rejoined the community-based methadone program.

Lexi’s 2009 pregnancy also ended with the death of her baby, and she was offered and consented to long-term birth control during the same hospitalization for the premature delivery and loss. At this point, she had received a bipolar disorder diagnosis, added to her PTSD. Her main focus was her Social Security Income (SSI) disability medical documentation. She told me: “That is what will get me stable, getting my paperwork. That is what I really need. It is the only thing that will help me at this point.” In the spring of 2012, Lexi was still in and out of the shelter system and began receiving dialysis at the local hospital; she finally gained SSI disability and subsidized housing in 2014. In the summer of 2015, Pano found Lexi dead in her hotel room.

Jen

In June 2016, I was fascinated to read Jen Simon’s (2016) brave and provocative article in *The Washington Post* entitled, “I am a stay at home mom. I am an addict.” In it, she describes her struggles with pain and depression after her first child was born, her subsequent 5-year long addiction to opioids and benzodiazepines, and her recent yearlong sobriety. Tracing the origins of her journey toward opioid dependence, she states that it began with motherhood:

I had looked forward to reclaiming my body after pregnancy, but it was no longer the body I knew. In addition to physical changes, my mental state was also rocked by motherhood.

My son didn’t sleep. His piercing screams woke my husband and me every 45 minutes throughout the night; every morning he was awake for the day at 4:30 am. Depression and anxiety crept into my life until they fully consumed me. It felt like nothing was right and nothing would ever change and nothing would ever get better. And the pain, the unbearable pain that lasted for a week out of every month, added to my inability to function. To want to function. I started many days not wanting to open my eyes. I ended many days thinking about ways to end my life.

Simon describes seeking out clinical support for her deteriorating mental health and being prescribed opioids. She outlines the escalation that frequently occurs—from tolerance to dependence to misuse—in opioid and benzodiazepine use. She reflects upon the fact that she was never identified as a risk for misuse and thus never warned about dependence. Indeed, one of her (many) clinicians who was coprescribing opioids and benzodiazepines apologized for the inconvenience of having to deal with the practices of opioid pharmacovigilance, such as pre-authorization and written prescriptions, which have now become customary in primary care settings (Knight et al., 2017). In a brief parenthetical, Simon affirms her abstinence from opioids and benzodiazepines during a prolonged pregnancy and nursing period with her second child:

When my son was 6 months old, he napped in his stroller while I cried in my doctor's office. "Maybe you could try Percocet," my doctor offered. I had tried Tramadol, Soma, Flexeril, Skelaxin — none of them worked. None of them made me feel better. I was still in pain. I was still unhappy. I hadn't started taking antidepressants yet and wanted something, anything, to fix me so I wouldn't kill myself.

Percocet dulled my pain. With just one pill, my period was no longer insurmountable; I was able to uncurl from the fetal position and leave my bed. One pill made it possible to pick up my son without wincing at a muscle spasm. Percocet was the magic elixir I was seeking. It did the impossible: It made me feel better ...

It wasn't long before I started taking Ativan daily, too. The Percocet made me feel better; the Ativan made me not feel. Although Percocet was my drug of choice, for the majority of five years (excluding my second pregnancy and the months I spent nursing), I took any opioid (Percocet, Vicodin, Tylenol 3) and any benzo (Ativan, Xanax, Valium) that I could get prescribed, beg, borrow or steal.

For more than a year, I had four different doctors prescribing Percocet to me. None of them checked to see if I was getting prescriptions from anyone else. No one warned me about the dangers of addiction; in fact, a few times my doctors apologized for having to write me a physical prescription instead of being able to call it in to my pharmacy. These new laws, my obstetrician complained, they make it harder for regular people like you to get your pills. Regular people like me.

(Emphasis original)

While Simon does not offer details about how she remained abstinent from opioids and benzodiazepines while pregnant, she is clear that drug use for her was not about pleasure or about child neglect: "I didn't take pills to get high. I wasn't out of control. I didn't nod off and I wasn't unable to take care of my children." So while she describes a moment of reaching "rock bottom" when she raided the medicine cabinet of a friend's dead father, she also knows that her relative social position placed her beyond the veil of scrutiny in most social situations: "I used my privilege to 'pass.' My life as stay-at-home mom was the perfect disguise. There are millions of us addicts disguised as regular people." This same privilege affected not only the course of her "addiction" but also the pathways of her recovery. Simon hid, like many persons who recognize they have a problematic relationship with substances and feel shame about it. But when she was ready to "take responsibility," she did not face the specter of the loss of child custody or treatment access. Rather, she had the resources for multimodal treatment to stabilize and "to cope with problems and stress." Admirably, Simon decided to share her story publicly, making her herself visible, so other women in similar situations can seek help, avoiding the ongoing despair of addiction or worse, an overdose death:

Although I was afraid of telling my husband, when I did, he was supportive and understanding. Last June, my family cared for my children so I could go to rehab. Since then, I've been in group therapy and individual therapy and have gone to 12-step meetings. I see a therapist and new psychiatrist who specializes in addiction

recovery. Through this help, I have found a combination of prescriptions that works for me: an anti-depressant, a non-addictive anti-anxiety medication, a mood stabilizer, and Suboxone, an opioid blocker that reduces cravings.

The past year has been extraordinarily difficult. It's strange how not doing something is the hardest thing I've ever done. But it's vital for my family and for myself. I'm learning that while there is no magic fix for feelings, there are also non-medicinal ways to cope with problems and stress. I'm learning that it's imperative to be open and honest, to take responsibility and let other people, other moms, know they're not alone. I've been there. I know how you feel. It can and will get better.

You don't have to die from this like Prince did, but you do need help.

My name is Jen. I'm a stay-at-home mom. And I'm an addict.

Broad stroke comparisons between two divergent women are tricky, of course. Yet, within the larger conversation about opioids and anxiety, Simon and Lexi have many striking narrative similarities that are worth noting. Both women sought out and became dependent on opioids and benzodiazepines while pregnant and parenting; reported suicidality, stress, and depression; were critical about their experiences with health-care clinicians and institutions; and self-reflective about how their relative positions in racial and class hierarchies influenced their health outcomes. The societal demand for abstinence is similarly placed on both Simon and Lexi, as it is placed on all pregnant women. But this demand is differently distributed among the two women. Because Lexi is poor, access to medically assisted treatment (methadone) is contingent on her being pregnant: When her baby dies prematurely, her treatment is terminated. Simon's period of abstinence during pregnancy and breastfeeding is unaccounted for; her access to treatment retold as a matter of course ("My family cared for my children so I could go to rehab"). Indeed, it is hard to imagine Simon's story being told while she was still actively using benzodiazepines and opioids. Simon's is a recovery story. One that is meant to be, and is, both a cautionary tale and an inspirational entreaty. It reads, in this sense, very differently than Lexi's narrative: a story of a woman caught by a pregnancy in the middle of an addiction, in the middle of a McDonald's, uncertain and untethered to social or institutional supports.

Another difference between Lexi and Simon's narratives of substance use and parenting is more subtle: We don't expect Simon to be addicted and we do expect Lexi to be addicted. The "we" here represents a rhetorical American public that has naturalized inequality (Holmes, 2013) and that chooses to remain uncritical about the unequal distribution of the burden of addiction across racial and class groups. The title of Simon's story reveals the irony: "I am a stay at home mom, and an addict." These are not supposed to coexist. The racialized and classed notions of poor, addicted mothers that we have inherited from the "crack baby" era stubbornly persist in both women's experiences. This naturalization of inequality is deeply associated with the racialization of addiction. Coates (2017) has argued that the racialized construction of the "new" opioid epidemic travels hand-in-hand with the persistence of White supremacist ideology in American politics, historically and in the present day. He states:

Nevertheless, the argument that America's original sin was not deep-seated white supremacy but rather the exploitation of white labor by white capitalists—"white slavery"—proved durable. Indeed, the panic of white slavery lives on in our politics today. Black workers suffer because it was and is our lot. But when white workers suffer, something in nature has gone awry. And so an opioid epidemic among mostly white people is greeted with calls for compassion and treatment, as all epidemics should be, while a crack epidemic among mostly black people is greeted with scorn and mandatory minimums. Sympathetic oped columns and articles are devoted to the plight of working-class whites when their life expectancy plummets to levels that, for blacks, society has simply accepted as normal.

(Coates, 2017, p. 9)

For pregnant and parenting women who share similar structural circumstances to Lexi, failing to address addiction as a chronic relapsing complex medical, psychological, and sociostructural condition perpetuates poor health outcomes for women and their babies. It leaves them ironically overinvolved with institutions of punishment and control and underengaged in care (Knight, 2015). Simon represents a kind of addicted mother who is getting increased media and political attention: The "it can happen to anybody" narrative of addiction in which a mom of "privilege," with social support and the economic means to access treatment, is iatrogenically addicted to opioids. It is reasonable to assume that Jen Simon, as a widely published author, was self-reflective of her audience (*The Washington Post* readership) and savvy in her construction of this piece. She presents the unexpected: Her confession about stealing from a dead man's medicine cabinet is intended to upend the perception that an educated, White, wealthy woman might escape the "criminal" behaviors addiction is thought to inevitably produce. In this way, the narrative succeeds only by evoking the "other" racialized addict as needed foil. It presents women on opioids as "regular people" embedded in recognizable, whitewashed social worlds (in the minivan, at the Parent-Teacher Association meeting, at the doctor's office)—not extraordinary social failures like Lexi (homeless, addicted, of color, and alone). The two women are bound by their shared addictions to opioids and benzodiazepines. Yet, one narrative receives empathy, the other scorn. They are also both caught in the current production of the U.S. opioid epidemic, one in which the differential costs of actual and social reproduction need to be questioned given the context of widespread American pain and anxiety.

(Not) Reproducing the American Dream

In her prescient paper, "Theory on the Market: Panic, Incorporating," Jackie Orr (1990) offers a "feminist inquiry into the social and political economy of panic disorder" in which she seeks to "rework the dominant construction of panic disorder as a medical problem towards a critical understanding of panic as a social problem within the postmodern" (Orr, 1990, p. 460). As Herzberg (2009) demonstrates, the pharmaceuticalization of gendered anxiety has a long American history, ranging from early marketing efforts to link tranquilizers with redeemed masculinity in the workplace to later feminist accusations that women were medicated to ensure docility and dedication to reproduction and housewifery. *The Insecure American: How We Got Here & What We Should Do About It* (Gusterson & Besteman, 2010) introduced an edited volume in which anthropologists grappled with ever-

prevalent individual and sociostructural anxieties which had come to characterize U.S. daily life on a number of registers. Barbara Ehrenreich, in her foreword to the book, seeks to outline how this American insecurity has been mounting through many decades of neoliberal policies that disenfranchise less educated and employable Americans, while supporting the criminalization of disparity through social policy mechanisms such as the now widely critiqued War on Drugs. She states:

Fifty or sixty years ago, the word *insecurity* most commonly referred to a psychological condition. Some people suffered from “insecurities;” otherwise, though, Americans were self-confident to the point of cock-iness ... In the old version of the American Dream, a college graduate was more or less guaranteed a middle-class lifestyle. In the emerging version, there were no guarantees at all ... The war on poverty gave way to a war on crime, and when there were not enough crimes to justify this massive punitive enterprise, the authorities invented new ones—like the “crime” of drug possession and use.

(Ehrenreich, 2010, pp. ix–x)

In the present moment, the anxious every (White) woman is being constructed as a critical component of the new opioid epidemic and the deadly co-prescription of benzodiazepines and opioids has become a clinical signifier of broader, gendered social ills. Case and Deaton (2017) connect economy with epidemiology in their analysis of premature mortality. They insist on qualifying the geographic argument about “deaths of despair” to argue that despair is widespread and adhering itself most strongly to those without a 4-year college degree throughout the country. Opioids fan the fire:

The popular press has been saying that this [rising mortality] is a rural problem, or this is a problem in Appalachia. And indeed that is true. But, by geography this is happening throughout the US. Mortality rates overall are rising in almost every state ... So this is a problem in cities, it’s a problem in suburbs, it’s a problem in rural areas. And the people who are getting really hammered are the people with less education. It is almost as if now there are two Americas: people who went to college and people who didn’t. And it’s the people who didn’t go to college who are actually facing these larger mortality rates. And the opioid crisis in America is certainly an accelerant to what’s been going on.

(Case & Deaton, 2017)

The “new” opioid epidemic provides an opportunity to identify age-old social anxieties about drug use while pregnant and parenting, while opening up new lines of inquiry about how and why drug use epidemics become gendered. From Miltown in the 1950s to Prozac in the 1970s, narratives of being overwhelmed, stress, and gender-role associated fears in relation to white-normed notions of beauty, health, and success abounded (Acker, 2002; N. D. Campbell, 2000; Herzberg, 2009; Metz, 2003; Reagan, 2010). These narratives have circulated in popular discourses about motherhood and provided productive fodder for feminist-informed critiques of neoliberalism, labor, and the modern American family (N. D. Campbell, 2000; Flavin, 2009; Roberts, 1997). A parallel discourse generated in public health circles has called attention to the rise in U.S. women’s prescription, legal and illegal drug use, and its associated morbidity and mortality (Back et al., 2011; Jamison et al., 2010).

Women of reproductive age, and specifically pregnant and parenting women, sit on the nexus of these multiple discourses (Knight, 2015; Vestal, 2016). They are a group toward which much social anxiety is directed. Demonstrating the multidimensionality of the opioid epidemic for pregnant and parenting women reveals how calls for empathy and understanding in the new opioid epidemic scaffold atop racialized and classed social constructions of ideal American motherhood (Hansen & Netherland, 2016; Roberts, 1997). There are many women who are struggling with severe anxiety and opioid addiction in widely divergent structural circumstances. As the national discourse persistently identifies opioids as a leading cause of the breakdown of the American family (Talbot, 2017), one cannot help but wonder if women who are opioid dependent have come to reflect, reproduce, suffer, and die behind the fears of a nation?

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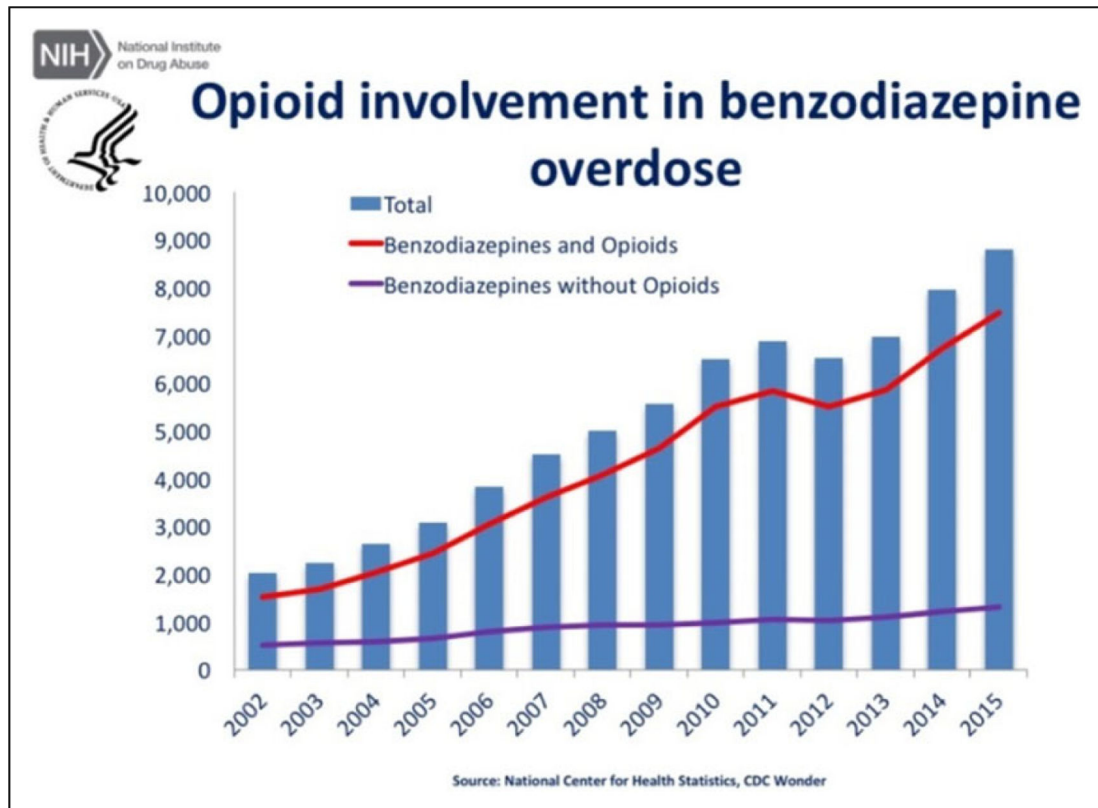


Figure 1.

National Overdose Deaths—Number of Deaths from Benzodiazepines, With and Without Opioids, 2002–2015. The red (darker) line represents the number of benzodiazepine deaths that also involved opioids, and the purple (lighter) line represents benzodiazepine deaths that did not involve opioids. (Centers for Disease Control and Prevention Wonder, 2017)

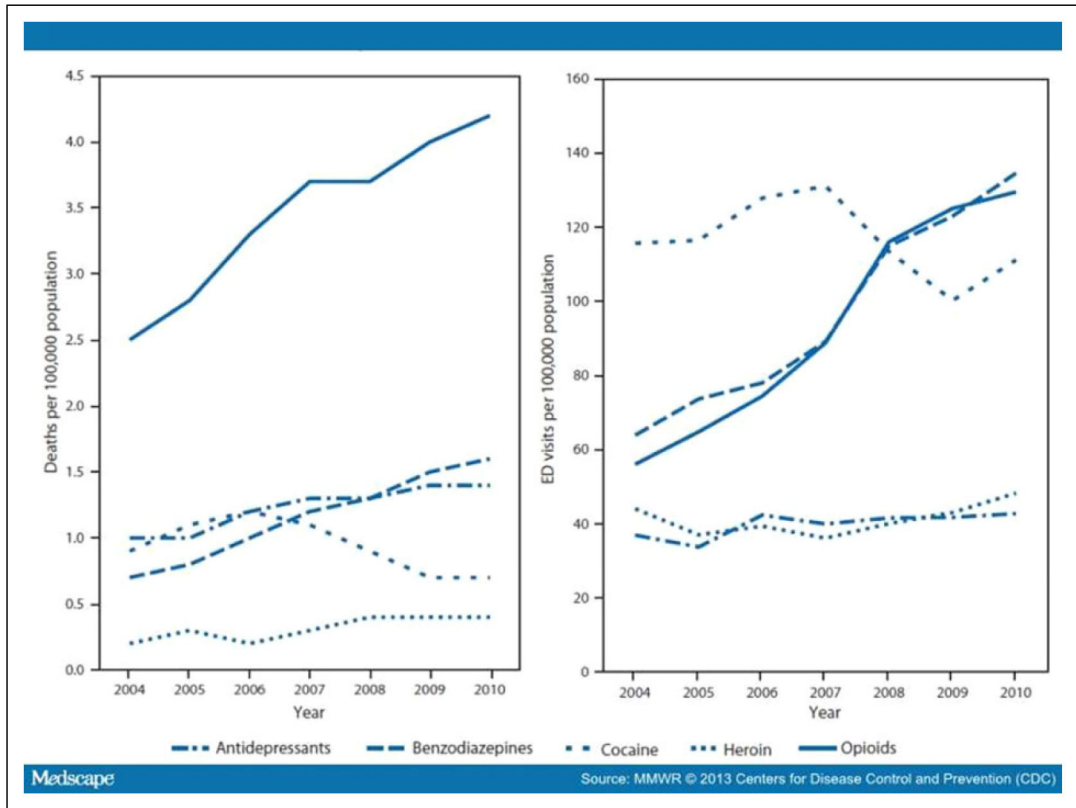


Figure 2.

The figure above shows crude rates for drug overdose deaths and drug misuse- or abuse-related emergency department (ED) visits among women, by select drug class, in the United States during 2004–2010. During 2004–10, opioid pain reliever (OPR) death rates and ED visit rates increased substantially among women. Starting in 2008, more women visited EDs because of misuse or abuse of benzodiazepines or OPRs than for cocaine. (Centers for Disease Control and Prevention (CDC), 2013)