3. Substance

Published by

MaiaDolphin-Krute.
Opioids: Addiction, Narrative, Freedom.

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Substance

Risk

The opioid epidemic is many people in deep proximity to the substance of opioids, within the rubrics of addiction and pain treatment, physical dependence and psychological dependence, pain and desire. What is it that maintains any of these proximities, and that keeps people and substances within certain distances? What is it, really, that maintains distances when it comes to any substance? It is a combination of factors and events: architecture, a relationship between the built environment and the legal system, business interests and lobbying groups, personal preferences, human biology, and so on. When it comes to specific substances, and mostly harmful substances, these factors coalesce within the field of risk management. When substances are risky, certain factors and distances take precedence over others, like the legal system and complete removal or abatement of substances like lead or asbestos — an extreme distancing that must always be maintained; there can be little to no safe proximity in relation to such substances. But are these factors and systems adequate when accounting for the proximities of opioids? Do the paradigms of risk management truly answer the question of how
one lives with opioids? Given many of the questions and points of contention surrounding opioid use currently, it would seem as if yes, in fact, risk management should be the main guiding discipline. For instance, in questions of who should be given legal access to opioids (who should be exposed or where the risk should be), risk management guidelines may prescribe that only those patients in acute, intractable pain as part of an end-stage terminal disease should be prescribed opioids, thus limiting both the length of an exposure to opioids and relying on the extenuating circumstances of severe pain and end-of-life experiences to counteract, or cancel out, the risks of addiction that opioids pose. But such black and white situations must be extrapolated from, because such extremes are far from the only kind of situation in which opioids are present. Are guidelines like these actually useful when applied to a situation of existing widespread opioid use? Here is where opioids fail to adhere to the models of risk management. With a substance like, again, lead or asbestos, it is not just that the risks of exposure to them are clear, it’s that the risks are constant and universal. Asbestos causes mesothelioma in all humans, and lead poisoning will always occur if lead is ingested.

But when it comes to opioids, there has always been an undercurrent of confusions, false appearances, and surprise, an affective structure that undermines the usefulness of risk management in thinking about how to live with opioids. Beginning even with the narratives of surprise within opioid epidemic coverage, and the surprise that these are the people who are dying, opioids have often been (or been representative of) something other than what they seemed to be. And how do you assess the risks and benefits of a substance when what is uncertain lies in the very nature of that substance? Risk management does, of course, deal in uncertainties—but these are often the uncertainties of a future, of what might happen. In a proximity to opioids, we encounter uncertainty not within the temporality of opioids but within its very substance. A substantial uncertainty.
Over the course of the past two years, there has been an incredible surge seen in the rates of overdoses caused by synthetic, incredibly strong opioids. As discussed previously, these substances are most commonly fentanyl and carfentanil, and are usually manufactured in foreign labs and imported, relatively easily and freely, into the United States. Once here, these raw materials are processed in specific yet simple machinery (similarly available for order online) into pill form. These pills are identical in appearance to a pill one would be prescribed. And, in fact, this appearance is intentional, beyond being the appearance of just any opioid pill: drug traffickers and manufacturers commonly manufacture synthetic opioid pills that look identical to OxyContin or Vicodin — pills that command a higher street price than any unlabeled, unknown, synthetic opioid pill would.

Counterfeit pills are an object into which all of the undercurrents of surprise and false appearances within the opioid epidemic have condensed. Counterfeit pills represent the instance, incidence, and accident of dying because you do not know what something really is. Counterfeit pills, as a copy, a substance, and a cause of death, both are and are not unique. On the one hand, counterfeit pills are only able to remain deeply unidentifiable because they take advantage of the very features of “actual” pills that made pills desirable and necessary in the first place: pills were originally manufactured at a point within the history of chemistry and the pharmaceutical industry that marked a turn from plant-based, accessible, small-batch remedies to manufactured and synthetic ones. Pills were manufactured precisely because they provided identical, regular, and assured doses of a substance, through the very state of uniformity. Counterfeit pills are a perverse reversal, or deep undermining, of this. On the other hand, the dramatic rise of deaths attributed to counterfeit pills, with deaths due to synthetic opioids alone rising 73% in 2015, stands in unique contrast to anything that has come before it.¹

Counterfeit pills are and are not opioid painkillers. In a particularly sick sense, counterfeit pills can be seen as part and parcel of the you won’t believe it’s not industry that has primed consumers to always already be prepared for and desire a product or object that seems like one thing but is actually another. But no one is prepared for this.

To better understand the standing of counterfeit pills and their implications within the opioid epidemic, I will turn to a seminal text concerning authenticity, originality, copies, and aura: Walter Benjamin’s “The Work of Art in the Age of Mechanical Reproduction.” While this text may be specific to visual art and media, it remains one of the best examinations of the quality or set of qualities a given object has in direct relation to that object’s status as original or copy.

The original itself would be the best place to start: “The presence of the original is the prerequisite to the concept of authenticity.” And it is this authenticity that does or does not continue through the multiple iterations of copies that surround or are subsequent to an original. It is opioid painkillers that lend a sense of authenticity to counterfeit pills. But what quality, exactly, of painkillers provides this sense of authenticity? While Benjamin may have been referring here to processes of original artworks, like paintings, being reproduced through mechanical techniques, like photography, or theater into film, the relationship Benjamin articulates between originality and authenticity makes clear that what we need to think about here is what is original, what is necessary, to have led to the creation of counterfeit pills. With the counterfeit pills, the original is not opioid painkillers per se, but what painkillers are representative of. The original is the feeling of a painkiller. Thus what counterfeit pills reproduce is not an object as such, but a relation to an object. Counterfeit pills produce the feeling of being in proximity to opioid painkillers, and the desire and anticipated pleasure and necessity of this proximity. It would also follow that without this

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experience of an original, or original experience, a person would not be actively seeking substitutes to that original, when opioid painkillers become out of reach (financially, geographically, or otherwise as shaped by market pressures). And it is these very market pressures that contribute further layers of authenticity to counterfeit pills: it is not only that counterfeit pills are opioid painkillers, but can be the specific objects of OxyContin or Vicodin, the two most widely abused substances within the opioid epidemic and those with the highest street prices.

And yet, counterfeit pills are distinctly not OxyContin nor Vicodin. They are more than either of these substances. This substantiality, the more-ness of counterfeit pills, is a product of exactly the processes of reproduction and mass production they are part of, because “process reproduction can bring out those aspects of the original that are unattainable to the naked eye yet accessible to the lens...can capture images which escape natural vision...technical reproduction can put the copy of the original into situations which would be out of reach for the original itself.”

Counterfeit pills are an object in which the substance of opioids is able to inhabit and occupy different situations, spaces, and proximities than “original” or “actual” pills do. Counterfeit pills can, for instance, kill a person at rates and at a speed out of reach for more common, legally manufactured forms of opioids. Particularly at the level of a single pill: a single pill made of carfentanil or fentanyl can and does act in ways drastically different from an identical looking pill made of morphine or oxycodone; a lethal dose of fentanyl is 2 mg, approximately the size of a grain of salt. It is not just the fact of reproduction, but the illicit or black market nature of this reproduction that positions counterfeit pills in this way; what makes counterfeit pills deadly is a change in substance, in nature, without a change in form. Does this mean that the groups of people manufacturing and distributing counterfeit pills are intentionally trying to kill

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people? No. It means, more so, that market pressures, the market pressures that drive the desirability for massively available forms of opioids, are also bodily pressures and deadly pressures. The opioid epidemic is many people in the same place at the same time and the pressure of this mass.

Within this situation surrounding counterfeit pills, we can see the ways that a desire for an original (including, especially, an original feeling) outweighs or interacts with the unique capabilities of a copy. In other words, intense, addictive desires tied to an original experience outweigh what is also common knowledge of the dangers of opioids, particularly among active drug users who may have witnessed or have first hand knowledge of the overdose of another. At what point, if any, does this transform into or become a desire for the copy itself? At the point, perhaps, of an epidemic. Benjamin identifies this point or movement as what happens when “making many reproductions…substitutes a plurality of copies for a unique existence.”5 This speaks to the very nature of an epidemic of drug abuse, especially when seen in relation to the patterns of drug manufacture and trafficking counterfeit pills are a part of; this speaks to the very nature of the mass market, of mass desire and pain, of the many qualities of many bodies in the same place and the qualities and shapes of the many desires of those bodies. Furthermore, the details of the manufacture of counterfeit pills provides a more pragmatic reading of Benjamin’s sentiment. Attempting to stay one step ahead of US law enforcement, as newer synthetic substances become identified and banned, overseas labs manufacture endless variations of similar chemicals in order to sustain and guarantee a stable, easily distributed supply. The plurality of substances is far more important than any’s unique existence.

Beyond sheer mass, what drives a desire for a copy, or what enables a desire to become detached from an original and move towards a copy? In a sense, this is the very nature of addiction. As Benjamin notes in relation to the desires at the heart of processes of reproduction: “Every day the urge grows stronger to get hold of an object at very close range by way of its likeness, its

5 Benjamin, “The Work of Art,” 221.
reproduction.” In a moment of desperation and withdrawal, what matters is the closeness and immediacy of an opioid—not necessarily precisely which opioid it is, especially if you cannot ever identify it until after the fact. Desire is inseparable from time and distance, from proximity, and the feeling of such a distance over time, especially in relation to opioid addiction, and the state of having been in this proximity for longer periods of time. As a deeply cyclical disease and a disease of habits, addiction imparts deeper layers to an understanding of the idea that “the unique value of the ‘authentic’ work of art has its basis in ritual.” Taking a pill, the feeling of taking a pill, the feelings after taking a pill, are both unique values and rituals in which an addiction may originate, and simultaneously the very state that allows certain desires tied to an original to become unhinged. What is authentic and original can be overtaken, canceled out. Every high is exactly like the one before it, and nothing like the one before it. Habit, as much as it is about sameness, is also always the medium of the most drastic changes. In illustration, I would point to the nature and use of a recent pharmaceutical development within the opioid epidemic. In attempts to maintain access to opioid painkillers for those patients who need them (and maintain wide profit margins on newer, patented, and non-generic opioid forms), the pharmaceutical industry has been widely touting the benefits of newly developed ADFs, abuse deterrent formulations. These pills, in a sense, attempt to be identical to opioid painkillers in every effect if not in every quality, in that they provide as effective pain relief, but cannot be crushed or otherwise tampered with in ways drug abusers may utilize. Yet these pills fail to be convincing or successful in preventing drug abuse, as “drug abusers quickly drop the reformulated drugs in favor of older painkillers or heroin.” The object of the pill no longer matters: the originality of an experience with “older painkillers or heroin”

becomes stronger and more desirable than any other, even non-counterfeit, opioid experience.

Counterfeit pills are a point within what is really a constellation of physical, social, and political diseases, situations, and affects that these undercurrents of originality, desire, and copies are moving through. From poverty and the daily small violence of the rural to HIV, hepatitis C and other illnesses related to intravenous drug use, people engaged in and encountering one of these instances, like counterfeit pills, are far more likely to be simultaneously or soon thereafter entangled in a related instance. Drawing on the work of anthropologist Merrill Singer, these clusters of illnesses that “[encompass] nonbiological conditions like poverty… and other social, economic and political factors known to accompany poor health,”9 can be termed syndemics. One could, therefore, detail a syndemic of opioid use within the United States as existing as or within a cluster including: both licit and illicit pharmaceutical manufacturing, poverty, joblessness, global drug policy, lack of social support, addiction and substance abuse, diseases related to IV drug use, overdoses, opioid withdrawal, and so forth. Studying the patterns of physical illness and social situations of a heroin-using population in Hartford, CT, Singer termed the cluster he found to be a syringe-mediated syndemic.10 Given the prevalence of not only counterfeit pills, but pills generally, I would argue that the opioid epidemic is pill-mediated: pills are the technology that is both actively being used to transport, distribute, and ingest the substance of opioids, and this specific technology, whether intentionally or not, is providing the parameters within which these actions—and their consequences—are taking place. Pills are easy to distribute, easy to take, and easy to produce large quantities of. They require no paraphernalia to abuse, though some users do crush or otherwise augment them to make pills injectable or able to be snorted or smoked. As users transition to drugs like heroin or otherwise begin using intravenous methods,

10 Wapner, “Austin, Indiana.”
rates of related diseases will rise (and have been), though as the opioid epidemic has focused on pills, this has been much less of an epidemic of diseases like HIV or hepatitis than it could have been. Though easily manufactured, pills (particularly legal, branded forms like OxyContin) fetch high street prices; driving a transition to heroin is often the fact that heroin is less expensive than pills. Even within a brief sketch of the current situation as a pill-mediated syndemic, we can see the breadth of causal factors and effects, from economic to biological, that are generated by qualities of the pills themselves. “Epidemic,” while still a useful word for its sheer mass, may also not be entirely what it seems, or encompass all there is.

For the people who are dying, of either counterfeit or “actual” pills, how do these layers of false appearances affect their deaths? Though this practice has begun to change, it was common during many of the early years of the opioid epidemic for death certificates to not list “overdose” or “substance abuse” as a cause of death; acute intoxication or respiratory failure or an otherwise accidental and unspecified instance were more commonly used. As the consequences of this practice have become apparent (primarily pertaining to the miscollection of opioid use and overdose statistics it engenders) and it has begun to be discontinued, such death certificates still present another instance of false appearances within the opioid epidemic: a statistical false appearance, or the false appearance (or presentation) of many deaths. What is it about an addiction that disqualifies it as a cause of death, aside from stigma? If one were to fully follow a model in which addiction is a disease, would it not make sense to consider an overdose as part of the prognosis? With the rates of overdose and death for opioid addicts so high, such a conceptualization is not unfounded; the data certainly supports the fact that overdoses are a frequent end of addiction. And thinking of an overdose death in this way would make it more analogous to experiences with death in other diseases. While an infection may not be

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completely expected as a cause of death in cancer, it is absolutely understood to be a normal event for a terminal cancer patient. But even while drawing this comparison, it is possible to recognize the paradoxical situation at the heart of how an overdose is perceived and talked about: how can something feel so inevitable, yet always be so surprising?

Over the course of the epidemic as a whole, it becomes apparent that time itself is frequently what creates this disjuncture between inevitability and surprise, contributing to an overall sense of disbelief. Epidemics, as a function of epidemiology, are always already about and structured by time, through many instances happening at the same time—and by the fact that the collection and interpretation of epidemiological statistical data takes time. Often, it seems, it is the slowness of this process—particularly as interpretations become translated into policies and public health recommendations—that directly contributes to a sense of things not being what they seem. Perhaps it would be more accurate to say that things do not anymore seem like what they once were. One of the clearest instances of this process and its consequences can be found in recent data collected for the state of Massachusetts. Struggling with some of the highest rates of opioid abuse in the nation, both state and local governments have been active in working to bring down not only abuse but prescribing rates. And, in fact, they have been successful in these efforts: opioid prescribing rates for Massachusetts have decreased in 2016 from previous levels. However, overdose death rates are on track to make 2016 the deadliest year yet. There are and are not clear answers to explain this pattern. On the one hand, it could be assumed that a vast majority of overdose deaths are being caused by stronger synthetic substances, and the data certainly shows a rise in availability of and overdoses due to synthetic opioids. On the other hand, it continues to be true that prescription pills, including nonopioids like benzodiazepines,

continue to be found in significant numbers of overdoses. Is this simply a legislative false appearance? What, exactly, is out of sync? How long does something have to seem like one thing, like what it is, in order to actually be that thing?

Sackler

This last question, in particular, applies as much to pain patients as to anyone else involved in the opioid epidemic. How long does opioid use have to continue for it to no longer seem like medication, but physical dependence? How long does a person have to be in pain, or how much pain, to outweigh what seem like risks? At what point does a pain patient themselves come to seem like a different kind of person as shaped by beliefs about their substance use? Just as any opioid user is acting in an environment that has become deeply saturated with these substances, so too are pain patients, and in ways that may be even more imperceptible: the status of a pain patient in recovery from prior substance abuse issues may be paradigmatic of this sentiment.

Though this could also be illustrated with a much more personal example. I, myself, seem like any other pain patient (despite not having any of the most common conditions, like back pain or arthritis, that opioids are frequently prescribed for) and I am like any other pain patient, but this status is not constant. Like any relationship, my proximity to opioids is shaped by the physical space I find myself in. One of the most complex, opioid-saturated spaces that I find myself in frequently and, at times, even daily, is that of Harvard Square. Upon entering this space, many other instances and situations become apparent within the frame of “pain patient” than may meet the eye initially.

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This happens because of the proximity of bodies. There is, on the northeast edge of Harvard Square, the presence of Arthur M. Sackler. A founder and CEO of Purdue Pharma, along with his brother, Sackler has become known as the father of modern medical advertising. Through his positions within the pharmaceutical industry and as an owner of an advertising agency, Sackler developed the techniques like direct-to-doctor advertising that have subsequently become the mainstay of pharmaceutical marketing, and were put to particular use in the aggressive marketing of OxyContin. Though he passed away in the early 1990s, Sackler remains in the square through his endowment of the Sackler Museum of Art at Harvard University. OxyContin can be found, in a sense, throughout the rest of Harvard Square as well. Long home to groups of homeless or itinerant individuals, Harvard Square is often a space in which people are more or less visibly using drugs in public; the majority of experiences I’ve had in witnessing people unconscious or nodding off in public have happened in and around Harvard Square. While it is difficult to ascertain how many people are using opioids there at any given time, Middlesex County, of which the city of Cambridge and thus Harvard Square are a part, have had the highest number of opioid deaths over the past 15 years in the state, and Middlesex County continues to have the highest rate of opioid abuse in Massachusetts.

16 Massachusetts Department of Public Health, “Number of Unintentional Opioid-Related Overdose Deaths by County, MA
I am exactly where one of these things ends and the other begins. I have, at times, been dependent on Harvard University, either as an employee or because of the employment of my partner; I have also been tied to the museum itself through my position as an editor at an arts-focused publication, and have attended events and exhibitions there as the museum’s guest. It is difficult to determine how directly I have benefitted from the money of Sackler, or of the museum, but however roundabout this may be, it is present. Though I have only been prescribed OxyContin once, during an emergency room visit, I have paid for other opioid prescriptions with money more or less tied to Harvard; this relationship is almost cyclical. On the other hand, I am deeply, biologically, in proximity to all those within the square abusing or using opioids: opioids are ours—even as the legislation of opioids and the experience of that legislation has come to belong very much more to some people than to others. This relationship, for me, has become condensed within a particular set of objects within the square, a set of public restroom stalls. The First Church, located near the northern side of the square, has maintained public restrooms throughout its lengthy history, but closed these restrooms in 2012 as the church administration no longer felt they were able to handle the opioid overdoses that were or might take place there. Following this closure, local business owners saw a sudden rise in people using their front steps or back alleys as restrooms. The Harvard Square Business Association, a lobbying group that has also recently played a major role in other urban planning and redevelopment decisions in the area, participated in a lobbying effort to have the city of Cambridge install public restrooms to replace those closed by the First Church. The city did so, and spent $400,000 to install the two, now operational, stalls. On every walk


through Harvard Square, now, I think about the money of these restrooms: who was it spent for? How many doses of naloxone, the overdose reversal medication, could this have paid for? What does this money, used in this way, express? I think, too, of all of the overdose awareness posters on all of the trash cans throughout Boston: because of their solar compacting ability and design, each of these trash cans costs $2,000; $2,000 plastered with the outstretched hands of presumed “junkies,” but not, directly, money supporting such people.

These instances of the legal-architectural relations contained within or engendered by opioids are and are not uniquely current. Boston, in particular, has long been shaped by the money of opioids. On university buildings and hospitals throughout the city, one can see the names of families whose money was made in 18th- and 19th-century import-export businesses, primarily focused on the distribution of opium in China: Perkins, Cabot, Cushing, and Delano. Perkins, in particular, was influential in the founding of Massachusetts General Hospital, McLean Hospital, and the Perkins School for the Blind. Elsewhere throughout the city, one can visit the Cabot Library at Harvard or the Cabot Intercultural Center at Tufts (or the Sackler School of Graduate Biomedical Sciences, also at Tufts).

If nothing else, it is illustrative of the many objects of opioids, beyond what is apparent. While opioids are, of course, painkillers and pills, they are also: money, specific buildings and the names on those buildings, institutions (and institutionalized), lines written into city budgets, objects encountered in public areas. What this situation and space demonstrates is the way that a material proximity, as in my own personal proximity as it is augmented by my presence and embeddedness within this (public, institutional) space, is a legal-architectural relationship.


It is produced from interactions between physical and legal bodies, and from the way that the written law structures the built environment (as in, for the most obvious example, building codes). It is not constant. It is always, simultaneously social, biological, economic, and political. It is the way I walk past groups of other opioid users, and the stack of pay stubs I have from Harvard University; it is the budget and policies passed by the city of Cambridge, and it is the press releases I receive from the museum. It is my own pain, and the physical, emotional, and economic pain of those within the square who are also using, if differently, opioids. It is a relationship of multiples. What does it take to notice beyond false appearances, beyond what is simply a name on a building or a person on a sidewalk? What does it take to notice how much opioids contain?

Using

Through all of these instances of false appearances and mimesis, opioids disrupt the norms set by the histories of other dangerous (and useful) substances within the disciplines of risk management and public health. Opioids are neither something to be entirely avoided, never used again (as if that were even possible, now, given the presence of illicit labs manufacturing synthetic forms of these drugs) nor a substance that should (continue to) be prescribed widely—nor even, always, a substance that is visible and apparent enough to be avoided. Opioids are a gray area. Because of these disciplinary disruptions, a relationship and proximity to opioids also exists in and as a disruption to normal and existing ideas about how we understand a substance to act within our bodies.

A normal idea of how a harmful, perhaps addiction-causing substance acts within our bodies is set by the paradigms of risk management and, I would argue, fields of ecology epitomized by studies like Rachel Carson’s *Silent Spring*, which examined the effects of a chemical or outright toxic substance within an ecosystem: a harmful substance produces the effects it does because of an exposure to too much; whether through repetition

over time or a sheer initial quantity, a harmful substance over-whelms the body of the organism or ecosystem it is released into, wreaking havoc because it throws what had been there out of balance. Within our own bodies, the most basic model we have that conceptualizes this harmful substance-balanced ecosystem (or substance-self) relationship is that of eating. This is a model based on putting something in sensibly, having sensible and insensible or invisible things happen to it, and having both sensible and insensible or invisible (inasmuch as they are much slower things) come out or become apparent. The indicators we have for what a substance, like food, is doing to or within us exists on a wide spectrum of times and timing, encompassing both slow-to-immediate and singular-to-repetitive: weight gain, allergic reactions, feeling more energetic, feeling tired, having a headache, having cravings. How long does something have to seem like a thing in order to be that thing?

Another way to express this substance-self relationship and our experience of it would be through a neuroscientific lens and an explanation of the somatosensory system and the somesthetic senses it produces. To apprehend and understand an object, whether an internal body part or state or an external object, the body and nervous system continually, minutely, and across multiple body areas and systems collects data: signals that travel within the nervous system to the brain, becoming neural patterns that generate actions, whether the regulation of hormones within the bloodstream or a set of emotional responses and the physiological states that accompany them (i.e., the involvement of the hormone cortisol in the affective and physical “fight or flight response”). The importance of the somatosensory system in this process is twofold. First, by constantly monitoring bodily signals, homeostasis is simultaneously monitored and regulated: incoming signals about too much or too little of a given hormone, say, will prompt the brain to send signals that correct any imbalance. Secondly, the importance of bodily signals and the body maps they produce is crucial within an understanding of consciousness, of knowing awareness, as consisting of “constructing knowledge about two facts: that the organism is involved in relating to some object, and that the object in the
relation is causing a change in the organism.” In other words, in order to understand how a substance acts within our bodies, we must be able to both gather information about the substance and information about ourselves; ultimately, information about our proximities.

Thus, to understand an object, we rely on primary sensory systems (i.e. visual, auditory, touch) to record different aspects of an object, and integrate them to produce an experience of the object. For instance, I am relying on my sense of touch to record the softness of this particular sofa, which I will recall later when choosing a seat. Crucially, it is not only sensory data that is recorded and remembered, but the response we had to that object (which is always simultaneously emotional and physiological, consisting of “feelings” and mechanical, thermal, and chemical reactions that accompany them), thereby producing perception and recall. When we remember an object, we always also remember how it felt, even when those feelings may appear to be just a series of nonconscious motor adjustments made in the presence of the object. What this should recall is our discussion of the necessity of an emotional experience of an original opioid in subsequently producing a desire for even a copy of an opioid, an instance in which clearly what is being recalled is both the object of the pill and the feeling of taking a pill—and the clear effects of this kind of emotional and biological recollection. How we understand a substance is thus always based on physical aspects of the substance itself (the size and shape and weight of a pill) and our physical and emotional reaction within an encounter with that substance (how good it felt to take a pill; how this desire may extend to similar, even if crucially different, objects of the same size and shape and weight). Here, therefore, we may expand our understanding of a material proximity to include even more deeply the biological and emotional, and the constant interplay and inseparability of the two. A material proximity describes the way that a relationship to an object, down to the level of non-conscious, nervous system workings, is always generated both by characteristics of the object and characteristics of ourselves.

This complex process involving multiple physiological systems, only a portion of which we may have conscious access to at any given moment is, in a way, a kind of behind-the-scenes orchestration of our bodies and actions—all, ultimately, in the aim of maintaining homeostasis, to return to the former noted importance of the somatosensory system. The practice of maintaining steady, precisely calibrated levels and rates of everything within a body, from blood oxygen levels to insulin production, homeostasis is the basis of life and its maintenance. This is not to say that the levels maintained by homeostasis will be permanent and unchanging within the life of a given individual. As we saw in the neuroscience of addiction, long-term alteration of homeostatic levels (such as, within addiction to opioids, levels of dopamine and other neurotransmitters) leads to a state referred to as allostasis: given the elasticity of the nervous system, in particular, homeostatic processes can be altered and then, in a way, reset and maintained at these new, altered levels. The amount of change a body can withstand and maintain is termed the allostatic load. Simultaneously, of course, elasticity is not the same thing as positive change; as “load” would suggest, allostasis takes a toll on the body that sustains it, physiologically and emotionally, as in the case of addiction. And this is where the field of ecology and its substance-ecosystem conceptualizations become especially relevant and equivocal to the way we conceptualize a substance within a body, whether through the terminology of allostasis and homestasis, the model of eating (and weight gain or weight loss) or the social constructs of “once an addict, always an addict”—a proximity to any substance can potentially overwhelm because of the ability of a substance to throw off the normal functioning (homeostasis) of a body or group of bodies (an epidemic). What is of crucial importance to the way that this relationship is expressed about opioids or other addicting substances is that at the very center of the model is the black box of the body: while we may know what we put in and (eventually) what comes out, and while our somatosensory system may translate mechanical, chemical, or thermal data into feelings and behaviors, we do not

consciously know what is going on “in between.” What becomes overwhelming cannot, always or reliably, be predicted, nor is it always true that just because a substance was not overwhelming before means that it will not be overwhelming next time, especially given that we are always also constructing an experience of and knowledge about a substance based on prior personal experience. While “it is a biological error to confuse what a person puts in their mouth with what it becomes after it is swallowed,” it is one of the most common and accepted errors. And one that becomes even more common and acceptable when surrounding it are layers of sociocultural constructs that surround substance-individual relationships involved in addiction, or other common conditions like obesity, in which an obese person is equated with the “bad fat” they must surely be consuming, thereby mistaking not only what a person puts in their mouth with what it becomes after it is swallowed, but what a person puts in their mouth with who they become. You are what you eat.

What bridges this conceptual transition from ideas about a substance (bad fat) to ideas about a person (bad fat person) are a series of categories used to classify substances, which incorporate and are based on physical, somatosensory information about an object, personal and emotional experiences of an object, a recollection of these experiences, information about others’ physical and emotional experiences, and, again, our own emotional and physical relationships to this information. In other words, substance categorization is both scientific, as in based on the collection and interpretation of physical data, and a sociocultural construct, as in based on the collection and interpretation of ideas about other people. Used to describe the risks, benefits, and uses of both sensible and insensible proximities to substances, these categories include: carcinogen, medicine, placebo, vitamin, nutrient, healthy, fat, and so on, with many subcategories and related instances therein, like that of cure with the category of medicine, or carcinogen and fat existing within a broader category that may be termed either toxic or harmful. The category

we believe a substance exists in drives our behaviors in the use or avoidance of that substance. As much as possible, we try to avoid carcinogens, based on scientific data collected about the physical effects of certain substances and our emotional responses given the experience of people subjected to these effects; nutrients we try to eat as much of as possible, difficult as it may be to identify how much of one we may be getting, given scientific data that informs current nutritional recommendations and sociocultural premiums placed on healthy eating and/as thinness. Thus, though these categories are in no way unchanging or uninfluenced by the science and culture of the time, substance categorization does drive black and white thinking about proximities to substances. Within this model, substances become objects to avoid or incorporate; everything is either good or bad, or pain or relief. And while there are certainly examples of substances that change from one category to the next (as in the recent revision of fat from a “purely” bad substance to a healthy or beneficial one, at least in certain forms) there are less examples of substances that exist simultaneously in multiple categories, or that fully express the transitoriness or multiplicity of the category they are situated in. Except, perhaps, for very specific substances within the category of drugs used in medicine, which may provide both beneficial, even pleasurable effects and simultaneously negative effects—but even here, we have a category to separate these effects, overriding a conceptualization of the multiplicity of a substance: side effects.

And it is in this last category, of course, where we may find opioids, providing both relief and pain. Exemplified by the very term painkiller, as if a double negative, pain+killer, always produces a positive. It is the many double negatives of opioids that prove so disruptive to ideas about substance use as shaped by substance categorization. Opioids do kill people, and are, in fact, killing many people; opioids do treat pain effectively, and there are very few other effective options for the treatment of intractable pain. How should opioids be categorized? How do we understand—and come to accept, incorporate, and work around—the limits of category-based conceptualizations? What can be abated? What can be maintained?
Living With

When we find ourselves in proximity to opioids, when we are living with opioids as pain patients or as someone abusing drugs, and when this proximity is taking place within a sociocultural context in which substance-related behaviors are shaped by processes of categorizing substances, themselves based on physical, emotional, and neurological experiences, what assumptions and ideas predicated on the substance are we with—and how do we choose to act, based on the multiplicity of these ideas? How do you live with opioids? How, when conceptualizing a proximity to opioids as a substance-ecosystem relationship, do you maintain balance?

Ultimately, these questions are about the affective and physical work of managing relations to substances. Not unlike other homeostatic processes, we do this work continually, making minute adjustments and reevaluating our proximities constantly. The difference, though, when acting around and with substances that produce affective and emotional experiences is that this work can never be completely physical, as if injecting heroin to return to a high is just like regulating levels of blood sugar. This affective work of managing relations to substances, while perhaps extreme in the case of heroin, is actually incredibly common and simple: just think of how many people, across so many substances, regulate their proximity to a substance based on the perceived or known effects of that substance set against time and within an emotional field in order to generate limitations and guidelines for their proximity. For instance, the diet plans that set aside two days a week for eating whatever you want after five days of intermittent fasting, or the perceived difference between an occasional after-work drink and daily drinking. Guidelines for substance use like these, whether for a drug like alcohol or an everyday substance like food, are thus time-based, physical parameters (two days a week for eating anything) that become affectively reinforced (if my proximity remains within these parameters, I’ll lose weight, maintain health, etc.). It is also important to note that within this affective reinforcement is another layer of what is being managed through our material proximities: it is not just that we manage physical experiences to...
substances, but that we manage our relations to our own emotional states and experiences through substances. In other words, it is not just that we choose to regulate our relationship to food as reinforced by affective logic, as in the dieting example, but that we regulate our relationship to our own emotions through food—in other words, the very existence of the term “comfort food.”

This work of managing physical experiences through affectively-reinforced logic is based on the expectation of force and the force of expectation. While we will return to this concept in a later chapter in much greater detail, for now we can understand this on its most basic level: we expect a substance to produce effects with a given forcefulness, and the force of our expectations becomes the affective structure that reinforces the logic of our use and its parameters. For instance, if we expect a substance (say, a single cookie) to exert relatively little force in producing an expected or known effect when encountered in a given process and performed only once or for a limited time (how eating a single cookie once will not make me gain weight) then we may be much more likely to go ahead and use that substance, or remain in proximity to it. On the other hand, if we expect a substance to exert a powerful force when producing a known or expected effect, and we know that we will be in proximity to that substance repetitively or for a long time (how eating a dozen cookies every day will, most likely, make me gain weight), then we may be more likely not to use that substance.

Of course, what about when we don’t know? Within my own proximity to opioids, should I expect pain or relief? Or, is pain relief or the possibility of addiction a stronger force? Is my expectation of pain relief a stronger force than the force of addiction? While we can turn to data collected scientifically to address these questions, as in a recent study that demonstrated that most pain patients are, contrary to the constant media rhetoric that says otherwise, actually unlikely to develop long-term opioid abuse, we also are always effected by personal and emotional

experiences, like my reaction to what I have come to understand about everyone around me being affected by opioids. Are sets of expectations like these—and their forces—always calibrated by fear? And with this fear is there not always also the specter of blame, in the event of failure? In many ways, these questions are more easily answered when we are thinking about how substances act in others’ bodies. An ease, perhaps, generated by the fact that in judging others what we have access to is only the visual, or observational (as of their behaviors), and at a slight remove from the intricacies of our own personal affective logics. Again, dieting or obesity and the you are what you eat principle make this clear. We understand substances to act within others’ bodies as predicated on an assumption of free choice and what a failure to choose “correctly” looks like—i.e., obese people are such because they chose to eat the foods they did, or chose not to exercise, etc. This, of course, completely disregards that which may be beyond the realm of the immediately apparent and perceptible, like genetic predispositions, environmental factors influenced by sociopolitical and economic systems, and so on. The same holds true for opioid abuse, particularly as we have already seen within narrative tropes like that of the standing of addicts as victims/perpetrators. In short, this is the view that “people should be responsible for what they put into their bodies.” Given that this quote was taken from a participant in a survey about blame within the opioid epidemic, it is clear that with responsibility always comes (potential) blame; that these questions about the risks and perceptions of the effects of opioids, and how these risks and perceptions should or are already affecting the use of opioids, are not only about who should be at risk, but who produced the risk in the first place and who should be at fault—even when a substance is only producing the effects (binding to mu receptors, changing neurotransmitter levels) that it would in any person. In the survey quoted, a majority of people blamed doctors for reckless overprescribing, an attitude that

users.

can also be seen in countless other instances of opioid epidemic coverage. Even within a scenario in which groups like major companies within the pharmaceutical industry have clearly played a predominant role in producing the opioid epidemic, we are still more likely to place blame on an individual.

This focus perpetuates misunderstandings and ultimately allows for the continuation of, if not the epidemic itself, at least behaviors, systems, and scenarios that have led to it. By focusing on the responsibilities of individuals who we assume are “free” to make choices when encountering a substance and acting in relation to it, even when there is no definitive information available about that substance or whose effects may be unpredictable, we fail to fully attend to the systemic nature of substance-based proximities. Even when this systemic nature can become apparent within our own personal experiences, like the institutional and legal-architectural nature of opioids within my experience of Harvard Square, it remains invisible elsewhere. One may, instead, continue to focus on the groups of opioid-abusing people within the Square or county. The conceptual difficulty in articulating this issue is the slight but ever-present suggestion within these ideas that individuals are entirely not free, that individuals simply, somehow, “happen upon” a substance—an attitude that comes dangerously close to the “people becoming subject to a substance” attitude of a larger addiction rhetoric. This is not what I mean to suggest. It is possible, instead, to maintain a position that allows for a broad multiplicity in understanding the material proximities people come into and maintain. People are free to choose in relation to substances, and many have chosen to take opioids; at the same time, both this initial decision and the subsequent decision(s) to continue taking opioids are shaped in part, yet definitively, by biological and neurological factors that are not within the conscious control of an individual; at the same time, perhaps an individual is aware of these biological factors to begin with, and can choose or try to choose to act accordingly; at the same time, the very fact that so many people have so many opportunities to encounter and choose to act towards opioids is not a neutral fact but a product of governmental and medical-industrial relationships. People being “free” to choose—and thus people being “always” at fault—is in no way constant or
singular. A material proximity condenses these factors. And in appearing to be a singular situation, or a singular act of taking opioids, this kind of condensation can make such proximities easier to judge. But no less easy to experience.

To challenge such an attitude focused on individuals and choice one could ask, instead of “how do you live with opioids,” a question focused on a mass of individuals: how do you live with the opioid epidemic? In living with an epidemic, one is not only living within an environment saturated with a specific substance, but an environment more generally saturated and overwhelmed. In living with this epidemic and sensing the pressures of it, I feel myself to be living with prior epidemics as well, and their residues — specifically, again, that of the AIDS epidemic. In living with the opioid epidemic now, the residues of the sheer loss of life, medical and governmental inaction, and the physical consequences of social assumptions and attitudes within the AIDS epidemic have come to coat my current experience. In living with this residue, I am living with the immobility of policy or the irreconcilability of policy and daily experiences of pain, in multiple senses, places, and situations. This irreconcilability is apparent in the institutional and legal-architectural nature of opioids far beyond any specific or personal space. For instance, why is it that treatment centers, particularly those focused on medical maintenance treatment, are relatively few and far between and difficult to access? Is this a reflection of the substance itself, something unique to methadone, or a product of governmental systems as influenced by popular opinion? And when it becomes apparent, whether related to residues of the AIDS epidemics or living with opioids, now, that the saturated environment we are to be living with is such because of systemic, legal-architectural relationships like these, should we not understand substance abuse to include not only the behaviors of an individual, but exactly this network of governmental, industrial, and medical powers that move, and move through, substances and distribute them? What becomes abusive? What can be accounted for, or held accountable? What is one encountering in proximity to a substance, and what can be taken responsibility for? What can be abated?