Abstract

This thesis explores the lived experience and structural conditioning of Substance Use Disorder (SUD) treatment in rural Vermont. It is based on seven months of ethnographic research with an SUD recovery center, where I participated in various modalities of clinical and social treatment for those with SUD. In this text, first I highlight the interconnections between biomedicine and policing as they come into conflict with the care goals of individuals with SUD, resulting in a need for advocates in the form of Recovery Center staff. I then discuss the moral stakes of SUD in the local area, with particular attention to the dimensions of social suffering related to SUD. Finally, I look into the ways in which current shortcomings in this realm might be addressed through the usage of art and art therapy, not just as treatment for SUD in and of itself, but also as a tool for advocacy that can affect the landscape of stigma and subsequent treatment of people with SUD.

The Art of Witnessing: An Ethnography of SUD treatment in Rural Vermont

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Preface

When I first ventured into medical anthropology as a discipline, the most salient aspect was that it was a way to understand disease outside of biomedicine. It showed me that preventing disease could be about a cultural shift and addressing the lived conditions that people endure on an everyday basis. My Anatomy and Physiology professor, at a small local college, is the one who changed my worldview. I got into anatomy because I was interested in the interconnectedness of the body systems, how when things failed, you could tangibly see outcomes and degenerations. But this professor taught me to see the same things not just in anatomy, but within the medical system and society as well. He pointed out how the biomedical system is reactive, that it functions on the belief that everything can be treated through the application of drugs, radiation, or surgery. In this first exposure, I thought this expression of medicine to be unfair and far too black and white. It seemed blind to other forms of suffering or ways to help people beyond those three primary metrics. This opinion has been supported by research done by other anthropologists such as Thomas Csordas (2002), Joao Biehl (2013), Adriana Petryna (2002), Paul Farmer (1997, multiple works), and many more.

At the same time as I was taking anatomy, I was also enrolled in a class called "Multicultural Health Illness and Healing." Originally, I had hoped it would help me become a better doctor, researcher, or scientist by sensitizing myself to greater issues of culture and healing. I had read many studies where people of color were misdiagnosed by doctors who were unable to identify conditions on skin colors other than white due to the way that science and

technology are based on a white male model. I didn’t want to become that kind of doctor, but this wasn’t that kind of class; it was, at its core, a medical anthropology class. Here, I learned about issues of organ trafficking in low-income countries, structural inequalities and their impact on health, and alternative medical systems such as empathy-based bone setting by sense of touch and experience alone. This redirected my course of study dramatically as I chose to focus on these kinds of topics: the importance of history, politics, social interactions/expectations, and environment on human health.

This meant exploring a career field that was a stranger to me, one which made me apprehensive in many ways. There is a regiment and a sterility to being a doctor; you know what to expect. In medical anthropology, you learn every day, and you can’t expect that kind of rigidity. You are the student to the people you want to learn more about. Of course, I wasn’t entirely sure how to begin learning about these things, but during my second semester at Mount Holyoke, Professor Mark Auslander pointed me in the direction of studying substance use due to the fact that it was and continues to be a prevalent issue in my home state of Vermont. I reached out to big corporations asking if they took interns, and was told they only did internships during the school year. This made sense since the University of Vermont and their Medical Center are positioned well to funnel interns into those programs, but was impossible for me who only spent summers and short winter breaks in Vermont. I was then pointed in the direction of a small Recovery Center in my hometown. I spent most of January 2023 sending emails and phone calls to the center, trying to learn if they even took interns. I got no response, but I was born stubborn and have been in non-profit human services circles for long enough to know that they are underfunded and understaffed. So, I showed up in person over my spring break and chatted with a couple of visitors for 45 minutes while waiting for the director, the only staff on site that day, to

get out of a zoom meeting. When she came out she explained what they did, and tried to express that the center is small and not medically focused, so if that was what I was looking for then I needed to go to the town over to the bigger, better-funded program that had nurses on staff and multiple locations. I told her that was actually against the very purpose of what I wanted to learn, which was how substance use treatment and recovery works on the day-to-day, and what harm reduction looks like – specifically non-biomedical treatment. I would later find out that there is a lot of crossover with traditional biomedical systems, but that only helped me learn more.

Even though this was my home town, this felt new; I was taking on the position of a different person with different experiences. Consequently, in this thesis, I am able to draw on both my familiarity with the surrounding area, as well as all that I had to learn as a new anthropologist, in order to understand the local moral world of the center and its place in a larger set of structures. Furthermore, I sought what the insights of its everyday operations might offer for efforts at community-based substance use treatment.

One of the primary modalities I have learned as an anthropologist has been ethnography, which pertains to working with people to obtain information experientially and recalling that experience with as much detail in order to learn from the interaction. I believe that an image presenting the actual situation communicates more about the individual people and forces acting upon them than any quick snapshot or vague analysis could. As a result, I have chosen to frame this thesis around a collection of ethnographic vignettes of events, discussions, and salient moments of understanding. I use these vignettes as a guide for my analysis to help situate the reader with a sense of place and all the knowledge that these people have to offer. Thus I open with an image of the events that made up my second day working at the Recovery Center

Planting Seeds

When I arrived at the location of my first health fair I realized that I didn't know where to go and that I really didn't know what I was supposed to be doing. I'd been in the building many times before: attending open houses when my oldest sister was studying studio art and design; touring with my school to learn about the tech tracks; and when my brother graduated from the pre-technical program the year before. But suddenly, it wasn't a location where I existed in the background and only interacted with immediate relations. Rather, I realized that things would be expected of me here, and that I would be representing both the center and people in recovery as a whole.

I followed my boss as she crossed the parking lot, stepping over vegetation growing out of the cracks in the ground and avoiding potholes, until we reached the front door. I thought it would be locked and we would have to be buzzed in – as is the case with increasing numbers of highschools across the country. But the door opened easily and a rush of cold from the AC washed over me. It was easy to find the room, right across from the front door with a sign just outside it. The same room where my sister was inducted into the Vermont Technical Honors Society four years prior.

The room was bright, with large windows around the top of the walls near the ceiling that let in the early summer sunlight. Tables created a semi-circle around the room, branching from either side of the double doors, and a large table was piled with items in the center. It held pieces of paper and instructions for a scavenger hunt raffle. Our table was on the left, just inside the door. Large canvas signs proclaimed that "Words Matter," "You Matter," and "Recovery is Possible."My coworker stood behind the table, talking to a group of students and pointing at various items arranged over the tablecloth.

We stepped behind the signs and slid in next to him silently, waiting for him to finish his pitch and stamp all of their little white papers. I looked around, trying to catalog all of the tables. I recognized a few as being student made. Products of the various tech programs, such as "Stop the Bleed" – a first aid table being run by the nursing track students. Other tables run by community organizations were less familiar, such as one that seemed to be focused on tick safety. While I was looking around I found that my boss had passed my coworker the requested file of anti-stigma campaign posters that our assistant director had previously designed for a grant program. She reintroduced us and told him to take care of me before returning to her car and heading back to the Recovery Center.

I wasn't sure what to say to him or the students, and I was luckily saved from having to come up with something as another wave of students came by. I took this opportunity to learn

what he was saying and listen to what kinds of questions students would ask. The monologue basically explained that we represent the Recovery Center, which is located on the same street as the grocery store a little way down. Additionally, we had a variety of free recovery support resources and services, such as Narcan, acupuncture, group support meetings, recovery coaching, and meal support. I talked to him later and asked why he emphasized the "free" part multiple times. He explained that we use what is called a "no barriers approach," so "we don't ask for names, phone numbers, or any money; we want anybody to feel comfortable coming in and asking for help without worrying about cost or stigma".

Over the course of the afternoon, teachers led their students down during designated times, and a few students ducked in during lunchtime for a second look. I got a chance to walk around the room to the other tables; the one next to ours was Elm County Mental Health. They had some interesting "swag" and display items that my coworker took photos of just in case we get a grant in the future that would let us invest in new ones. There were more student-run tables than I saw during my first glance; one was a project on substance use and memory, and then there were several run by the nursing students about how various substances affect your vision – especially while driving – and reproductive care information. The table I had seen with tick information turned out to be another referral and support agency within the community which focuses on preventative care for most things but especially substance use.

I tried to make small talk with my co-worker. He had previously been a drug counselor in Massachusetts and Connecticut and explained that the stigma was different between those places and Vermont. From his standpoint, there was much less stigma against mental health in Vermont but much more against substance use, meanwhile it was the opposite in Massachusetts and Connecticut.

Students approached us throughout the day, escorted by teachers. They mostly just let us do our monologue. Again and again. And they took a few business cards or pens with the center's name and phone number on them. Mostly, they stopped by because of the raffle. It was required that they fill out a sheet of paper that had boxes labeled with each presenter on it, getting stamps from every table in order to put it in a raffle. While going through these motions I felt awkward, thinking about how I would have received an event like this when I was their age. Uncomfortable around the topic because of stigma, I was a teacher's pet who would never imagine using substances and was too awkward to have a real conversation. I could imagine myself not even trying to do the raffle or doing it and failing to engage. I saw both of these reactions in some of the students who came through the door, as well as an unexpected one: enthusiastic kids excited for a chance to get out of class and do interactive activities with various tables and new people. Through it all I didn't see anyone take anything we said to heart in a meaningful way. They heard the words, they got their stamps, some asked questions about using the naloxone, or wanted demonstrations. But it didn't seem, to me at least, like we had made an impact or like these students were going to be the first people through our door the next day.

I asked my coworker about it while we were packing up, explaining that I thought that our services were valuable to students who could certainly struggle with substance use, but that they were really intended for adults. It felt like an untouchable domain where teenagers were in the thralls of their use and not looking for recovery, still feeling like they had their whole lives ahead of them without feeling the tangible impacts of how substance use would change their life direction. Meanwhile other tables, like "Stop the Bleed" or a student nursing table focused on pregnancy had high engagement as students heckled their teachers to wear the fake pregnancy belly. I saw different interactions here as those tables felt more accessible or age relevant to them

unlike ours; I was confused as to why we were talking to these highschoolers when they clearly didn't take us or what we had to say seriously. Many didn't have cars, and couldn't get to us anyway.

My coworker's reply surprised me. He said that we were "planting seeds." That working in substance use recovery is tricky, and most people we talk to aren't going to be ready for recovery. They'll keep taking substances for a long time after we talk to them. Even when we meet them in the Emergency Room, we'll be brushed off repeatedly and see them again and again. But the point isn't to get more people in the next day, or the day after that. The point is to affect them in small ways and pop up all over the place so that when people are ready for recovery, the seed is there. They know who to go to for help and the ways that we can help them to make the changes that they are looking to make in their lives.

I didn't expect these kinds of experiences going into the project; I thought most of my time would be spent at the center itself or directly helping people who were in crisis or struggling. But it gave me a wider perspective on the topic. I began to ask questions that I will later explore about my coworkers' offhand comment about different areas stigmatizing different things (mental health versus substance use) and what might be morally at "at stake" in this area as physician anthropologist Arthur Kleinman would say (Yang et al. 2007). It made me more curious about the mechanisms and interactions involved in substance use recovery in this place, as well as about the dark shadow of stigma and how to combat it.

My coworker Ezra's statement became the way that I looked at my work from then onward. My job wasn't immediately to change or save someone's life, that is something that is left for doctors who live their high stress lives, triaging by severity and saving or curing patients every day. The role I was taking on was one that creates small shifts every day, triggering a

ripple effect in the community, encouraging education, and ultimately becoming a resource. Substance use disorder comes with a plethora of comorbidities, some of which include abscesses, broken bones, and alcohol toxicity, which need to be treated at the hospital. Others - like homelessness, lack of food, and joblessness - need to be addressed in other ways. Treating this second kind of comorbidity is what the Recovery Center does; it helps people get their lives back on track, treats them with dignity no matter what they do, and provides a safe place to learn and grow.

Chapter Overview

Chapter One lays out the landscape of this research, and how I began, maneuvering myself as an intern and researcher. But it is ultimately about what the Recovery Center is invested in as a project, to what ends it is trying to work, and how it supports the people reaching out to it in search of care. I discuss this in respect to harm reduction and the ways in which the Center itself engages in care models such as accompaniment and what I would term "not so anonymous care" – in contrast to what anthropologist Lisa Stevenson terms commons forms of "anonymous care" (Stevenson 2014). This allows me to focus on the critical aspects of community for people with SUD, which will be explored in greater detail throughout the rest of the thesis.

Chapter Two investigates the failings of existing care structures. First I explore the impact of triage-based care in emergency rooms on care for those with non-emergency and social diseases like SUD. Then I move on to an exploration of the ways in which policing intersects with biomedical care and results in medical violence against those with SUD, leading people to search for alternatives in an area that could and should be considered a health desert. I follow this

question of policing further by looking into the laws around SUD stemming from an ethnographic moment wherein staff from another Recovery Center question the justice system's ability to protect people with SUD from distributors.

Chapter Three focuses on the social issues that drive stigma against those with substance use disorder by exploring both the historical interactions that have led us to today as well as the ways in which people with SUD struggle to engage properly within the social contract. I follow this by looking more deeply into the moral worlds of those with SUD to highlight the ways in which people with SUD create their own community with its own social code that contrasts the normative social framework. I then address related impacts of living within drug use affected worlds through the framework of Social Suffering (Kleinman et al. 1997), as well as through attention to issues of habituation and situated biologies.

Chapter Four further explores the interpersonal and structural struggles I discuss throughout this thesis. Specifically, I look at how these struggles interconnect, serving to reduce a person's ability to communicate, as well as obstruct their ability to exist within the public sphere and to advocate for themselves. I juxtapose this with a vision for how people can and do use art both to get in touch with and move past that feeling of struggle. In this way, I suggest that art can be used as a tool for advocacy to change the landscape of substance use care in areas where care is in short supply.

Chapter 1: Harm Reduction, Accompaniment, and Not-So Anonymous Care in Rural Vermont

Introduction to the Site of Study

A very small town in Vermont, which I will call Elm, contains a population of 5,438 people as of the 2018 census, having decreased by 400 since 2009. The central village has 2,260 people, the main street comprises the high school at one end, a pre-school, 3 churches, 2 coffee shops, a library, and a gas station. It is the largest town in the entire county by virtue of being the only one with a hospital in it as well as being the only one with a franchised grocery store rather than a general store or gas station. It takes between 45 minutes to a 1 hour drive by car in order to get to a bigger city with anything beyond one's basic needs, and public transportation was spotty at best and basically nonexistent until a new company took over in 2020 to provide slightly more reliable service. This leaves the community insular and largely independent, relying on home gardens, farms, and farm stands for food needs and delivery shopping from Amazon and its contemporaries for anything else.

University of Vermont, the largest hospital system in Vermont is well-known and progressive; however, it is an hour long drive away from Elm. The town itself is served by Elm Hospital, a two-floor hospital building with an ever-changing staff list. It does not pay well and relies on traveling nurses, both ones who come of their own accord and those sent by the Vermont State Government when the hospital declares a healthcare provider shortage crisis. The

County itself was rated 46 out of 100 by US News for access to health care, having ⅓ the number of beds per thousand citizens compared to the rest of the state supported by a similar deficit in access to primary care providers (2024). Further, it was given a 60/100 score for mental health, with 16.4 percent of the population experiencing mental distress and 19% of Medicare beneficiaries having clinical depression (US News 2024).

Growing up in this place I rapidly found that there was a limited amount of things to do. Elsewhere, people could watch movies, go to a cool store or a mall and spend the day there, or go to the zoo or a museum. I spent the first 10 years of my life largely in my backyard. We built biking trails with jumps, caught a plethora of snakes, turtles, lizards, and frogs that had temporary stays at my house, and dared each other to walk across downed trees over large pits we couldn't see the bottom of. Vermont got its very first Target store in 2018, and I didn't have Chipotle until 2023 when visiting a friend to watch the Barbie movie in New Hampshire.

The stereotype of a sleepy rural Vermont town is strong in Elm. Nevertheless, the area has recently been entering a time of development and introducing new people from larger areas. During my part-time job at the local coffee shop, the most frequently asked question from out-of-towners or new residents was, "What do you guys do at night?" Or "Where is the nightlife here?" These are difficult questions to answer, partially because the answer is largely "there isn't one," and partially because the other answer is "teenagers and young adults spend most evenings in one of the local state parks drinking alcohol or doing other substances because there's nothing else *to* do."

Methodology

Entering this project, I was interested in forms of non-allopathic medicine. I wanted to understand more about harm reduction and how care can be given to people outside of the traditional hospital apparatus. While this has been my interest for the majority of my Undergraduate career at Mount Holyoke, I was inspired by vanessa german's art museum exhibit "The Rarest Woman on the Planet Earth," which was hosted on campus from Fall 2022 to Spring 2023. Being in the exhibit and going to the various events surrounding it, I learned about how people can describe and learn to be at peace with or move forward from embedded traumas (german 2022). This exhibit focused on systemic racism and enslavement. but it provided a sense of power and agency. This made me keen to explore more versions of art-based elements of non-allopathic healing, which became one of the driving influences of this particular work.

The initial lines of questions I submitted to Mount Holyoke's IRB for interviews focused on whether the staff and clients I talked with thought that the Recovery Center was helpful and did it do its job. What was valuable about the Recovery Center specifically? What drives them to do this work (is it satisfying, would they do it even with a long commute, a favorite aspect of the job)? But, as I started working with people in the center and refining my research interest, I was able to come up with more pointed questions about art, and the importance of a recovery network like this one. Some examples of this line of questioning include:

- How do you view the work you do at the recovery center relative to the wider medical system? (Specifically Local health partners and the Emergency staff at the Hospital)
- Do you feel like working in a peer recovery center has changed the way you think or feel about recovery? If so, in what ways?
- Do you feel like art or other community projects have helped you in any way

during your recovery?

These interviews supplemented my ethnographic experience as a researcher and intern, allowing me to focus on the more specific and unspoken aspects of being a person in recovery and especially being a leader/mentor in that community.

This project is not intended to be an exhibition of the grim goryness of rural substance use. I feel that there is enough anthropological work that showcases the suffering of people with substance use. Rather this work is intended to provide a picture of the way that a rural location both propagates substance use while struggling to treat it. It delves into the intertwining of the medical and carceral systems, in both overt and subtle ways. Further, it shows avenues of healing and reforms to community care and consciousness, and it discusses the implementation of art therapy as a way to support recovery from substance use and related chronic and stigmatized conditions, including mental health issues.

Harm Reduction in Rural America

In the American consciousness, the best way to combat drug use, sexually transmitted diseases, or other behaviorally associated health problems that exist in opposition to the dominant moral framework of work is straightforward: abstinence and eradication. The war on drugs, like wars on other diseases such as polio and measles, was intended to squash illegal drug use and put an end to substance use both as an illness that needed treating, as well as any related undesirable and stigmatized behavior (Penal Reform International 2013). The war on drugs, however, failed; it had negative impacts including overcrowding of the penal system and displayed the unequal policing procedure that enforced policy in low-income minority

communities while allowing affluent whites to go unpunished (Penal Reform International 2013).

One of the most controversial responses to substance use has been the introduction of harm reduction practices, which intend not to eradicate drug use but rather to focus on safety while using substances to minimize risks associated with it (Harm Reduction Coalition 2019, Kai Cheng Thom 2019, Erickson et al. 1997). Common harm reduction methods include providing safe places for injecting and clean injection materials. Sites that provide clean injection materials to be used alongside previously obtained substances have the benefit of trained supervisors who can administer Naloxone if needed (Levengood 2021). Materials kits can include new & sanitized needles, alcohol wipes, bandages, fentanyl test strips, cookers & filters, and informational booklets on safer substance use practices (Iknowmine n.d.).

These practices are often derided or punished through legal sanctions (Beletsky 2008, Bluthenthal 1997). Safe injection sites, even when legal, face community scorn. One of my interlocutors said that people often support harm reduction policies in theory, but when it becomes a reality in their community they block efforts to follow through. He called this phenomenon “Not in My Back Yard,” shortened to “NIMBY,” occurring most often when there are plans to build a rehabilitation center, homeless shelter, and safe injection sites. The concern is that those kinds of community support buildings will result in an increase in crime rates or substance use in adjacent areas.

While the overall focus of the Recovery Center remains fixing the conditions that cause people to use substances, it can otherwise be understood in part as a harm reduction initiative. The center is currently in the process of getting a community health vending machine to carry xylazine wound care kits, naloxone, fentanyl test strips, COVID tests, as well as more general

hygiene and menstrual care kits. Formally it is considered both a Recovery Center and a referral agency, which means that they interact with people to help them find or navigate the resources that they need. This ranges from getting a job, finding an apartment, and accessing public transportation, to working through Restorative Justice processes. The following vignette helps show the more mundane aspect of harm reduction in practice, even amidst an overall vision for recovery from substance use disorder and redress of its antecedents.

Crisis in a Phone Call

At the center, we didn't get phone calls that often. We carried the phone with us whenever we went outside and there wasn't a volunteer sitting at the front desk to answer it, but it was rarely necessary. The few phone calls we did get were usually call-backs – like the time I called the local church to talk about food pantry drop-offs. Consequently, the phone was mostly for clients when they came in and used our big book of resources or had a call they needed to make but didn't have a phone or enough minutes.

But one day, the phone went off more times than I had ever heard in a single day. I was spending the day running in and out of my office. In the process of painting a cornhole board that would be raffled off the following month, and creating a form for participation in a recovery-friendly workplaces program. The second time the phone rang I was inside and nobody was at the desk so I answered it. I generally don't like talking on the phone, a facet of my status as Generation Z that I've never quite overcome, so if anyone else were around I would have let them take the call.

When I answered it with a polite, "Hello, this is Christi from Elm Recovery Center, how can I help you?" I expected a routine question like, "What are your hours" or "Can I get

involved with recovery coaching." Instead, the person on the phone was crying. I immediately switched gears and started trying to ask her questions about where she was and what was going on. She was at home and struggling badly. She couldn't come to the center because she was in an even more rural location than us and didn't have a car. She was really upset, expressing that she felt all alone and that everybody was out to get her; they kept taking her things and breaking them and she had nobody to rely on. She'd had our Recovery Center branded pens and her son took and broke all of them; they were her favorite. At this point I wasn't entirely sure how to help her. I knew the landscape of the issue but felt like there wasn't much I could do just talking to her over the phone. So I walked down the hall and brought the phone to one of my recovery coach coworkers, certain that she would be able to provide better support than I could.

Mellisa looked at the phone knowingly and took it from me, and she nodded at me when I stood there anxiously. I took that as a sign that she had it covered and that I could continue my other projects. As I left the room, she spoke in a moderate and even tone, asking similar questions as I had earlier trying to figure out the layout of the situation, before moving on to just chatting with her. I returned to the front desk and told the volunteer that Mellisa had the phone so that they didn't think it had gotten lost, then went outside to continue my project.

A while later when I had gone back inside I decided to check in and see how it had gone. I wanted to learn more about what to do in that kind of situation so I wouldn't panic next time. Melissa explained that it was this person's second time calling. Additionally, she would probably call again since she hadn't ended it voluntarily: the police were at her house and demanding to talk to her since there were calls about a disturbance.

I wasn't able to take recovery coaching courses because they're a once-a-month event that lasts eight hours every day for a week, which fell outside of the parameters of my internship.

So, I thought that this might be a valuable chance for me to learn more about what a recovery coach would do in this situation. When I asked what they talked about, she explained that this person was having a really difficult time and she felt out of control. So the primary concern was helping her to feel more in control so she wouldn't do anything drastic. During the call, Mellisa was concerned since the woman kept yelling at her kids and she was worried it would turn into a serious domestic situation. As a result, she tried to keep her distracted and talking, as well as brainstorming something tangible that she could do at that moment to make herself feel better and more calm. The woman said that she could roll a cigarette, so Mellisa talked to her and walked her through the steps, bringing her back when she got distracted and started getting upset again.

Mellisa also helped her figure out how she could get to the Recovery Center through Rural Community Transport (RCT), a form of public transportation that will take people who have been diagnosed with disabilities to medical locations and community support services. This way she could come in for regular recovery coaching and work continuously toward a more stable life, as well as come in when she felt distressed like this. It would provide her with the opportunity to be in a different place with people to talk to whom she didn't feel personally attacked by. This would also solve a problem that I had originally considered minor, but in actuality was very important to her: she was able to get more swag pens.

Later, when she returned to the center, we ended up giving her an entire handful of pens and by the time she got down the hallway and sat down in the lobby, she was smiling brightly. The swag pens –despite being cheap handouts– were something that she enjoyed and that made her happy, and when they were destroyed it felt to her a bit like she was destroyed. As though she didn't have anything else. Lessons learned: small things can matter greatly.

What I find most poignant about this interaction is the way it is seemingly antithetical to popular harm reduction techniques, the ones that are politicized and discussed in higher-level substance use circles. This is the core of harm reduction, trying to make people more safe in whatever way possible, to reduce the harm associated with a given situation. Usually,this is depicted through injected narcotics and the harm being addressed is potential overdose, bloodborne illnesses caused by reused needles, abscesses, or muscle & nerve damage.

In this context, we are not worried about that. The bigger concern at the moment is that this woman may hurt her children, so we try to protect them both for their sake and for the sake of the mother who could possibly lose her children or have to go into the justice system. So my coworker goes through a process in which she says. "I recognize that you're in a really dangerous place, we need to do something to de-escalate, and if that something isn't good for you but it's a lot better than the alternative, then that's what we're going to do and I'm going to be here with you while you do it." One of my interlocutors said that sometimes helping someone doesn't feel like helping someone, and sometimes something you think is trivial can have tremendous meaning to someone else. So you cannot judge; you just do what you can.

Harm Reduction creates support in order to reduce the negative consequences associated with substance use behavior with no motive for people to cease their aforementioned behavior (Harm Reduction Coalition 2019, Erickson et al. 1997). Again, the Recovery Center I worked at ultimately is a site focused on people and their recovery, and ongoing recovery can be interpreted as a motive for people to cease their substance using behavior, further, the majority of funding, programming, and effort is put into that end goal. Thus it is only partially useful to frame their work in terms of harm reduction. People in the Recovery Center certainly do feel as though their

lives are better in recovery versus being someone using substances; this is exemplified both by the health of their interpersonal relationships as well as the stability in their lives to have a home and a reliable job.

However, it is also important to recognize that the center does not force anyone into recovery. Bringing back Ezra's description of the work as "planting seeds," the Recovery Center provides avenues and support for recovery, but if someone isn't ready or doesn't want to transition into recovery, that is okay by them. The support services are the providing of a place to be, free food, a computer and phone, telehealth services and more, all free to all, with no conditions that someone behave in a certain way aside from abiding by building rules and doing their best not to trigger other clients in the space. Thus this location is able to hold both harm reduction and other forms of support simultaneously without jeopardizing their efforts in any direction.

Accompaniment

So how does the Recovery Center try to recognize and address structural causes of SUD while also supporting people in their struggles? While not modeled explicitly on the work of physician anthropologist Paul Farmer and his colleagues at Partners in Health, that work does provide a framework for understanding some of the contours of the Recovery Center work. In particular, their emphasis on accompaniment.

For his undergraduate thesis in the anthropology department at Harvard, John Mei shadowed the boston program "Prevention and Access to Care and Treatment project" (PACT), consisting of community health workers (CHWs) who administer Directly Observed Therapy (DOT) for tuberculosis and HIV (Mei 2012). This is an urban version of Partners in Health's

community health worker program in global rural areas like Haiti (Farmer 1997). Mei reports that the staff at PACT "embed caregiving and community within an insistence on the importance of place, communication, trust and consistency" (Mei 2012). PACT had to adapt to Boston's plethora of clinical services by distinguishing themselves less as hospital case managers and more as focusing on medication adherence for individuals who physicians designate as their "most difficult" (Mei 2012). With attention to structural barriers to treatment and a commitment to harm reduction principles, CHWs in PACT worked to help those otherwise deemed unhelpable.

In a similar way, Recovery Center staff function as community health workers who bridge the gap between what can be done by clinical professionals and the needs of patients/clients. In Mei's thesis he focuses on the way in which community health workers –who the Partners in Health organization calls: *accompagnateurs* (Farmer et al. 2001) - can interact with people consistently on a day-to-day basis, form connections, and help them to reach goals that they themselves set up. This is ultimately the same mission as that of the Recovery Center and its staff. In the above vignette we were able to see the way in which Mellisa talked with the caller and helped her to ground herself, that then blossomed into her coming to the center and meeting with the staff in person, and then returning to the Recovery Center repeatedly throughout the summer. Mei calls this "keeping the door open," accepting people's choices and providing an avenue for people to obtain care by being a recurring presence in their lives. Akin to Ezra's idea of planting seeds, accompaniment is about existing, and repeatedly showing up for someone so that they know they can depend on you whether or not they feel able to do so. Later in this chapter I will address some of the limitations of accompaniment. For now, I turn to the contrast of this model to other common forms of humanitarian interaction.

Not-So-Anonymous Care

In her book *Life Beside Itself*, anthropologist Lisa Stevenson discusses the work of a suicide hotline amidst the suicide epidemic within the Nunavut tribe in northern Canada. The idea, as in suicide hotlines elsewhere, is for a person in distress to call talk to someone ready to help you feel more calm and stable, with the goal of reducing the incidence of suicide. Anonymity is a core value of these programs. Care is offered to all, whoever they are. As Stevenson describes:

> To care anonymously requires being able to care intransitively, to be able to say, "I care" without specifying for whom. As one volunteer explained to me, even if you recognize the voice on the other end of the phone, you treat that person as if you didn't; you even come to believe on a certain level that you don't know that person.

Stevenson goes on to explain how this is experienced as a kind of violence in Inuit communities, where *who* someone is matters greatly for care. The suicide hotline worker cared about people instead in an abstract or innate way but not in the same way that one might care for someone that they have physically come across (Stevenson 2014). It's a care for the community at large working toward an end goal of reducing the suicide epidemic but it isn't a particular care toward a specific person.

The Recovery Center staff takes a different approach. Instead of focusing on keeping people entirely anonymous and supporting people through the guise of confidentiality, they focus on human connection and building community. When someone reaches out to the Recovery Center, there is an expectation of confidentiality and anonymity outside of the context of the Center due to the sensitive nature of SUD and stigma, which I will explore later in Chapter

Three. Connections at the Recovery Center are not clinical, detached, or disinterested. The staff instead engage in deep connections with the clients and the end of the interaction or phone conversation does not mean the end of care. As demonstrated in the above vignette, even though the phone call ended multiple times, Mellisa did not treat the woman as a new case like suicide hotline (or related Vermont "warm line" https://www.chcrr.org/community_resource/pathways-vermont-support-line/) staff would have. Instead she communicated recognition and participated in a continuous form of care that allowed the woman to feel recognized and cared for. It is linked to creating concrete forms of community through care rather than administration of care due to obligation or other forms of concern.

Familiarity Breeds De-escalation

One day I walked to work and was greeted by my boss, Jennifer, at the front desk. It was usually reserved for volunteers, but staffing was low on Fridays, and everyone covers for everyone else to make sure things get done. She told me about an engagement fair happening at the high school, explaining that it was an event to help get our name out into the community. Before long, I found myself in her car headed to the neighboring town to tell teenagers about what we did to support those who are seeking recovery from substance use disorder – even though, to be honest, I didn't think I even knew that much about it.

On the ride there, my boss slowed down, watching two people walking down the sidewalk. One was a tall man wearing a baseball cap and hunching slightly, the other was a slightly shorter woman with dark hair. They were fighting. We couldn't hear everything they were saying, but Jennifer rolled down the windows to hear a bit better and pulled into a side street, following as the couple turned a corner. Slowly, as we trailed behind, the two of them became

less animated, quieting down and dispersing the tension. My boss sped up and turned around at the roundabout near the local family physician's office. When I looked at her with confusion she turned to me, smiling slightly, and explained: "Those two come to the center pretty often, I just wanted to make sure it didn't escalate to a violent situation." At my surprise, she was quick to reassure me that she wouldn't have jumped out of the car and confronted them. Especially not with me in the car and so new to the field; rather, she admitted she probably would have called the police instead.

In this vignette, due to the tight-knit nature of recovery spaces, the director recognizes the people walking along the road. She's familiar with the specific way they struggle and their general behaviors when facing conflict and anxiety, and as one of my interlocutors said "Addiction is not a 9-5 thing." So, even beyond the physical walls of the Recovery Center, she watches out for them and formulates plans to minimize risk to people involved as well as potential bystanders. This ties in with the earlier discussion of harm reduction as she tries to reduce the ways in which those with SUD cause harm to themselves and others. The role of Recovery Staff, Harm Reductionist, or "*accompagnateur*" (Farmer et al. 2001) is one of interacting with people who are continually trying to get better while fighting against their environments as well as their diseases. In return for that effort, the people at the Recovery Center help them, not just because it's a job and they're paid to, but rather because the staff is invested in their well-being and success regardless of if they're "on the clock."

Staff in Flux

The above experience, which occurred on the way to attending the health fair described in my preface, soon became emblematic to me of the particulars of this center's space. Talking to

other Recovery Centers in bigger areas, or other students in internships across disciplines, I learned the “Director” position generally came with a certain level of managerial detachment, focused on what could be considered the business side (networking, bookkeeping, promotional work, board management, etc) of an organization rather than the day to day running. Seeing her sitting up front in reception, and the overall shortage of staff and volunteers, drove home that non-profit organizations are under-resourced. Grant funding and the terms of the grants determine what programs can be offered and what staff can be hired.

So while I do want to emphasize the importance of familiarity between staff and clients in this not-so-anonymous care setting, this familiarity also reflects certain problems. Jennifer sitting in that chair was both a choice of her own making, a decision that being a director did not mean that she had to reduce her “front-facing”[1] duties, but also a reflection of a wider issue regarding lack of available staff who could be sitting there instead. It was not uncommon for volunteers to start working one week and then be MIA the following week. One of the goals of the volunteer program was to give opportunities to people in ‘early recovery’. It provided a sense of routine and stability that was beneficial during this period. Additionally, some clients would be required to serve a certain number of volunteer hours due to interactions with the justice system, part of a hiring program, and requirements of their sobriety home program. However, substance use and early recovery are intertwined with instability and unreliability. Several volunteers started and then had recurring health problems, or had issues being able to get to the center due to a lack of reliable public transportation, or simply stopped responding to calls and didn’t show up. The

[1] When the center was rearranged in September of 2023 following the expansion into the other half of the building, the director initially planned to be in the new section of the building, furthest away from the front door. She said she wanted to be less “Front facing” and immediately accessible to clients in order to focus on her managerial work. She was in this office through my visit during winter break December 2023 and January 2023. When I returned in the summer of 2024 she had taken residence in the office right next to the front entrance room with a window allowing her view into it. She wanted to be more connected with the issues going on in the center day to day and be accessible to staff, volunteers, and clients.

volunteer was a position constantly in flux, a section of staff vital for everyday running but at the same time unpredictable.

Conversely, professional staff require stability in recovery. Such positions come with a requirement of reliability, the ability to work full time and to deal with issues beyond the volunteers' purview and comfortability, such as violent confrontations, disposal of triggering objects like discarded injection needles, willingness to treat overdoses with naloxone, and interacting with the police (to name but a few of the more severe instances). Hiring requirements were strict. A lack of understanding and empathy for people in early recovery was a quick disqualifier, as such traits are critical to being in a staff role at the Recovery Center. The position offered flexibility regarding in-person and remote status on a day-to-day basis, which was beneficial for staff with children or those who lived further away from the Recovery Center during severe weather conditions. It was also a chaotic position, with to-do lists building up that got pushed further away in the face of everyday needs and often unmet goals. This environment requires a specific kind of person who knows how to go with the flow while also using time management skills and discipline to tackle tasks as deadlines or grant cut-offs loom. It isn't something that everyone can handle or that they expect to spend a large portion of their life doing. For example, the Recovery Coaching Program/Programs Manager was inhabited by 5 different people within 3 years.

Considering these positions and their realities, it comes as no surprise that staff was low. Despite this, the connections made between staff/volunteers and the substance use and recovery community were strong. Part of being in recovery is being painfully honest about what you're struggling with; you become vulnerable with peers in recovery in ways that you wouldn't with anyone else in your life. There's an understanding built by similarity and implicit non-judgment.

But again, such an ethos, while vital for community-making, is not necessarily a remedy for staffing shortages.

Limits to Accompaniment

These staff may be in flux, but they are often the only direct carers. Earlier this chapter I discussed John Mei's undergraduate Harvard Thesis and the value it places on accompaniment. Accompaniment again being a kind of care that interacts with people outside of the biomedical system, with attention to harm reduction principles and structure barries. An accompaniment model prioritizes care by establishing consistency and trust while "keeping the door open" for them to reach out with they are in need of assistance no matter how many times they refuse it. However, it's worth noting that there are some limits to this accompaniment. Exploring this, the the first thing to note is that the Recovery Center is not open to all people. It is emphasized that due to the limits of funding, the staff has to focus on supporting only the recovery community rather than stretching themselves thin and supporting the entire community. There are other programs that are not demographically focused, who can support the general public; as a result, several people have been asked to leave the premises for behaving in ways that are not conducive to the Recovery Center's mission.

The Recovery Center is small, with a primary staff of about five people the majority of the time, only three on site most days, expanding to eight around the time I began my work there. One of the most frequently utilized services was access to the kitchen and associated food pantry. Yet in the years during and post the COVID-19 pandemic, the partnerships that kept the food pantry full had largely fallen apart. One of my roles then became working with the VT food bank and reaching out to other programs such as Salvation Farms to bring that resource back.

Being such a prominent resource it is unsurprising that the food pantry would become a site of conflict. During the drop-in hours a man came to the center hours after a delivery from the food bank, in which we had gotten a variety of items including a large amount of frozen chicken. He sat by himself on a couch most of the time he was there, but eventually wandered around a little bit. I was outside most of the day painting corn hole boards for a raffle later on in the summer, so I heard bits and pieces when he came outside but the majority of this scene is a description of events I learned later. At one point he called someone –presumably his father– and told him that we had all this chicken so he should come down and pick up a whole bunch. When the volunteer coordinator and another individual overheard this and tried to talk to him about it they found out that he was fully intending to take the majority of the chicken. Hearing this, they explained that it was not allowed because the food is supposed to be a shared resource for everybody, which means that there is a (somewhat vague) limit to how much people can take at a time. He then got angry and started to swear, overall attempting to make the staff uncomfortable before storming out of the building.

As I learned later, this man wasn't a stranger to the Recovery Center; he had been associated with recovery for a long time, was a regular visitor at one point, and had recently started coming to the center only around food donation deliveries. However, despite his deep connection to the community at the Recovery Center, this interaction –in conjunction with several other infractions– led to him being banned from the premises for 3 months. Accompaniment in the Recovery Center context due to its open community aspect is contingent on the accompaniment of one person not leading to the disadvantage, damage, or trauma of another individual. Thus in this situation, working with this man and allowing him to reap from

the services whatever he wanted at the disregard of other people's need became a breaking point for his access to accompaniment and care from the center.

Contrasting this quick encounter, I present one that feels more like a long term descent that has negative results. It began my first summer (2023) at the Recovery Center, another man who was one who visited the center frequently, during some periods even every day. He was friendly and wanted to support the center, having ties with many centers across town and a deep value for the work that they do. Yet at the same time he had a certain disregard for the rules and values of the Recovery Center, ex: frequently disregarding the aforementioned pet regulations that staff had to at least try to enforce. He had been in recovery for a long time and had built up a series of commitments that had him working even during his visits to the Recovery Center. This became a burden for him later that summer as he suffered from the loss of someone close to him. He, like many people with Substance Use Disorder, had a history of mental health struggles and this loss created strain on his progress with those struggles as well as his recovery. During a meeting in which the staff began to brainstorm ways in which to support him, the director stated that he had psychiatric care as well as other support from his many community ties. Thus, we were part of his "support network" and that we would care for him as we could but that we didn't need to take on a full responsibility. He continued to face mental health challenges and the following summer of 2024 he had an outburst in the kitchen with a staff member. Although there is a certain expectation of chaotic behavior as a result of working with people in need of care, there is also a requirement of safety for staff, volunteers, and clients. Although there weren't other people there at the time there was no guarantee that this situation would not happen again. Thus, for the physical and mental safety of staff and others who rely on the center they had to issue him a short ban.

These short case-descriptions show the way that even in community focused programs like the Recovery Center, the staff becomes entwined, despite their efforts otherwise, in a type of policing. [Note more on this in the following chapter.] I don't intend to say that policing of the type depicted within the carceral state that becomes all-encompassing is a form of inevitability. In the entire two years I worked there these were the only stand-out cases, thus although there is a form of surveillance and policing on behalf of staff in order to prioritize the collective well-being of the community it attends to a different kind of scale and has different consequences (i.e exclusion from the community itself). What I do intend to show is that I do not believe that the Recovery Center, or its accompaniment model is without its own difficulties and that people always behave in ways that do not result in conflict. Rather, despite moments of conflict, the staff are involved in a valuable and complex effort to provide continuing care for a large community in ways that are not available through traditional structures.

Companions and Equals, Peers in Recovery

In the end, one of the most critical features of a center like this is the peer-to-peer aspect, otherwise known as "peers in recovery." When our members go up to speak at an event like the Opioid Forum[2] or talk to someone at the emergency room through the Recovery Coaches in the Emergency Department program, they are often speaking from their own experience. Not only is substance use inherently characterized by uncertainty and various forms of traumatic events, but the life that is lived prior to substance use is often similar. Rates of Substance use are higher in low-income communities, rural areas, and people who have a history of mental health issues or abuse (in all of its forms) (CDC 2022). As one of my interlocutors stated, *"A high percentage of*

[2] This event will be explored in greater detail throughout the second half of Chapter two.

people also have mental health problems and are self-medicating, burying that stuff, it's too bad. In that way, substances are serving a need." Furthermore, lack of stability both in and out of substance use is compounded in my research area of rural Vermont due to a lack of public resources. Many of the support services have limited funds, grants, or beds in the case of hospitals and rehab facilities.

The desire for all staff to be peers in recovery was made explicitly clear to me after a conversation I had with Ezra mid-summer just a few days after the Opioid Forum:

Some days I worked at the Recovery Center were slower than the rest. On this particular hot, lazy day I was sitting in my office at my desk, laptop open and a breeze coming through the Air conditioning that, despite the 80-degree weather, had me wearing one of our branded Recovery Center hoodies indoors. My office mate and a few of my other coworkers had either gone home for the afternoon or left to attend off-site meetings, so I figured it would be me, my laptop, and my bag of goldfish hanging out for the rest of the afternoon.

But after a little while, one of my coworkers dropped by. He was always in and out so I never knew when he would be by, even when he put his expected hours on the spreadsheet for our schedules. He always came in with new newspapers, books, or magazines, which he added to the unstable mountain that he had already left on one half of my desk and was beginning to spread to the adjacent chair. He asked where everyone else was, and I told him they were out. He followed up by asking what I was doing and nodded thoughtfully before asking what I was eating for lunch. He had already picked up on my lackluster food preparation habits and sighed as if personally offended when I lifted up my half-empty bag of goldfish.

Immediately, he pulled me outside to the picnic bench and sat me down with one of two slices of pizza he had picked up across town. We always had some of the most interesting conversations about substance use and recovery, thanks to his past in drug counseling and current position as both a normal recovery coach and one often was paged to the local emergency department. He read constantly and always wanted to share it with people. On my first day, he left a book about the science –around and behind– modern versions of recovery on my desk. Another day he talked about Indigenous people and substance use, and the statistics around suicide as an act of immediate overwhelmedness and hopelessness.

Today we talked about the opioid forum from a few days prior. I was interested to know more about his bias against the other recovery centers in town, specifically their owners and director. My experiences with their director had been overall pleasant when I met him at one of our health fairs and we had talked about Mount Holyoke; he had gone to school nearby and his girlfriend at the time had attended MHC. We talked about my research interests and ever since then we had been on good terms. Ezra, meanwhile had many issues with him, As he explained:

"Charlie used to be our *director, and he was the only one on staff who wasn't in recovery. During Covid when we were closed he wanted us to be open because we had to 'be there for the people in recovery!' But* we're *people in recovery! He just kept doing all of this othering stuff that separated us from people"*

One of the core parts of this recovery center is that it's peer-run, people know when they come in that the people they talk to have the same experiences and priorities as them. The way that my coworker described it, as we ate our pizza crusts and got violently sunburnt, was that the previous director was more focused on business and numbers than on people. It worked for his current position where the owners were similarly focused on numbers rather than people, but in

his position at our center it created a scenario where people felt uncomfortable in the space which is the opposite of their goal.

At the core of this conversation is the intense need for people to have community members who they can connect with, rather than people who see them as pity cases or as an "othered" group that needs to be served. Such "othering" is indicative of a bigger issue regarding the criminalization of and stigma against people with SUD, which I will discuss in turn in the following chapters. In community-based recovery, the goal is connection and community: but the challenges to such relations need some further unpacking.

Chapter 2: Triaged out of Care:

The entanglements of care and policing

Policing of Information

This chapter focuses on the interfaces between Substance Use Disorder, Biomedicine, and Policing. As such, I think there is no more apt way to begin this chapter than by stating the fact that while I will be discussing two cases which occur in the emergency room context, I did not get to experience these personally.

At the beginning of my internship at the Recovery Center, the Assistant Director Tyler attempted to obtain permission for me to accompany an emergency-room-authorized recovery coach during a page. In the correspondence, he requested that their "intern" be allowed to do this accompaniment, which in turn confused and panicked the staff there, leading to my inability to go. They requested that I undergo weeklong training, fill out various confidentiality forms, and meet with supervisors on a consistent basis; this was beyond my abilities as a part-time intern. It is critical to note that the actual recovery coaches who perform this service, like Melissa as described in Chapter One, do not have to undergo this process. They are simply people who have gone through traditional Recovery Coach training and to whom the center gave a name-tag, badge, and pager.

This situation provides a critical commentary on the way that certain kinds of engagement are policed: an intern was asked to undergo far more training than an actual coach, due to confidentiality and legality concerns. Legal frameworks in some ways haunt this chapter through both individual actors and

institutions acting in response to the spectre of police procedures. My involvement as an "Intern" thus became representative of potential liability or legal cases that may occur as a result of my involvement. As a result, the concern over police intervention barred me from the biomedical sphere. Thus, the stories and vignettes discussed in this chapter are the product of descriptions and explanations provided by Emergency-Department authorized recovery coaches and may be subject to bias, or lack details that I would otherwise have included.

Biomedical treatment of Substance Use

During my December 2023 to January 2024 visit at the Recovery Center, my primary task was creating Recovery Data Platform files for patients who met with Recovery Coaches in the Emergency Room (RCED) Program[3], as well as standardizing that information on the spreadsheet we used to ensure post-incident phone calls were put out according to schedule. This task had gotten backed up in my absence, so I was left to do the last several months to catch up. In doing so I found a name that showed up nearly every day. This woman was constantly in and out of the emergency room, seeing our recovery coaches consistently and denying follow-up care from the RCED coach every time, potentially because she knew she would see them soon regardless.

There were a couple of lulls in the record where she did not appear as frequently. I became curious, so I reached out to the coach who had the most frequent interactions with her. When I asked, I was told that she was a perfectly pleasant person but that she was desperate for help. She wasn't able to handle her substance use on her own, but also didn't know any way to

[3] This is a relatively standard program across all Recovery Centers in Vermont that are geographically located near an Emergency Room or Hospital. Also of note is the general lack of Urgent Care facilities in Vermont. While there are a few in more urban areas: Burlington, Montpellier, Rutland, and Brattleboro, these programs really are interacting primarily with a hospital based Emergency Room program.

get the clinical care that she felt she needed, outside of going to the hospital. Most of the record lulls I saw weren't from her being unable to reach the ER (working, traveling, or any of the other distractions I assumed would take her away from her pilgrimage), but rather the result of her claiming serious mental health problems and admitting she felt suicidal. This terminology of "suicide" is an instant red flag in an emergency department and earns someone a week-long supervised inpatient stay in the psychology wing.

This struck me immediately because of the difference of care between those with mental health issues and those with substance use. As mentioned in the preface, my coworker voiced that in Vermont the stigma associated with mental health is less than it is for substance use (which is different compared to other locations he worked and which we will discuss again later on in this chapter). So, I knew that there would be differences in care for these two conditions. However, I did not expect the difference in care to be so drastic, especially considering how deeply overlapping those with SUD and people with mental illness are. I have come to the conclusion that this is a problem centered around the biomedical need to "triage" patients.

In emergency room situations, especially in areas of low funding and low staffing such as this hospital in rural Vermont, nurses and doctors have to prioritize care to patients whose lives are in immediate danger. Provided that the substance use patient is not currently overdosing and in need of overdose reversal medication –a short and relatively straightforward process– a patient with a gunshot wound, a serious burn, large cut, or even unexplained abdominal pain will always be prioritized. Substance use puts people's lives at risk only in very acute situations, and thus, it falls low on the treatment hierarchy. Further, in many situations substance use is not something that can even be treated in a hospital, aside from an overdose or use-associated conditions, like injury post car crash in a drunk or high driving incident.

Triage and Social Illness

I contend that in these contexts, triage loses its power as a life-saving device and instead becomes a tool of the biomedical regime to support the lives of specific people. Those with substance use disorders, mental health, and other chronic conditions have a long history of being ignored and marginalized by the medical system (see: Biehl 2013). The former two especially face social backlash along with medical violence: as historian philosopher Michel Foucault described in his book *History of Madness* (1961), the mentally ill are discounted, perceived as less human because of their inability to interact with the normative social world. In his 1999 Tanner Lectures, anthropologist Byron Good furthers this discussion by bringing to light not only the interplay between culture and concepts of disorder, but specifically the way that people understand illness through a moral framework. Underlining this idea in relation specifically to substance use, anthropologist Mariana Valverde (1998) termed substance use a "disease of the will," socially critiqued as a failing of the individual. All this to say, to be worthy of medical attention, one must be considered worthy as a person.

Human worthiness is intricately tied to social stigma and situational cultures. This is described in the article "Culture and stigma: Adding moral experience to stigma theory," by Lawrence Hsin Yang, Arthur Kleinman, Bruce G. Link, Jo C. Phelan, Sing Lee, and Byron Good who are concerned about the moral stakes around behaviors in a given social world. They affirm that stigmatized behaviors are a powerful indication of what a given social world values. When my coworker Ezra says that the stigma has been different in the places he has worked, he may thus be referring to a difference in what each community values, and the ways they view occurrences like substance use or mental health to be acting against those values. In both this article and in Arthur Kleinman's 2007 book *Deep China,* he refers to mental health (specifically

schizophrenia) as a mental disorder which violates the importance of maintaining and existing within a social network. People who are not able to do that important task become non-persons and are no longer afforded the same rights as persons, such as medical care or even the right to life.

Together, all these scholars highlight the ways in which constructions of personhood and stigma affect the care that is afforded by both the biomedical system and the legal system. This history and research specifically connects to triage because it shows the way in which certain people are triaged out of care due to the social constructedness of who deserves it. Thus we might begin to see triage and systematic neglect as a form of biomedical violence against those who have become stigmatized.

Returning to the case of the woman who frequently visited the Emergency Room, we see that there are limits to the care that can be offered for SUD in an ER. More generally, care related to immediate injuries such as broken bones, concussions, and burns are well within the realm of treatability for professional staff in an ER. Yet, even if one has one of these perfectly understandable and treatable illnesses, their status as someone with SUD may affect the way they are treated. For example, Sameena Mulla, a rape advocate in Baltimore Maryland writes in her book *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention* that patients who come in claiming that they have been raped are discounted or abused by nurses if they are also thought to be drug addicts. The thought process being that these people have not been raped, are only in the ER in search of drugs, and are a waste of time for professional staff. We will delve deeper into Mulla's work in the next chapter, the point to be made here is that the label of "addict" or "person with SUD" means that care is delayed or, more often, delegated to other carers like the staff at the Recovery Center. This section unpacks how triage as a practice

creates and defines who the medical and social rejects are. As a result, it creates a procedure of non-care that perpetuates the unhealth and death of those with substance use disorder. The dominant medical regime is not outright killing people with substance use disorder, which means they can claim moral righteousness as they focus on saving lives that are in critical danger. However, they are instituting a set of procedures that allows the deaths of people with chronic and socially associated illnesses through a policy of negligence.

Objects of Care

Were it not for the RCED program, there would be *no* care for non-overdose or non-injury associated substance use cases in the Emergency room. They take on the role of advocates, standing up for those for whom they have been paged Annemarie Mol expresses in her 2008 book *The Logic of Care, Health and the Problem of Patient Choice* that consent is difficult if not impossible in doctor-patient interactions due to the inherent power dynamic that allows doctors to be prescriptive of care without patient input. This is expanded in her later 2010 book, *Care in Practice: On Tinkering in Clinics, Homes, and Farms* where she concludes that consent can be achieved only through collaboration between patient, technology, and professional. The current care model in this rural emergency room is one dominated by the professional. As a result, the RCED advocate acts not only as another form of carer who provides information on external support, but also as an individual who begins to tip the scales toward more collaboration. They interpret and help to provide an avenue for communication between patient and professional.

Despite the efforts towards agency in care, we find in substance use cases that the focus of care is not on the condition of substance use itself but rather the associated injury incurred as a *result* of the substance use. Bringing attention to SUD as an object of care is nearly impossible.

Here we have an opportunity to see both the challenge to care and the ways the carceral system begins to enter triage situations for people with SUD. To do so, I want to draw attention to discussions in Sameena Mulla's previously mentioned book *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention*. She shows how when women (and occasionally men) go to a hospital for what is colloquially termed a "rape kit," the main focus is to obtain DNA to be used as evidence of that rape which would (in a perfect world) lead to the conviction of their attacker (Mulla 2020). Mulla brings to light that the forensic nurses who provide this care function in a Medico-Legal space where they are concerned with care only insofar as it connects to the implied legal proceedings (2020). Their focus is on the DNA left on the patient rather than the patient themselves, often creating violence as a result. (This is, incidentally, worsened when the victim is considered morally deviant or otherwise suspect.) Mulla terms this care-based violence to be a "Second Rape," as nurses focus their clinical and detached attention on the DNA rather than on the human being who has experienced a traumatic event. She then extrapolates that in these cases, the "Object of Care" is the DNA as forensic nurses perform their duties as an extension of the legal justice system (Mulla 2020). Meanwhile they are ignoring the victim's need for human-based attention and care. Thus, human-centric care became delegated to other forms of carers (non-professionals) such as Mulla herself who worked as a rape crisis advocate (a position parallel to our RCED coaches). These carers are responsible for showing up, holding the patient's hand, talking with them, and advocating for them when the professionals determine a course of action without consulting the patient.

Of course, I am not researching sexual based violence, itself an important genre of care to study. What I am focused on is substance use. Yet, these two fields are good parallels to one another due to the similarity of intersecting medico legal care violence as we see in this vignette:

Breaking Point: Challenges in Substance Use Care at the Emergency Department

The Recovery Center has a group of recovery coaches who are approved to get paged to the emergency room whenever a patient comes in with a substance use problem. These issues can range from a DUI, a fall down the stairs with alcohol in their system, family checking them in, checking themselves in for treatment, or an overdose. On one summer day, one of our recovery coaches was paged for a self-check-in. When they arrived at the emergency department it was chaotic: the patient had been tired and out of it when she arrived so the nurses had left her to take a short nap while they waited for the coach to get there and the labs to go through. When they returned with the coach the patient was active and manic. They concluded that she must have taken something while they were out of the room and wanted to conduct a strip search of her and her bag to check for substances. The recovery coach intervened, saying that would be dehumanizing and rude, especially since she had checked herself in and clearly both wanted and needed help. They made jokes about her just being a "junkie," saying that strip searches should be mandatory for substance use cases.

The recovery coach later explained that this happens frequently, especially because our rural location means that we have a higher-than-average number of "Traveling Nurses" who are specific staff that work short contracts and go from place to place frequently. Our center tries to do education seminars with the nursing staff yearly but it does not happen often enough to keep up with this specific kind of staff movement. The negative attitudes of undereducated or

intentionally ignorant staff spread rapidly – infectiously. The recovery coach in question had reported these nurses before. They still tried to search her. In response, the patient tried to lock them out of the room in order to remove their access to her. At that point, she just wanted to leave. She was no longer interested in getting services and our recovery coach was barely able to talk to her.

This would-be patient left without receiving the medical care that she originally sought out, nor did she learn about any of the support services that we had to offer whenever she was ready to try detoxing or transitioning into recovery. She went back into the world confused, upset, and afraid of her next trip back to the hospital because of their complete lack of respect for her and her disease.

In this vignette we are once again seeing a medico-legal problem where some substances are illegal or the impacts of them have legal consequences (ex: drunk driving accidents, public aggression episodes, carrying high quantities of controlled substances). As a result nurses and doctors feel that the object of care/attention in this scenario is the drugs (as if their care functions as an extension of the police state). They are less concerned with the woman who has willingly checked herself into the emergency department, and more concerned with the hypothesized presence of a substance in and of itself, regardless of the fact that this scenario does not carry the weight of a criminal case. Even if they obtained the substance from her, it would not and did not get reported to the legal system. They simply fell into a trap caused by long-held stigma against substances wherein the presence of a substance is a breaking of a taboo. They zeroed in on that trespass of taboo rather than the person's desire for care.

Additionally, this vignette highlights a critical aspect of care in the rural context: the high presence of "traveling nurses." This position is described as registered nurses who work short

contracts and relocate frequently to areas in need of additional nursing staff. This is done in an effort to counteract the fact that otherwise this area would be considered a medical desert, defined as:

> "Areas where population healthcare needs are unmet partially or totally due to lack of adequate access or improper quality of healthcare services caused by insufficient human resources in health or facilities, long waiting times, disproportionate high costs of services or other socio-cultural barriers."
>
> (Brinzac et. al. 2023)

Despite the continued efforts of local hospitals to increase staff, I would contend that this transient staff reduces the quality of care in these areas. Recall the importance of familiarity with people and with the tenets of harm reduction for SUD treatment, as described in Chapter One. The recovery coaches at the center do conduct yearly educational meetings with the nurses and emergency room staff, focused on reducing stigma as well as reinforcing the fact that people struggling with substances also need care and respect. This process is often aided by the fact that the coaches themselves are peers in recovery, proving that people with a history of substance use can still live strong lives to the point that they become peers to these professions. Even so, these trainings are unable to keep up with the staff turnover from short term (2-4 month) nursing contracts. This leads to inconsistent care depending on who has or has not been trained, medical professional violence, and an increased workload on community health providers like the Recovery Center as they endeavor to help reduce the negative impact of this violence on patients.

What I am trying to show here is a clear image of the lack of health care available in overlooked areas. On one hand, it's important to recognize the privilege that comes with the ability to check oneself into an emergency room in the first place. This town is positioned as the only one in the county with a hospital, the next closest real hospital being at least 45 minutes to

an hour away by car, even longer if not completely inaccessible by public transportation. On the other hand it's critical to highlight and discuss that even in a context where healthcare is available, health care is sub-par and in many ways damaging.

Looking for an Alternative

Outside of caring for substance use, my coworkers had many stories about people going to this hospital: being ignored and kept in waiting rooms for hours, looked at briefly only to be told that they are fine. They then go home and die within 24 hours despite having a doctor declare them healthy just beforehand. One of my coworkers has a boyfriend who went to the hospital for a Urinary Tract Infection (UTI) caused by his work conditions not allowing him to drink water or have frequent access to a bathroom. They did one test, said he was okay despite his serious discomfort, and sent him home. They then decided that driving an hour to the next closest hospital was warranted, and there, he was diagnosed with a serious UTI and was given IV and prescription antibiotics. This is all to say that substance use is simply the latest entry in a long history of rural medical malpractice. These patterns are only exacerbated by SUD, again, particularly because of the criminal and moral valence of the condition.

Overdose in a parking-lot

During downtime two of my coworkers started going over all the things I may have missed in terms of the day-to-day rather than larger scale staff changes. The big thing they mentioned was a change in atmosphere and general misunderstanding for what the Recovery Center was intended to be. They named a specific instance earlier that spring when someone had been dropped off in their parking lot. The person was unresponsive and still had a needle in their

arm, small bits of blood leaking into it. One of the program directors, Cynthia, emphasized the danger of the situation, stating that it took 4 doses of naloxone in order to resuscitate the individual, that newer and increasingly synthetic opioids are becoming immune to reversal and requiring these stronger administrations. After completing this process they had brought the individual into the center in order to give them water and ask them if they wanted to be transported to a hospital. The person took out their phone, texting a couple of friends who quickly showed up at the center, despite dropping them on our doorstep and running just shortly beforehand. Immediately they began to discuss their next score.

This vignette juxtaposes the previous scenes that were located in the hospital, and instead offers an insight into what people might do in areas without hospitals, or when they understand that a hospital won't save them. Further, it exemplifies an isolation-connection paradox resulting from the fact that substance use is a chaotic space where one can depend on others but only until something goes wrong (*Burroughs's Junky, 1983*). This person's friends simply dropped them on the front steps of the center, not sticking around to see if they would be okay or not. A large reason for this may be because of the ingrained fear that if something goes wrong and the person had died, they would be held responsible, showing once again how legal corollaries disturb care networks.

When one goes to a hospital, especially in this area where smaller clinics like an "urgent care" do not even exist, one decides to enter into a series of events. Those events include but are not limited to: long wait times (at least 6 hours), intrusive questions, potential judgment, paperwork, and, for many, expensive hospital bills. There isn't a true alternative to this; the closest thing in this area is having a friend administer naloxone (which the Recovery Center

offers and provides for free no questions asked). As a result, the Recovery Center becomes a critical location for the health and wellbeing of people who feel unsafe in hospital settings.

Direct interfaces with Policing

Opioid Forum 1.0

One Tuesday I agreed to attend a community based forum despite it not being one of my usual work days. I was picked up by a coworker after a shift at another job and we arrived in the parking lot of the event soon after. While walking toward the door I looked around; my boss had said previously that there tended to be a high police attendance since one of the speakers was a head of the department and another was an officer from the Drug Enforcement Administration (DEA). They considered the event to be their "Monthly Staff Meeting" so attendance was encouraged. She was proven right as I saw three police cars parked along the side of the school in a "No Park Zone," even more so as we got inside and the presentation hall was filled with tall white men in bulky black uniforms. Our table was the first one on the left, alongside several other community partners such as the MAT team and Healthy Lamoille Valley.

My coworker made a joke while looking at all of the police officers and three community members who were in attendance: "It looks like we're on the verge of a drug bust." I laughed and my boss told him to be quiet and to stop trying to antagonize people –both the police officers and Daniel.

The forum was opened by the police department, followed by welcoming each community health partner to the stage. Each one talked about their organization and the things they'd accomplished the previous year. We had just promoted our assistant director, Tyler, to his current

position and despite his anxiety, and general hatred of public speaking –which he says is the primary reason he didn't want to be assistant director in the first place– he did an incredible job. The director did a great job of laying out the playing field. She used statistics and anecdotes to help people understand what our organization is and what we do to both people in need of our help as well as general community members, or organizations who may be interested in partnering with us. Meanwhile, Tyler went for the human approach, talking about his personal substance use experience and how the recovery coaching in the emergency department program helps people in visible and tangible ways. It lets them be seen and become part of a community of people who have shared experiences. This point stuck during the entire conference, as people kept bringing up what he had said during their own discussions.

One of the other organizations talked purely in revenue and statistics, discussing how they had gotten x people jobs and y people into rehab and z new facilities. I felt like it was in some ways contradictory to the purpose of this conference, which centered on vulnerability and illness narratives.

In this vignette we begin to see the interconnections between law enforcement and substance use. This event was organized by community organizations, the Recovery Center included, in combination with the local police captain, so we might look at their respective interests in order to unpack the issue of an overwhelming police presence.One might be tempted to say say that this situation was caused by a simple lack of knowledge, that the organizations who planned the event did not know that there was going to be such a high police presence or the way in which this would affect people's willingness to attend. However, since there was the

expectation that the police captain would be a speaker, along with the DEA officer, it seems unbelievable that organizations would have not known to expect police involvement..

Rather, I believe the immediate interests of the organizers and the implicit values of the community organizations may be at play here. In the case of the police officers, their immediate interests are learning more about mechanisms of drug distribution across the United States and ways to address substance use from the DEA officer. They themselves are not particularly concerned about the community members and thus are not able to see the way that their presence negatively affects the initial goal of community outreach and education. The intention for this event from the point of view of recovery centers was to provide an educational and supportive space for community members who are struggling with or simply want to learn more about SUD. Yet, it became an educational space for police officers instead, excluding the community members who were the original target audience.

Police officers, especially in this rural community where people often know the police officers by name, went to school with them, or have kids going to school with their kids, have an ingrained belief that regardless of issues of police brutality in other areas, they are the good apples. In other words, they don't believe that their presence or the presence of the uniform should create any kind of tension within others around them because they are "good guys" and "everyone knows them." However, this is not the way that they are always perceived, especially due to the long-standing history of tension between substance users and legal powers. The law functions as a controlling arm punishing those who break it. Even in this area, policing is ingrained in care spaces, both biomedically and now in this forum.

As mentioned in the vignette, even our director stated that officers believe the event to be akin to a "monthly staff meeting" to learn from the DEA officer and support their captain who

spoke at several points during the event. Since we didn't see people drive up and then leave upon seeing the police presence, it becomes clear that the announcement of the event having police actors involved became itself a deterrent for community members who chose to abstain from the event altogether.

At the same time however, I think that it is important here to highlight Tyler, the assistant director of the recovery center. Even in this situation where police officers were swarming and everyone was talking about revenue statistics, he was able to bring in another story. Preparing his speech, I don't know if Tyler intended for his audience to be largely police officers as it was, or largely community members as it was intended to be. Regardless, he flipped the script. As mentioned in Chapter One, people who think "person with substance use disorder" do not generally think "assistant director." Tyler used that image of himself to draw attention to the real and tangible ways in which the recovery center is able to help people, while at the same time creating a new image as he described the process, lows and highs of being a recovery coach who works with hospital personnel. His message reverberated, even as we see in the next vignette, a couple becomes righteously angry about police protocol and a believed oversight for people with substance use disorder

Opioid forum 2.0

After all of the community organizations finished their presentation, a representative from the Drug Enforcement Administration discussed the drug pipeline into Vermont. A large portion of this presentation felt out of touch, as it focused on the Mexican cartels and drug seizures in Arizona. There were some statistics showing how heroin has become obsolete in the current drug landscape and that fentanyl is a rising and dangerous problem that we should be concerned

about. He talked about how Synthetic opioids are a problem because they can be manufactured, unlike traditional opioids which have a limit to the amount that can be harvested synthetic opioids are a resource that can never run out, and they're multiplicatively more addictive.

Focusing on Vermont he said that the northeast is an endpoint of the drug trade in the United States, and that the state is well positioned to bigger dealing cities in Boston and New York. It's easy for big dealers to simply do a day trip, driving up and then driving back out of the state without repercussions. He also mentioned that the laws in Vermont are relatively light on drug dealers, which he attributed to the state's pro-medicalization and deeper social understandings of substance use as a result of circumstances. He said that the state doesn't want to punish people – friends, neighbors, and family – who are selling drugs in order to sustain their own substance use. So when people are caught with drugs and the intent to distribute there is often simply a fine, warning, or short stay in jail.

One of the organizations at the forum was another Recovery Center from the next town over. They were founded by a couple in 2019 after their daughter, Alyssa, passed away from an overdose. Hearing this information from the DEA officer, they immediately began a barrage of questioning. They said that a week before their daughter had passed away, the drug trafficker who sold her the fentanyl that caused her overdose was caught by the police and then released, which gave him the opportunity to come back and wreak that havoc on their lives. The officer clearly wasn't familiar with this area or expecting this kind of response, especially since it was so emotionally charged, but he tried to provide diplomatic responses. He stated that the incident that caused their child's death was unfortunate, but that the law is intended to be protective.

The rest of the forum devolved into somewhat of a call and response as this woman and her husband kept raising their hands to make comments and ask questions to criticize the

government, police, and medical system. They kept trying to lay blame on everyone, that their daughter had been failed by the community resources and by the law. This was done in an entire room full of police officers and created a very hostile environment; it didn't involve other organizations and felt like a blame game. The DEA presenter tried repeatedly to redirect the discussion failing every time due to their persistence as they tried to find the sole reason their daughter had died.

During this altercation, Ezra kept saying "they need therapy to get over their daughter dying and they won't get it, it keeps hurting people" highlighting the way that their position as owners of a Recovery Center gave their voices more weight, especially to the few community members who did participate. Them putting forward a belief of blame is damaging to few community members who did come to the event. He said that they created their organization as part of their grief and that they see their daughter in every woman that comes through their doors. But rather than doing so in a protective, helpful, and supportive way they do it in a pushy way, they aren't as kind and inclusive as they could be.

Later on I had a conversation with a community member who said that she talked to some women who went to other organizations or states in order to get away from the shelters run by this family's organization. The pressures that were placed on them in those rehab shelters were so imposing and invasive that it made their substance use worse and caused them to start hating themselves.

This event was intended to be a nice gathering for people to get snacks, pass out harm reduction bags, and learn more about the resources available to them in a welcoming setting. However the combination of police officers flooding the room, and the way that the owners of

this organization flipped the script into accusatory territory lost that purpose, it felt structured, unstable, and defensive.

Legalities Statues of Substance Use in Vermont

After this event I became curious about the actual legalities and how it might explain some of the cultural shifts that Ezra mentioned a couple times as differences between Vermont and Massachusetts or Connecticut. I was looking for evidence of values, trying to understand within Kleinman's framework what the community sees as "at stake" and what is being focused on that might be threatened by SUD. Surprisingly however I found that a large portion of the laws around SUD to be protective. For example in "Title 18: Health Chapter 94: Substance Use Disorders § 4801. Declaration of policy" it states that:

1. It is the policy of the State of Vermont that alcoholism and alcohol abuse are correctly perceived as health and social problems rather than criminal transgressions against the welfare and morals of the public.
2. Alcoholics and alcohol abusers shall no longer be subjected to criminal prosecution solely because of their consumption of alcoholic beverages or other behavior related to consumption that is not directly injurious to the welfare or property of the public; and
3. (2) Alcoholics and alcohol abusers shall be treated as persons with the condition of alcoholism and shall be provided adequate and appropriate medical and other humane rehabilitative services congruent with their needs.

(Vermont 2023)

Further, it is stated in section 4810 that if a police officer comes across someone who is intoxicated, as defined in section 4802[4], " the officer may assist the person, if he or she consents, to his or her home, to an approved substance abuse treatment program, or to some other mutually agreeable location."

These laws show that the stance of the Vermont Government is that Substance use is a Medical problem and should be treated as such. This is a very strong step away from viewing SUD as what Mariana Valverde (1998) called "A Disease of the Will," which it was often considered throughout most of history and it's a transition into considering SUD as a "Disease of the Brain" (Rose 2003). As a result, the legal consensus is that if someone commits a crime in association with substance use it is the belief that that person should be given the chance to obtain proper care or make amends if needed. This supports the statement that the DEA officer made about Vermont focusing more on providing treatment to people we know, who are fundamentally community members caught up in the throes of their substance use, rather than punishing them.

One of the limitations to this kind of medically focused care, especially in rural Vermont where rehabilitation services are scarce and often expensive, is that these systems only "make

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[4] 4802. Definitions

As used in this chapter:
(1) "Alcoholic" means a person with the condition of alcoholism.
(2) "Alcoholism" means addiction to the drug alcohol. It is characterized by:
(A) chronic absence of control by the drug user over the frequency or the volume of his or her alcohol intake; and
(B) inability of the drug user to moderate consistently his or her drinking practices in spite of the onset of a variety of consequences deleterious to his or her health.
(7) "Incapacitated" means that a person, as a result of his or her use of alcohol or other drugs, is in a state of intoxication or of mental confusion resulting from withdrawal such that the person:
(A) appears to need medical care or supervision by approved substance abuse treatment personnel, as defined in this section, ensure the person's safety; or
(B) appears to present a direct active or passive threat to the safety of others.
(8) "Intoxicated" means a condition in which the mental or physical functioning of an individual is substantially impaired as a result of the presence of alcohol or other drugs in his or her system.
(9) "Law enforcement officer" means a law enforcement officer certified by the Vermont Criminal Justice Council as provided in 20 V.S.A. §§ 2355-2358 or appointed by the Co
(13) "Substance abuse crisis team" means an organization approved by the Secretary to provide emergency treatment and transportation services to substance abusers pursuant to the provisions of this chapter.
(14) "Substance abuser" means anyone who drinks alcohol or consumes other drugs to an extent or with a frequency that impairs or endangers his or her health or the health and welfare of others.

someone well" for a short period of time. Psychiatrist Brendan Daughtery (2020) and physician-anthropologist Kimberly Sue (2019) comment on the way that when people are picked up by authorities for mental health or substance related reasons they enter a system, usually the carceral system in a wing or program focused on treatment. They then enter a short period of recovery where they have all that they need: hands on medical treatment, support groups, and shelter, and they have a tendency to enter periods of wellness (Daughtery 2020). This treatment is temporally limited, the most common SUD treatment center has treatment lengths between 14-35 days, often on the shorter end because of a demand for beds.

These cycles of legal intervention, wellness, and then being released into the environment that was likely a causative agent of their use reinforces a stereotype. It creates a type of person, or "invents them" in the words of philosopher Ian Hacking (1999), which makes it more probable that the situation will happen again. The stereotype creates identities and tends to mold understandings of selfhood for people who are associated with aspects of those expectations. I interacted with a woman who mentioned that she had a history of legal interactions and that she was thinking about applying to go into rehab again because "that's what people like me ought to do." She didn't think of herself as an individual but rather she was being acted upon by larger historical, legal, and political expectations that prescribed for her the actions of someone with her disease.

All of this is not to say that the transition from moralistic causative reasoning to a biomedical understanding of SUD is wrong, but rather that it is not enough. The interventions, even ones like police officers escorting those with SUD to hospitals or Rehab centers, do not address the deeper causes and emotions associated with the use. Instead, they prescribe actions and de-incentivize health by encouraging health and unhealth cycles that propagate the

understanding of health only being achievable through medical intervention. This encourages people to go to the emergency room as we saw earlier in this chapter despite the fact that ER interventions are not capable of caring for those with SUD.

Repercussions of Substance Distribution

Having gained insight into the way that the laws around substance use in Vermont benefit and harm those with SUD in a care capacity, it becomes important to understand what would be considered criminal, and thus punishable, under the current regime. As a result I felt the need to learn more about the specific penalties associated with distribution, which calls into a different category than mere use. I find it critical to fact check the statements that the couple made during the forum. Many of the laws about distribution of controlled substances are focused on distribution from medical practitioners and pharmacists with the connotation that distribution is contingent on ownership of a license to do so. The regulations that were more general are as follows:

> **4476.** Offenses and penalties
>
> (a) A person who sells drug paraphernalia to a person under 18 years of age shall be imprisoned for not more than two years or fined not more than $2,000.00, or both.
>
> **4228.** Unlawful manufacture, distribution, dispensing, or sale of a non controlled drug or substance
>
> (a) It is unlawful for any person to knowingly dispense, manufacture, process, package, distribute, or sell or attempt to dispense, manufacture, process, package, distribute, or sell a non controlled drug or substance upon either:

> (1) the express or implied representation that the drug or substance is a controlled drug; or
>
> (2) the express or implied representation that the drug or substance is of such nature or appearance that the dispensee or purchaser will be able to dispense or sell the drug or substance as a controlled drug.
>
> A person convicted of violating this section shall be subject to imprisonment for a term of up to one year or a fine of up to $5,000.00, or both. If the violation of this section involves dispensing, distributing, or selling to a person under the age of 21, the person shall be subject to a term of imprisonment of not more than two years or fined up to $10,000.00, or both.
>
> (Vermont 2023)

These penalties can be considered to be “light on (substance use) crime” as this family was accusing; they do not do much to discourage those who are part of a larger group or cartel –in other words, not personally suffering from SUD– from distributing. Especially when compared to New York State, wherein NY Penal §§ 220.03 to 220.25 states that substance use distribution charges can range between Class A misdemeanor with a 1 year prison sentence or up to 1,000 dollar fine. All the way up to a First Degree, Class 1-A Felony associated with 8-20 years in prison and a 100,000 dollar fine/bail.

Returning to the Forum

During the discussion at the Opioid Forum, Allysa’s family was concerned about the ways in which laws direct attention, who they support, who they don’t support and the very real potentially fatal impacts of legal oversight. This scrutiny is shared during election cycles, such as the one in 2022, where Democratic US House candidates U.S. House seat: state Senate President

Pro Tempore Becca Balint and Lt. Gov. Molly Gray discussed federal funding and Vermont Harm reduction programs in light of the current Opioid Crisis. There was a push for greater grant funding to go to substance use programs as evidence showed that smaller community based organizations have the greatest positive impact in communities due to their tight ties with the people and organizations in their area. The other most relevant point from this discussion came up when Balint stated that in revising laws she's looking to move more toward a restorative justice format.

> She said she believed in having those individuals take responsibility, but also allowing them to get the help they need. "It is holding people accountable within the criminal justice system," she said. "And it's also making sure that if it's appropriate for people to be handed off outside the criminal justice system, that there's actually support there to follow that person through for their own recovery. And restorative justice, making sure they are making amends." (VT Digger, Chien 2022)

This quote represents a continued effort of progression on behalf of decision makers challenging attitudes of substance use and criminality. It points to a belief that people who struggle with SUD are not fully in control of their actions, contending that new frameworks should recognize fault in criminal acts but still aid the individual in recovery practices. While this is valuable, it is counterintuitive to the justice system that Allysa's parents were looking for. They're looking for a more traditional form of justice, for the person to be imprisoned and never let out or able to harm anyone else ever again. Exemplified when at a similar event, Alyssa's mother, the woman from the opioid forum, asked "why the dealer who sold her daughter a lethal dose of

fentanyl was released on $500 bail." (VT Digger, O'Connor 2022). Based on the laws discussed above, this situation should not have been possible, if this dealer had been picked up he should have been at the very least fined 5,000 dollars. Regardless, even if he had been given this larger fine he likely would have returned and continued to deal anyway; the minor fine simply made it easier for him to return without repercussions. Yet at the same time, I am sure that they would have wanted the law to protect their daughter if she had been the one with police interaction. Thus we see that there are complex entanglements between care and policing, how people are cared for and how affording that care can be dangerous when abused. Whether the laws function as intended and genuinely protect the people of Vermont, or are another byproduct of the government's inability to see the negative consequences of their actions leading them to be in need of serious revision is certainly a topic worthy of debate. Ultimately, I echo the words of the DEA officer: this situation was unfortunate, but the laws as stated, are intended to be protective of those who are suffering from a very legitimate disease.

Throughout this chapter and the last, I have worked to show the ways in which treatment of Substance Use Disorder has positive and negative aspects. Positive is largely through the use of community based care, and the overwhelming amount of negative treatment is due to entanglements of SUD with the legal matrix. Policing interferes in all aspects of SUD care from my initial attempts to learn more about SUD and biomedicine as an intern that got rapidly shut down discussed in the "Policing Of Information" section, to the way that legal cases haunt biomedical spaces affecting the forms of care distributed to those with SUD, and the way in which policing itself is entangled with community values and concerns. Further, here we see how there is a push and pull in the relationship between community members and expectations of law enforcement. On one side, members of the SUD recovery community are afraid of police officers,

and on the other side, family members of people with SUD feel like the police should do more. Transitioning into the next chapter, I focus on stigma and social suffering, and the ways in which police interactions result in a construction of the individual with SUD as dangerous to the rest of the community. What becomes clear is that SUD does not only affect the individual who is diagnosed, but rather their entire social network, which will allow us to return to this couple and their experience with more depth.

Chapter 3: Danger to the Community

Moral Experience of Stigma and Policing

Last chapter, the discussion focused on policing, particularly in the way that institutional forces act on those with substance use disorder. This chapter –while focused on similar topics– looks to deepen and reframe that discussion into one focused on stigma and moral worlds experienced by those with SUD. I will call on several scenes from the last chapter to reframe and re-discuss while also bringing in new ethnographic work for further discussion.

When talking about stigma here, I am once again calling upon Arthur Kleinman's notion of the moral experience of stigma to understand what, within the culture, substance abuse puts 'at stake.' In this case, I am specifically pointing to the way that this community claims to treat those with SUD as humans in need of care. It also reinforces social expectations that those with mental health problems and SUD are dangerous and should be kept separate from the rest of society.

Moral and Social Construction of Stigma

In his article, "Culture and stigma: Adding moral experience to stigma theory," Kleinman calls on sociologist Erving Goffman to understand how people interact with each other in a community and how they then create rifts. One of the most commonly seen rifts is stigma, which Goffman described as "a special kind of relationship between an attribute and a stereotype."

Phrased differently, stigma alerts us to the presence of an important value held within the social world; the stigmatized condition is one where a group of people contradict or challenge that value or attribute. This is further supported as Goffman later concludes that "stigma: (1) consists of an attribute that mark(s) people as different and leads to devaluation; and (2) is dependent both on relationship and context—that stigma is socially constructed."

According to Kleinman's research, medical treatment is often contingent on personhood, a status acquired through existence within a social network. If one is unable to uphold obligations to the social network, it results in the loss of personhood status, meaning that the individual can be shunned, or even killed without repercussions (Kleinman 2011). Kleinman expresses this sentiment in mental health cases, like schizophrenia where people become a burden on their family, and if they are unable to interact with others or behave adequately in society, they are shunned (2011). Kleinman further demonstrates this in cases of physical diseases such as HIV/AIDS, where the disease status either automatically leads to stigma and violence, or the fear of stigma leads to self-isolation and a loss of personhood (Kleinman 2011).

All of this is to say that existence within a social network, and the key beliefs of that social network, are determining factors for the perpetuation of stigma. It's based on something that contradicts a mutually held value, thus creating a rift within the normative social network. We see this in Bourgois and Shonburg's book *Righteous Dopefiend* (2009), in which the self-titled "addicts" are able to form a social network, that of an alternative local moral world. Ultimately, although each of the individuals in the community is homeless and dependent on dope for their existence, they connect over this fact and create internal structures based on the use of reciprocal favors regarding dope access and injection in order to create their own social

world. This social world is stigmatized and is unintelligible to those outside of it who view them as breaking the agreed upon social norms that were discussed earlier.

The understanding of these norms is built out when physician biologist Ludwick Fleck wrote his article "Genesis and Development of a Scientific Fact" in 1979, discussing a similar concept where facts are ultimately socially constructed. Fleck argues that scientific knowledge is socially constructed and evolves through a process of negotiation and consensus within a thought collective. He emphasizes the role of language, shared beliefs, and cultural factors in shaping scientific understanding (Fleck 1979). This can be extrapolated to also express some of the ways that cultural norms are made. It reinforces the notion of unintelligibility that is experienced in the previous paragraph in that the breaking of these norms is akin to going against the facts that govern how people live and inhabit a community space.

Creating the Diseased Criminal

In order to gain a better understanding of why people at large have a distrust of those with a history of mental illness and substance use disorder, I bring forth both Foucault and Daugherty once more. In his article, "A Social History of Serious Mental Illness," Daugherty points out a long history of entanglement between those with mental health issues, those who struggle to abide by community rules in Kleinman's sense, and the carceral system. Not only were asylums and prison systems physically close –if not completely connected– but criminals who were too unruly for general cell blocks would be moved into areas designated for mental patients (Daugherty 2020). In this way, the line between those in need of psychiatric help and those who had been removed from society due to criminal acts are blurred. The two became synonymous as

'people who cause harm.' This reinforces a fear of those with SUD and an expectation of violence from them.

This practice continues to this day, evidenced in Kimberly Sue's book, *Getting Wrecked: Women, Incarceration, and the American Opioid Crisis*, published in 2019, where she describes the lives of women who go through cycles of incarceration and freedom. Here their incarceration is a result of actions associated with their substance use. Often, obtaining freedom is contingent on a period without use and progression through an in-house detox and rehabilitation program (Sue 2019). Sue says that "The prisons and jails in the United States are tasked with the problem of addressing, correcting, and treating substance use disorders in the wake of decades of legislation since the early 1900s that increasingly criminalized the consuming, selling, or buying of certain drugs such as cocaine, opium, and marijuana" (2019). Legislation in the latter half of the 1900's carried on this legacy when the supreme court ruled in the case Estelle vs Gamble (1976) that those who are incarcerated must receive adequate access to health care (Sue 2019). It may seem that I am alleging that providing adequate care for people who are incarcerated is problematic, which would be incorrect. Rather, I am arguing that the way in which people with substance use disorders are frequently incarcerated, and the fact that biomedical care is required to be distributed, creates a situation where incarceration of people with SUD can be framed as a form of care despite the fact that it actually causes more harm. It further positions the prison system as a parallel to the biomedical system, as they both are tasked with the health and well-being of those who they come into contact with.

Both Daughtery and Sue are pointing to the way that people with mental health and substance use care are inducted into what Foucault would term "total institutions" – rehab or incarceration – (1961), in which they are provided with complete physical and biomedical care,

however, that care is temporary and does not address the lived conditions that promote use in those with SUD. Further, it comes at the cost of being associated with criminal practices that perpetuate stereotypes of those with substance use being either violent or unstable people who should be kept away from the masses[5].

Even in the context of my research, I was able to find similar examples. Based on the legal conditions discussed in Chapter Two, we know that police officers are supposed to take those with SUD to a health facility to address their use medically instead of penally. This is done with the understanding that when they have been picked up for this, they have not become part of an associated crime like a drunk driving accident or murder, which would directly require a criminal case. I dug a bit into the local crime statistics and found a response where "*an intoxicated resident was transported to the detox center at the (nearby towns) correctional facility.*" Here we see again the interconnections between rehabilitation and criminalization.

This made me curious if the legal stipulations about escorting SUD cases to rehabilitation is conditional on the rehabilitation being within a correctional complex, as seen in this case and Kimberly Sue's research. After reading the book *Rx Appalachia: Stories of Treatment and Survival in Rural Kentucky* written by the harm reduction focused medical anthropologist Lesly-Marie Buer, I learned about "drug court," an inpatient rehabilitation program in Kentucky, similar to the programs described in Kimberly Sue's work in Boston. In Buer's experience in rural Kentucky, disqualifying criteria for rehabilitation focused incarceration was identified as having existing mental or chronic health issues, specifically those that require an individual to take medications

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[5] Another harm caused by incarceration is the fact that many higher level jobs require background checks or clean legal records. If someone has been incarcerated this in turn affects their ability to work any job beyond menial minimum wage jobs and limits the ways in which they can change their life or relocate to areas that cause less harm to them.
Another recovery center in the area was piloting a program for recovery coaches going into prisons to work with inmates with SUD. In a discussion about this a man asked if you could do this if you yourself had been incarcerated in the past and was informed that the prison would perform a background check and past incarcerations were an eliminating factor. Despite the fact that this man felt like his positionality as a previously incarcerated person with a history of SUD meant that he could connect with these inmates on a profound level, incarceration records limit what he could do to support others like him.

frequently. The concern in this case was that they did not want to "set people up to fail." (Buer 2020, 115). Following my coworker Ezra's statement from earlier when I looked into similar programs in Vermont, in this case "Adult Treatment Court/Docket(s)" these mental health conditions were not a disqualifying criteria which shows again how mental health treatment is valued in Vermont in ways that differ from other areas (Vermont Judiciary). However, several locations where the Treatment Docket program is held stated that:

> The Court will give incentives for progress, sanctions for negative behavior, and adjust the treatment plan as needed. If a participant does not follow their treatment agreement or the program rules, they may face sanctions or be terminated from the program and returned to the regular criminal docket. (Vermont Adult Treatment Court Policies and Procedures 2022, 5)

These programs are in many ways antithetical to primary harm reduction procedures in that return to desired, non-substance using behavior within a certain period, is a requirement of the court; failure to do so results in criminality. In this way although the Vermont justice system purports to support the wellbeing of people with SUD in the community, those supports are contingent on specific behaviors exhibited by the person with SUD and their willingness to conform to normative social values.

In this section we see that not only is stigmatization based on the trespass of moral community values as Kleinman points to, but also that there is a long history, continuing to the present day, that reinforces the belief that those who have SUD should not be included in normal society; there is something wrong with them and they should be sequestered if ever their SUD becomes a problem for anyone other than themselves. It reinforces Kleinman's discussion in

Deep China regarding loss of personhood as a result of stigmatizing conditions (2011). These people are not expected or allowed to interact in normative society unless they are rid of their SUD, and the community is not required to treat them as anything other than a social concern to be rid of.

In this specific context of rural Vermont the situation is less extreme: people aren't being killed by their families for SUD as was the case in Kleinman's work in China. Instead, people are being isolated from the rest of the community. If they misstep they become the locus of public discussion and controversy, creating a paradox of social attention and scrutiny juxtaposed by exclusion. This was demonstrated in the last chapter when the community members criticized both the government's ability to protect substance users as well as their ability to adequately separate those with SUD or who are associated with SUD from the rest of the community and reduce the damage they do to everybody else's lives.

It is also shown in the next vignette where a man with SUD faces hazing from the community.

Danger to the Community

Through this past section we have laid out an understanding for why people with substance use have a history of being considered a threat: they're considered people who put at stake the livelihood of others in the community at risk. In the following vignette, we will see this presentation of stigma clearly.

On one Tuesday afternoon a woman came into the Recovery Center. She had come a couple of times before, and I'd attended a group or two with her where she discussed her ongoing recovery and desire to improve her life to feel more like herself. She signed in on the

sheet in the entryway where I sat at the desk with my laptop. I waved at her and said good morning, asking if there was anything I could help her with. She replied that she was okay and continued into the center, taking a seat at one of the couches in the living room and pulling colored pencils and a coloring book out of her bag.

When people entered the center they became locations of congregation, which is one of the prime benefits of the center: when someone needs to chat they don't need to reach out first. Since it was lunch time most people had set aside their work and shifted to the living room with their salads and pastas in multicolor tupperware containers. Once everyone had sat down she asked, "did you see Facebook?" which is a fairly innocuous conversation starter. Yet, a look of understanding dawned around the room as people nodded somberly. "There are posts about him everywhere," one of my coworkers said. By this point I was well and truly lost, showing my age as the token Instagram user. So I decided to sit back and take it in as Tyler twirled his fork stating that "yeah someone took pictures of him walking across town the other day, god forbid someone with substance use walk anywhere," he added sarcastically. The woman started pulling up Facebook on her phone "It's just being pushed by this man and his wife!" She spun the phone around to show a profile photo to the room, Tyler confirming that it was one of the posts he had seen. "It's like you can't do anything in this town without everyone knowing, everyone judging" Elise declared. "You should report it for hazing, because that's what it is really". Rapidly multiple phones came out of pockets and within moments multiple posts had been reported for hazing and stalking. What I had gathered by this point was that there was someone specific with SUD who had become recognizable to the public, and the public was lashing out.

The following day, I wasn't at the Recovery Center, but rather at the coffee shop across town where I worked most days. During the half hour overlap between my manager's opening

shift and my closing one she pulled me aside and said to "Keep a look out for the guy." Puzzled I furrowed my brows and asked "What guy?" She seemed astonished that I didn't already know and elaborated. "The guy who overdosed in the Hannaford bathroom. He was found by a little kid and people have been seeing him all around town. Yesterday he sat on the bench outside the (staff) door nodding off for hours, we had to lock it for a while." At this point, the light clicked on in my head: this must have been the same man they were discussing at the Recovery Center. My second thought was that the town really did feel very small all of a sudden.

Although this situation occurred nearly at the end of my final summer of research I continued to hear about this man. To my surprise he came up more at the coffee shop I worked at than anywhere else. As I discovered, the staff and visitors at the Recovery Center didn't concern themselves with the details of his life. They didn't follow him through social media, nor did he come into contact with center staff through drop in hours or through the emergency department program (to my knowledge). In this way he was just like any other person in the public. Meanwhile, at the coffee shop this transgression became a site of public scorn and drama. Anything he did was a topic of discussion. I was told at one point that he had taken money from the tip jar in a bakery down the street, and that we were supposed to empty tips from the jar into the register more often so that if it happened to us, we didn't lose as much money.

A few weeks later, I heard that he was picked up by the police and put in jail. For what? It was never directly said. However, I was able to find an article in the local newspaper discussing a man who threatened a local cop, was detained, and then released and sent to a rehab facility nearby. While it isn't 100% conclusive that this is the same man, he was described to have a history of substance use and was a long term resident in the area (which would contribute

to him being recognizable as in this vignette). On the official report he was arrested for being "a danger to the community." I think there is a likelihood that this is the same man, and yet, regardless of true identification there is material here that can become the site of stigma analysis.

In the last chapter, we discussed how the DEA officer specifically pointed out the way that the law does not want to punish "friends, neighbors, and family – who are selling drugs in order to sustain their own substance use." This highlights a pillar of the community, something that we hold dear and would lash out if it were challenged. It's an example of something that is in Kleinman's words "at stake." In this vignette, the actions of this man with substance use disorder puts the wellbeing of these groups – our friends, neighbors, and family – at risk when he overdoses in a public place and makes his use a public and community problem. That is, the addict is the danger, not understood to be that family, that friend, that neighbor. This is furthered by the fact that he was found by a child. It is common, especially since the turn of the century for children to be protected, (ex: the difference in child monitoring over the last few decades). Consequently, the fact that a child discovered the man violated that protection which provided the parents with the ability to lash out. They were upset at the way that their child's life was now marred by these experiences, that it could cause lasting repercussions like PTSD, or would force them to discuss "adult issues" like substance use with the child at a much earlier age than they would prefer to.

Through the process of making substance use a community problem rather than an individual one, those with SUD lose status as a protected person. This man is no longer one of the "ingroup" or general community, he has separated himself into a form of "other."

Local Moral Worlds & Situated Biologies

In the second half of this chapter, we will delve into a more person-centric approach for understanding substance use. It will be focusing on local moral worlds and the stakes involved in them as well as how this creates a form of habituation and social inheritance.

Kleinman uses the term “local moral worlds” to indicate a small group of people who abide by shared structures of meaning (Kleinman and Kleinman 1991). It is a term that could be considered akin to one like culture, but specifies a smaller community within the culture of a larger area. In this way, I and many others have proposed to consider substance use communities to be groups of people within a local moral world that prioritizes different aspects of life in order to function according to their own personal codes of ethics.

It becomes important to think about how the local world affects an individual's health, specifically how our lived environment constructs our expectations of the normative body and its processes as well as the actual limits or expectations we have of that body. In 2018, anthropologists Jörg Niewöhner and Margaret Lock wrote an article called “Situating Local Biologies: Anthropological Perspectives on Environment/Human Entanglements” in which local biologies, refer to the way that experiences of symptoms and illnesses vary across cultures and geographic locations. Lock says that epigenetics and local biologies “point to the inseparable entanglement of material and social processes.” This is further emphasized in anthropologist Veena Das’ book *Affliction*, wherein Das discusses the concerns of poverty and health care distribution in upper versus lower classes in India (2015). She says in some cases, her interlocutors normalize their own health stating that “this is the body of aging.” or, “all babies when seething get some fever or some diarrhea.” At other points, they will search high and low for a cause to their illness (2015). In this way we can begin to understand how the specific

physical and social environment results in changes in *expectation* of our own bodies function. I present a few broader and more familiar examples of local moral worlds and situated biologies to set the stage before returning to the conditions of SUD in Vermont

The first example is from Jeff Schonberg and Philippe Bourgois' book *Righteous Dopefiend*, in which the researchers follow a small group of "dopefiends" and their complex interrelationships. By and large their lives are characterized by uncertainty and violence, they are frequently concerned with police surveillance and capture as this research was done during the early 2000's when the war on drugs was at its height. Further their very existence has come to be dependent on drugs; withdrawal from dope is a very painful process, so the "Edgewater homeless" community that Bourgois and Schonburg study takes whatever actions are necessary to stave off impending dope sickness (2009). The Edgewater Homeless community is then built on a series of reciprocal favors in which each person helps one another out, in terms of procurement and injection of dope. The stakes of this community are thus clearly different from those outside of it. Their bodies are largely wasting away from malnutrition and numerous years on the streets, but they are unconcerned about such things. Instead the social connections are built on a shared value for the euphoria that dope provides, along with a sense of reciprocity and the mutual aid along with that shared quest. In this local world, the situated biology is one where medical concerns like abscesses, malnutrition, track marks, and even potential or frequent brushes with death are not considered to be concerns. Rather, they are viewed as part of being alive and existing within their life goals; it's an expectation rather than an exception.

Our second example is in anthropologist Nancy Scheper-Hughes' book *Death without Weeping.* Here, the local moral world is one in which the community places significance on baby formula (1992). Specifically, possessing baby formula has come to symbolize not only that a

woman has a man to buy it for her, but that she herself is claimed by a man and taken care of (Scheper-Hughes 1992). It also takes on a form of status and emphasis within the area due to the fact that branding and quality of baby formula are considered factors in the aforementioned symbols (Scheper-Hughes 1992). This prioritization of baby formula initially seems innocuous. Yet, the water that is used to mix the formula is often contaminated, leading to high incidence of illness and infant mortality. Further, due to this cultural significance, if they are not provided with formula women will often simply let their infants starve to death. Women began to believe that they could not breastfeed because they were themselves so emaciated and hungry, that nothing would come out of their breasts, or that if it did, it wouldn't be enough to save their child (Scheper-Hughes 1992). This area saw an epidemic of infant death that was not seen in neighboring towns just hours away (Scheper-Hughes 1992). It was a specific group of people who behaved in accordance with a certain set of beliefs to the extent that child death was considered a natural biological process.

In the "Situated Local Biologies" article, Lock clarifies that " 'Local' may refer to a recognizable geographical space, but also signifies the process by which material bodies become embedded in specific temporal, spatial, and cultural contexts" (2018). This allows us to utilize the concept of local biologies in the context of SUD specifically to the idea of local moral worlds which, while geographically located within a wider community, have different social structures that can influence health expectations. To exemplify this, I refer back to one of my vignettes. Part of this vignette was included in Chapter one, in which a woman came into the Recovery Center and discussed her experience of inherited substance use where she thought that substance use helped her connect with people, yet really it was isolating her from friends and peers. In this section of the vignette I focus on her recollection of inherited substance use, I look at it such that

the family itself can be considered a local moral world, within which health expectations are wildly different from the surrounding community.

I Remember Everyone Who Leaves

Even as she seemed to want to melt into the wall, she told me more of her life story. She explained that: "My whole family has struggled with this, but the othering was the part that was really bad. We don't name it, even if we behaved suspiciously or like "go greet your aunt…" and it was normal. We would talk about who was fucking who in the family and who just got into a fight or was hit by their husband over lunch. My mom was one of eight children, over half of which had already died by the time I became an adult. But we didn't talk about substance use, so when I said that I really have a problem and that I need help with my chaotic use, my mom just said 'No.' It took months of conversations for her to even look at me anymore. She said that that was the worst part, not being othered by people who didn't know her, people just judging her on the street or DCF taking her kids. The worst part was when her family had been so normalized to being in pain and struggle that when she said that she needed serious help, she was ostracized by the people whom she cared about the most. This hurt, largely because, as she explained, people with substance use need a community. She gestured with her hands animatedly, nearly dropping her phone as she tried to put it into star-patterned leggings that lacked any pockets. She used the analogy of a car saying that you can't just stop using substances, it's like when you try to use hard breaks on a snowy road. You just keep doing it, and you probably end up in a ditch. You need people in that car, and you need to be able to trust them to speak up before it gets too bad and to do so repeatedly.

In this vignette, she points out a couple of critical aspects of SUD. First, that SUD is often inherited, both genetically and socially, and secondly, that when SUD is normalized in communities with high use, and it becomes common for people to die or behave violently, then it becomes unquestioned. Here, the physical effects of substance use become understood as normal biological processes to the extent that challenging this notion becomes problematic. She became ostracized by her family in attempts to become healthier and reduce her substance use.

This is an example of a local moral world where situated biologies are such that early death is common and unquestioned, and stakes of that world are deeply intertwined with using substances. When the woman proposes to recover she is threatening the stakes, as Kleinman would say, of that particular moral world and the pillars that uphold it.

We also see that life for many of those with SUD is characterized by interpersonal violence and abuse (all forms - physical, emotional, and sexual), to the extent that external and state-based interventions are feared and damaging. They're viewed as functioning against the livelihood of those within the community who see their behavior as normal even though it is only normal within their context. Thus, the way that the Department of Children and Families (DCF) took her children away from her becomes another form of violence, seeing as there is a barrier of understanding between those in the moral world and those outside of it.

Social Suffering

Having looked at local moral worlds and the way that groups of people are governed by alternative ethical considerations than their surrounding geographical cultures it becomes important to interrogate how this occurs. How are we to make sense of the suffering of SUD given the entanglements with law enforcement and ostracism that I have previously outlined? I

think the most valuable way to do this is through the use of the book *Social Suffering*, co-edited by Arthur Kleinman, Veena Das, and Margaret Lock. In which the term "Social Suffering" is explored through many smaller essays that attempt to show the interdependent features of suffering. The features that are defined include: structural violence, interpersonality of suffering, that interventions can have negative impacts, and finally, that there is an intermixing of social and health factors. In this section I will go through each of these features in turn in order to show more of Substance Use Disorder and the social world in which it arises.

Structural Violence

The first feature of social suffering is that there is an institutional structural violence that functions to limit the agency of people within the community. In physician anthropologist Paul Farmer's article "Social Scientists and the New Tuberculosis" he describes structural violence through the case of a man with acquired multidrug resistant tuberculosis (1997). When the man was first diagnosed with tuberculosis, he and his family tried everything to make him well. However he encountered many obstacles, such as the hospital he went to for treatment being a great distance away, and that his location in Haiti meant that medications were scarce to the extent that even if he was able to get to a pharmacy and pay the cost the medication wasn't even there for him to obtain (Kleinman 1997). Thus, he was unable to obtain consistent treatment and medications leading to his illness mutating and becoming untreatable despite his very best efforts due to circumstances beyond his control (Kleinman 1997).

In rural Vermont, the situation is very similar. Due to the fact that it is rural, getting to hospitals or care systems is very difficult for people with SUD. There is a public transit system intended to help people get to doctors appointments specifically. However, in order to call and

make the appointment you, one, need a phone, which discussed in Chapter Two is not something that all people with SUD have access to, and two, need a diagnosis. Due to the limited number of providers in the area, it is common for people to be on a waitlist for doctors or rehabilitation centers for months, even in times of crisis. One of the rehabilitation centers in town has 4 beds and is women specific, it is the only one in the main part of town, the next closest ones are multiple towns over. Thus, even if people want to get care for their substance use, they are unable to and are left to struggle.

Structural Violence functions to bring attention to the institutional and social forces that serve to limit the agency of particular groups of people. In this case rural location itself as well as a lack of infrastructure to support the location, accessible healthcare professionals and reliable transportation function to limit the medical agency of a rural community. However, it further limits the agency of the stigmatized individuals within the community who have even less access to tools which help them to overcome these barriers like their own reliable transportation in the form of cars, but also the fact that even if they were to get to a care facility there is no promise that they would be afforded the kind of care that they are in need of.

Interpersonality

The second pillar of social suffering is that the suffering is always interpersonal and never individual. To describe this, I would say that if a family member of mine is sick, they are themselves suffering; however, my family and those close to her also suffer due to our emotional connection to her as well as potential material strain that her suffering puts on the family. Although source and severity varies, the suffering becomes collective.

To discuss this I return to the last chapter in which a couple founded their own recovery center following the passing of their daughter who suffered with and died from using substances. In this situation, the person experiencing SUD was only the girl, in this case we will call her Alyssa. She had an ongoing struggle with it as she went through various rehabilitation programs and continually tried to enter into and stay in recovery. Yet at the same time, this struggle did not only affect her, as she went through this journey she relied on the support system that she did have, her parents. They helped her to get into rehab clinics and stood by her during her time outside of them.

After she passed, the grief became overwhelming for them; it became impossible for them to ignore or move past. So, they founded their own recovery center and named it after her. In all talks and forums since then they share Alyssa's story, in the Opioid forum discussed in the last chapter we saw the way that they continue to blame the legal structures for not doing enough to have prevented her death. They both publicly critique the infrastructure around substance use disorder while also using their money and the money obtained through grant or donation funding in order to create new infrastructure to support people suffering from the same disease. They have several of their own inpatient rehabilitation homes as well as a business that hires out of these homes in order to provide women with a reliable schedule and source of income.

As they work to protect the lives of other women, the specter of Alyssa haunts them. Several of the women who went to stay in those rehabilitation homes left saying that they felt incredibly pressured by Alyssa's parents, that they seem desperate in their treatment of the women who come to them for help. It feels to these women as though the couple takes their relapses to be either a personal failure on the part of both themselves and the women, but also a reinforcement of the trauma that they experienced with their daughter. In this way we begin to

see that Alyssa's suffering not only affected herself, but her parents as well, and that that suffering extends to other people in a myriad of ways.

Negative impacts of intervention

The third pillar of social suffering is that sometimes interventions intended to reduce suffering inadvertently make the suffering worse. For this I call on the work of Chapter two as well as the first section of this chapter wherein legal interventions intended to be protective of those with SUD. In the case of lighter repercussions for those who are caught with substances and the intent to distribute it is intended to protect community members who deal substances in an effort to support their own disorder. However, at the same time it protects criminals who intentionally profit off of other people's illnesses and have no connection to the community or the people in it. This makes it easier for outsiders to come in and do damaging things like provide community members with dangerous amounts of substances cut with a variety of other things in order to gain a profit without fear of legal repercussions. This is dangerous to people with SUD even though it's intended to be protective.

As mentioned earlier, the interconnected nature of the SUD and mental health rehabilitation facilities and the carceral prison system results in a community stigma against those with SUD. While the goal was to escort someone to rehabilitative services with respect to the medical aspect of substance use, the social connotations lead to the reinforcement of the belief that those with SUD are violent and a danger to the community who must be removed from the rest of the community. As a result these people are ostracized and have no choice but to connect deeply with one another and form complex social relationships like those seen in *Righteous Dopefiend (2009)*.

Mixing of Social and Health

The final pillar of social suffering is that social and health problems are intermixed. For example, the need for coordination of social and health policies in response to the clustering of inner-city violence, substance abuse, depression, and suicide (Farmer et al. 2013). Further, this piece is stating that the issues experienced by people in one place, like an upper class individual in the greater Boston area, is very different from the experiences of people in my rural Vermont town of Elm. The example that we've already discussed for this situation is health care and traveling nurses. Substance use care in the Elm Emergency Room is very different every couple of months as the staff rotates, substance use sensitivity training ranges depending on staff experience or whether the Recovery Center has been able to do a training event with staff. It's precarious and inconsistent. Meanwhile in areas where healthcare is more stable, there are less staff changes, protocols are established, and there is adequate funding this image becomes very different.

Veena Das builds on this in her book *Affliction* when she brings up biosecurity and biopolitics in respect to the way that nations are expected to secure or promote life of those within them through various programs. However, civil rights as well as biological and political citizenship are contingent on humans within a social network. Citizenship in this way might be understood as a form of belonging and a shared effort on behalf of institutions and communities to support the health of one another. As we've discussed however, those with SUD find themselves at the social margins and often lose the protections that ought to be afforded through the apparatus of biosecurity. In a sense, like discussed in Chapter Two, those with SUD become the subject of triage. In this case, the triage is a form of *social* triage where there is a decision for

which groups should be afforded the best care and due to assumed aspects of criminality, the long term socially determined nature of SUD, and high incidence of poverty they are not considered a high priority and their health suffers.

Das emphasizes this when she brings up the rollbacks of public health and welfare programs as well as the privatization and individualization of wealth (2015). Struggles with the welfare system include stringent regulations on who may or may not be placed on disability (Das 2015). Most basically it requires a diagnosis, which, for many in rural areas or with chronic conditions is difficult if not impossible. Additionally, the disability must be considered “severe” and be on the list of qualifying conditions which is limited at best. Public health funding is also reactionary, the US government allots more money in response to large scale and rapidly spreading illness such as AIDS and COVID-19. Outside of these crises funding is limited and rarely able to be spent on treatment for conditions like SUD due to the fact that they require high levels of emotional effort, and monetary investment. Instead funding often goes to other forms of preventative healthcare like health inspections and vaccine clinics.

Finally, the privatization and individualization of wealth has led to a focus of health distribution among the wealthy, while those in poor and rural areas have limited access. Despite the fact that the 2010 Affordable Care Act was intended to provide low-income individuals with higher levels of health care, there remains a high cost for health care both in the form of smaller scale day to day copays as well as larger debts for surgeries not covered by insurance. In Vermont, Medicaid insurance is provided for people who are low income and provides full or nearly full coverage for many medical and prescription costs. However it only covers procedures and medications that are desperately needed for the individual and it isn’t uncommon for both individuals and doctors to have to contest decisions made by Medicaid regarding coverage. Thus

costs like SUD rehabilitation facilities tend not to be covered or if they are it is only for a short period of time. Additionally, Medicare, the insurance intended for those who are 65 years and older, requires a certification from a doctor who states that you have a serious condition that requires 24 hour care and attention. Even then, a 60 day stay has a co-pay/deductible of $1,632, between 60-90 days it costs $408 per day, the cost increases to $816 for stays over 90 days. At 150 days, coverage ceases and you have to bear the cost. Even this does not discuss the payments for short stays in a variety of locations as tends to be the case for many people with SUD.

This aspect of social suffering takes into account the ways that health and policy are interconnected and these changes to society have insurmountable impacts on the wellbeing of people who are low-income, especially those with SUD.

Recap

Having gone through the pieces of social suffering it clarifies the enormity of social suffering that is caused by SUD, which is furthered by the ways in which social and relational worlds are implicated in that suffering. Each piece provides a different lens as we endeavor to understand the all-consuming nature of a disease like SUD that has such clear social aspects. The social is often buried, issues like structural violence are intended to be easily forgotten, as I will discuss in the next section on habituation. Other issues like the interpersonal aspects of social suffering show the ways in which entire social groups become engrossed in the suffering of one person in ways that become pervasive even outside of a given local world. Meanwhile negative aspects of intervention and the mixing of social and health demonstrate the ways in which the state is further embroiled in issues of individual and community health violences regardless of good intentions. This demonstrates and unpacks the interconnectedness of social and institutional that we have been working toward throughout this thesis.

Habituation

In this chapter we have discussed the many ways in which the social world impacts health for people with SUD ranging from stigma, to the complex inner workings of local moral worlds and social suffering. Yet this still leaves the question, how does this happen? Laid out like this it feels shocking and problematic, but it is something that we allow to happen unquestioningly. This section endeavors to wrap up that final thread by addressing the way in which people begin to stop asking questions about their circumstances and simply accept them as fact. To do this I utilize work in the psychology discipline, wherein habituation refers to a situation where a stimulus that is repeated frequently and at predictable intervals over a period of time slowly begins to be ignored by the brain. The brain stops seeing it as an intrusive issue as it becomes expected and therefore background to other things that are at the forefront of mind (American Psychological Association 2024). While this is primarily used in examples like ringing a bell and having someone react less and less over time, there have been some cases of emotional habituation. For example, school shootings, due to the fact that they have begun to happen regularly and in a sense predictably, people have begun to stop having the shock/horror reaction to their occurrence. An understanding of habituation allows us to have a greater understanding of the social suffering of SUD.

Thus, we return to the first pillar of structural violence, for which I find it valuable to refer to anthropologist Elizabeth Povinelli who encourages us to think of these instances of day-to-day structural violence or failings as “quasi-events” (2011). She identifies these as small events that happen and are overall upsetting or damaging but that are often ignored or even normalized unquestionably. This is compared to large institutional violence where there are “events” or “crises” that obtain great attention through social media and are thus provided

humanitarian aid and other forms of support. A Vermont example of this is the catastrophic flooding that began the summer I started this research in 2023 and has continued in cycles since. In this case we see an influx of outside support from organizations like FEMA, as well as support from less associated groups, for example car insurance companies extending bill due dates until later in the month and waiving “no payment” penalties for people in my area.

Meanwhile quasi-events in this context are things that become taken for granted and assumed as true, that this is the way of life or way of being. She says that it is something that "happens yet doesn't happen at the same time" a daily occurrence that while damaging doesn't demand attention on the same scale as a "crisis” (Povinelli 2011). These events and the reactions to them become habits, and people are desensitized to them as a result of the fact that they are beyond control or reproach. Veena Das says that “Because of the strong emphasis on intentionality and agency in our contemplation of ethics, habitual actions are often reduced to ‘mere behavior’”(Das 2012, 139). It expresses a notion that people's behaviors are a result of or otherwise routinized actions that embody social values. Because they are not moments of contention or violence they are overlooked, despite the fact that they speak more to the conditions that one lives in than many other points of focus.

Quasi-events inconveniences that cascade into damage, the beginnings of which are drivers of habituation, some examples we’ve discussed include: a lack of phone access, available health personnel associated resources (bed space, training, naloxone, etc.), public transportation, and education. Many of these are, if we dig even more deeply, a function of poverty within a rural area where there are scarce resources for those who are in need of them and the lack of any different history leads to an expectation that that is all that there can be. With the addition of dependence on even subpar medical systems, it creates a system where the needs of upper lower

class and middle class are taken care of and do not recognize a need for change while those whose lives are intimately defined by a “lack” are unrecognized and erased beyond their use as objects of stigma.

Habituation and quasi-events are in this way also connected to Margaret Lock’s situated biologies, as the sociocultural environment changes people initially have concern over the ways in which their access to healthcare and the ways in which they access it changes, but over time it simply becomes part of the landscape. Returning to the issue of flooding in Vermont, one of the areas that experienced severe flooding contained one of very few Health Centers in the rural area; it had on its grounds a community health vending machine with free naloxone. In the lens of habituation and quasi-events, this becomes the big event: the issue of crisis. All subsequent issues regarding access to care that were discussed earlier in the section on social suffering become quasi-events that are habituated into the community until people no longer question why they have less access to community care services than they did previously.

Ultimately, throughout this thesis we see that there are a variety of factors acting on an individual with substance use including a long history concerned with the moralization of personal action that manifests itself in current iterations of stigma that are individually damaging. The social constructs the individual as a danger to the community and largely strips them of agency as it pushes these individuals either into the carceral system or to the otherwise fringes of society wherein they build their own moral worlds. These moral worlds are a result of a variety of structural failures that manifest in social suffering as defined by Arthur Kleinman, and the repetition of them leads to a habituation and normalization of suffering for those both experiencing it and those who passively perpetuate it. All of this, in addition to the material from Chapter Two builds toward the understanding that those with SUD and similar sufferings are

rendered silent through multiple avenues and are thus unable to communicate their needs resulting in problematic systems of care. In his article “About Suffering: Voice, Genre, and Moral Community” within the book *Social Suffering*, David Morris states that silence is “a sign of something ultimately unknowable,” wherein he is referring to the way that suffering is largely considered to be directly untranslatable through language (1997). As a result one is silent. My contention, however, is that if people are unable to communicate and advocate for themselves and their struggle, another avenue should be created and emphasized in order to do so. In my fourth chapter, I will delve into the ways in which I find value in art and art therapy as an alternative form of expression and communication for those with SUD to support and advocate for themselves.

Chapter 4: The Feel of Struggle

Implicitly, through both Chapter Two and Three, I have been building up to an argument about voicelessness. This was exemplified in Chapter Two when nurses overrode patient opinions and choice because of their internalized notion of addiction, thus speech and self-representation are inaccessible to people with SUD. In the second half of Chapter Two as well as in the first third of Chapter Three, I focused on the legal system. Specifically, the way that people, especially those with SUD, are constructed, throughout history and as a result of a variety of social processes, to be considered dangerous. This is another way that people with SUD are unable to represent themselves: due to preexisting notions of the dangers they pose, they are often removed from the community for the safety of everyone else. In the second section of Chapter Three, I endeavored to emphasize the ways in which people with substance use disorders are living a life within their own set of terms as a result of the way that the built and social environment enforces all aspects of social suffering upon them. People with SUD are rendered voiceless due to the fact that their community confers social value in ways that makes their actions taboo compounded by structural barriers that render their problems incomprehensible to those without them.

In this chapter I endeavor to make this construction of voicelessness even clearer by focusing on the ways in which pain, suffering, and trauma[6] are experienced and the difficulties

[6] In this sentence I use the word “Trauma” and I feel the need to mention that I am aware that it is a word with a complex history. Even during the genesis of this project I discussed with professors who agreed that trauma is a word that seems to mark an individual specific event, a crisis, ultimately it feels as though it means something very

associated with expressing those experiences. I will begin this by discussing essayist Elaine Scarry's book *The Body in Pain,* in which she focuses specifically on the way that disturbances of bodily processes, such as pain, can lead in and of themselves to voicelessness due to the nature in which we can and cannot speak of pain. I then deepen this discussion through the use of David Morris's chapter "About Suffering: Voice, Genre, and Moral Community" in the book *Social Suffering*, in which Morris agrees with Scarry while also pointing toward the importance of seeing the ways that suffering is habituated. This is followed up by a discussion of Allan Young's chapter "Suffering and the Origins of Traumatic Memory" also in the book *Social Suffering*, which highlights the way in which emotional suffering can either become physical or be so severe that its ramifications are adjacent to physical pain. Young's work allows us to more concretely understand the ways in which suffering associated with SUD removes voice in similar ways to the ways pain creates voicelessness in Elaine Scarry's *The Body in Pain*.

I move on to bridge this work with an Imagistic understanding of suffering centering Lisa Stevenson's book *Life Beside Itself: Imagining Care in the Canadian Arctic* in a discussion about knowledge production through art work. Building on Scarry's notion of pain as something that is unreal and must be made real, Imagistic Care agrees that things that are "real," or otherwise

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specific. Throughout my research I found a variety of other words for trauma such as: suffering, *malheur* (french), illness, affliction, and more.

While it does seem important to me to dig in deep and discover the specific meaning of trauma and to use it most correctly, it is also a colloquial term. It wasn't uncommon for my interlocutors to use the word "trauma" to say that something upsetting or damaging had happened to them at some point in their lives. Further, other publications such as *The Body Keeps The Score: Brain, Mind, and Body in the Healing of Trauma* by Bessel van der Kolk which have the word trauma in the title do not clearly define what is meant by trauma but rather use it as a form of earmarking. It functions in this way to indicate that someone has gone through something that causes damage to them physically, emotionally, or both but is not described further.

Ultimately, a discussion of trauma and its many meanings is beyond the scope of this thesis. As a result I will be using the word trauma in a similar way to the one above: to reference a moment of pain that resonates and persists.

In general throughout this thesis I've chosen to use the term "suffering" for its wide applicability and instant understanding. In the next section, Elaine Scarry will use the term "pain" speaking specifically to physical pain but as I will discuss, pain's effects can and often are synonymous with the more general "suffering" that I am focused on.

tangible; but, she focuses on the meaning of images, concluding that they may ultimately be indecipherable yet still have value. Images here, build on and transition us into a discussion of art and the ways in which art creates and provides opportunities for people who are suffering. To further this turn I present a series of art and projects the Recovery Center is already invested in, the ways in which it is already a pervasive and appreciated aspect of the recovery project. Concluding this chapter I present a view for the future, a manifesto, highlighting the values of art in order to combat the varied kinds of suffering that have been discussed in this thesis largely centering on the topic of providing voice for people who have lost it.

Manifestations of Trauma, The Language of Suffering

At the center of this thesis, across all topics, –from biomedicine to policing and stigma– is an issue of communication. Repeatedly people with SUD have been unable to advocate for themselves, as a matter of fact, the only people with SUD who have really talked in this entire thesis have been people in long term recovery. Not people who are still facing the challenges of their use, and it's ravages on their health and social network. There is something behind this voicelessness, which Elaine Scarry delves into in her book, *The Body in Pain*. Specifically, she says in her introduction that "there is no language for pain." Pain is something that is starkly visible for the person who is suffering but largely invisible for someone who is not (Scarry 1985). She furthers this by asking "how is it that one person can be in the presence of another person in pain and not know it – not know it to the point where he himself inflicts it, and goes on inflicting it." (Scarry 1985). This quotation speaks to a couple of the aspects of social suffering

that were discussed in the last chapter. Specifically, she lets us hone in on the way that the breakdown of communication creates damage in interpersonal relationships when people aren't able to name the ways that they are inherently in pain as well as how someone else's words or actions compound that damage. In substance use we might think of this as people bringing up past trauma or conflicts that had a more damaging impact on the other person. Additionally it could be someone without SUD either trivializing the experience or failing to recognize it as a problem and accommodating it, ex: only having alcoholic drinks at a friendly gathering[7]. Further, the inability to communicate the specific kinds of pain or suffering one is experiencing to larger institutions results in legal, political, and medical interventions that do not meet the needs of the people they are intended to help. This often ends up causing more damage than simple non-intervention.

She expands on this issue by saying that "Pain enters into our midst as at once something that cannot be denied and something that cannot be confirmed." and "to have pain is to have certainty: to hear about pain is to have doubt." (Scarry 1985) These sentiments become increasingly salient in the cases of suffering that is not immediately visible to an outside observer. Someone who breaks their arm, tears the flesh open and bleeds profusely, is undeniably in pain. Even if the communication of that pain is fragmented or reliant on another person's assumption of what that pain feels like it cannot be dismissed. Pain related to illnesses that are not visible, like SUD, falls into an abyss. It requires language in order for it to be realized in its existence. Scarry emphasizes the lack of language here when she identifies the use of metaphors for communicating invisible pain: "Thus a person may say, 'it feels as though a hammer is

[7] This specifically has been a large issue in Vermont as drinking is a very social activity there. Most gatherings have alcohol of some sort and many teenagers start drinking very early. In the Recovery Center that I worked at there were stickers for people to put on drink coolers to indicate which one contained alcoholic beverages and which ones were non alcoholic. This was intended to: reduce the incidence of younger people from drinking alcoholic beverages, remind people to keep non alcoholic beverages on hand during these parties, and be sensitive to concerns of relapse by those with SUD.

coming down on my spine' even when there is no hammer " (Scarry 1985). This language based on weaponry has two advantages, it provides imagery and description relating to the attributes of the pain. It also connotes a sense of agency, implying that the pain is caused by someone or something that has been acted against them through some form of violence.

Through the implications of the language of weaponry we are able to deepen the discussion of institutions and systems as dangerous and violent to the individual who suffers from an invisible or social disease. Due to the fact that the pain is invisible, people often are provided with "absurdly negligent medical treatment" (Scarry 1985). Emphasized by the way that Scarry positions the doctor as the torturer's "right hand man" in light of how a doctor "inflict(s) brutality himself." (1985). This is another way to understand the discussion of Sameena Mulla's the object of medical care; particularly when carers associate themself with imagined criminal cases, their focus results in a "second rape" or secondary violence as the person isn't provided proper care and their suffering is compounded (Mulla 2020).

Yet with all of Scarry's discussion that focuses specifically on "Pain," the book is after all interested on larger issues of torture and war. So we need to bridge the gap between her descriptions of extreme pain, and a more mundane sense of "suffering." We are able to do this through the article "About Suffering: Voice, Genre, and Moral Community." in the book *Social Suffering*. The author, David Morris begins his discussion on voice by relating it to its opposition, silence. Morris says that "the basic opposition between voice and silence matters here because suffering, like pain, with which it so often intermingles, exists in part beyond language." (Morris 1997) This supports Elaine Scarry's belief that there is a disconnect between suffering and language, that there isn't a specific language for suffering beyond metaphors that are still unable to convey the suffering accurately and with all of its dimensions. He also posits

that "even when words prove at least partially adequate, even when speech occurs, communication fails." (Morris 1997) Morris says that this is often due to the fact that aversion and detachment are an outcome of a structural position that we construct and cannot help but occupy. Pointing once more to the way that both groups and institutions become passive in the face of suffering experienced by those who are marginal, suffering, and otherwise unable to communicate; silent. It also deepens the discussion from earlier on. The negative impacts of intervention, as we understand them, are often caused by not simply an unwillingness, but a pure inability of institutions and policymakers to engage in meaningful conversations with people who are the focus of that intervention.

Following this line of thought I'm interested in continuing to bridge the gap between general suffering and the physical "language destroying" pain described in Elaine Scarry's work. We've established that pain itself, which is largely characteristic of the local moral world inhabited by people with SUD, creates impacts on people's ability to convey their experiences to those outside of it. I now find myself more curious about these entanglements between the psychosocial and the body itself. How do these things work together in order to create the voicelessness and erasure that we see in cases of SUD? Psychiatric anthropologist Allan Young's 1997 article "Suffering and the Origins of Traumatic Memory" tackles this issue as he discusses the way that emotional or external traumas can be manifested physically within the body. A critical to the translation between Elaine Scarry's book *The Body in Pain,* which focuses on the way that *physical* pain breeds voicelessness, and SUD. Young creates this bridge through his use of the psycho-physio concept of Shock, a set of characteristic symptoms without causal mechanisms that follows traumatic experiences. These symptoms, as recounted by a doctor, include:

> Incoherence of speech and thought; the surface becomes covered by cold sweat; there is nausea, perhaps vomiting, and a relaxation of sphincters…, In extreme cases, the depression of power characterizing shock may be so great as to terminate in death (Young 1997)

Edwin Morris, a surgeon with an interest in railway incidents then defined Shock as an effect that is "produced by violent injuries from any case, or from *violent emotions.*[8]" (Young 1997). It's an instance of the nervous system acting directly on the brain (Young 1997). One of the primary associated causes in Shock cases was fear, often of pain, both physical and emotional. There were patients who died of fear before even having surgery because of the assumed pain of it (Young 1997). Thus, Young says, "fear is simply an assault, comparable in its action to a physical blow or injury" (1997). As a result the shock associated with an event is not always proportional to the event. The experience and symptoms of shock can be experienced even without a repetition of the exact traumatic event; this is considered to be a memory of pain, which develops into Post Traumatic Stress Disorder or PTSD.

Those with a history of trauma, or embodied suffering, often use substances, as mentioned earlier, to self medicate. Also as previously mentioned, those with SUD may be people who have lived tumultuous lives largely characterized by physical and emotional violence either as dictated within the bounds of a local moral world or through specific incidences and generational violence. Using Young's lens we are then able to understand the lifelong effects through his description of Shock and PTSD. Those with SUD are experiencing a biological and ingrained reaction to wounds that metaphorically continue to bleed long after they have been inflicted. The body responds in ways outside of their control, they have internalized a form of fear and go through their lives with recurrences of trauma that sometimes create physical

[8] Italics self added

symptoms like incoherence, cold sweat, nausea & vomiting, and depression[9]. In this state it becomes difficult to communicate, due to the innate and symptomatic incoherence, as well as dredging up emotional experiences which can be itself difficult. It can worsen those symptoms as well as simply be impossible to convey the severity of how something impacted them.

Imagistic Care

In the above section I've endeavored to use existing work to help understand the challenges associated with communicating pain, trauma, and suffering, in association with self-representation and agency. One of the issues then becomes one of knowledge production, throughout the rest of this thesis, knowledge has been produced by people without substance use disorder. People who are concerned about the impacts of SUD on others but less concerned about the sufferers themselves. Thus I call on Lisa Stevenson, who, in the introduction of her book, *Life Beside Itself: Imagining Care in the Canadian Arctic*, digs into the meaning of images. She says that knowledge is produced in specific ways and that it tends to be in ways that are concrete and unchanging, meanwhile images "have a power over us that we can't fully control" (Stevenson 2013) since they cannot be fully and faithfully translated, they "drag the world along with them." (Stevenson 2013). Further, she states that images, regardless of their ambiguity, simply exist, they can't be ignored even if their meaning is not clear (Stevenson 2013). This is both a parallel and a juxtaposition to Elaine Scarry's dealing with pain where she says that pain is not real to another person because they cannot see it, they cannot feel it. Stevenson proposes that there is a way to make something real for someone else, and it is through an image.

[9] It is also critical to note that these symptoms are also symptoms of withdrawal, which is another example of the ways in which SUD creates a kind of pain or trauma that becomes difficult to communicate.

Stevenson expands by saying that one does not need to formulate an emotion, meaning to describe its process, in order to experience it and for that experience to be visible on someone's face. Further, that images do not need to be formulaic, rather that as Roland Barthes (1997) says, images have a 3rd meaning which is the meaning beyond its obvious meaning, it's what the image symbolizes.

When investigating Freud's work on images and desire she says that "we do not always want the truth in the form of facts or information; often we want it in the form of an image. What we want, perhaps, is the opacity of an image that can match the density of our feelings. We want something to hold us" (Stevenson 2013). This is most explicitly a declaration of the lack of evocative value in statistics.

Through this description Stevenson constructs the image as: something that communicates, that exists undeniably, has multiple meanings, both the explicit and implicit symbolic meaning. The image is something that evokes, that "holds us" through recognition of an experience rather than something that merely tells the exact story of it. It's interpretable. Opening up the way for the image provides us with an avenue to incorporate community based knowledge and personal histories rather than simply focusing on scientific works. What both Stevenson and I are asking you to consider, is the utilization of the image, or other kinds of art as part of a bigger project of cultural change. I'll show in the next section how it's already being utilized in many ways.

Colorful Centers for Recovery

Before the above section, Art had not been thoroughly integrated in this thesis; rather, I've made points that show dysfunction, as well as both direct and indirect harm that are in need

of addressing. Here, I utilize art due to the ways in which it becomes another way of creating knowledge, of crossing a linguistic barrier in which the voices of people with SUD have been ignored and unheard. In a similar vein, art can also be utilized as "art therapy" which I contend is another form of communication. In this case, it helps people to communicate with themselves, creating stability and reducing tumultuous feelings. Here, I will show the ways in which art is already being implemented in the Recovery Center at which I worked before I propose the ways in which art may be extended to serve more people and purposes.

The best way to begin this is with a vignette that focuses on the different experiences of art within the Recovery Center context.

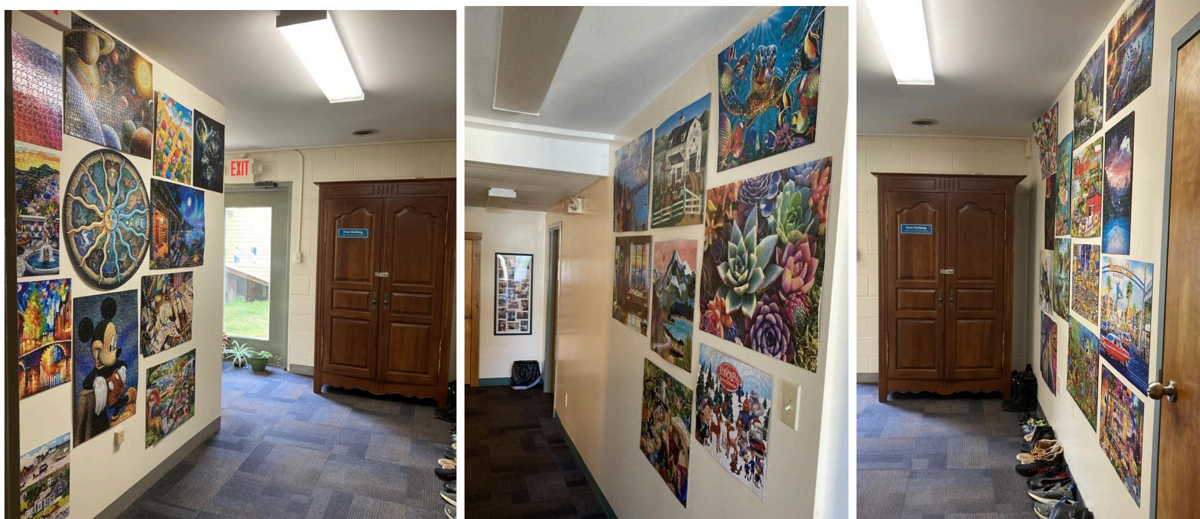
Making a Home, Making a Family.

Walking through the front door of the center for the first time I was confronted with a giant, half completed coloring poster that said "Welcome" in swirling multicolored cursive. On the chair below sat a basket filled with colored pencils. Just beyond stood the door to my office and to the right of it a floor-to-ceiling chalk art wall, covered with quotes and doodles by children along the bottom. Whenever I had any downtime, I was encouraged to do something artsy, to engage with these and any other art projects I wanted to. The staff was intent on creating a space that wasn't domineering or controlling, that encouraged brain breaks, creativity, and flexible workspaces; it was curated to be comfortable.

One of my projects was to paint cornhole boards for a fundraiser. They encouraged me to be as creative as possible and spend as much time as I wanted on it. I often spent days in the summer sun sitting on the top of the picnic table or in the shade trying to blow dry waves out of wall paint I'd mixed with water, it didn't go well. I often felt a pit in my stomach thinking "This isn't what interns are supposed to do." In my vision of what being an intern was intended to be, it was all dark offices, research projects, and getting coffee. This was warmer and felt more fulfilling.

Later in the summer, we started working on puzzles every day, the central table in the living room very rarely became a site for coffee, instead covered with puzzle pieces and half-finished edge sections. When they were completed we would break out the Modge Podge filling the entire room with the scent of craft glue, often causing us to open the

nearby garden door and let the fresh air in as we solidified the puzzle into one piece and added it to the stack of completed ones on top of the short white chest freezer. At first, it was just something we did because it was fun, because our boss had brought in a couple of hers and we were all quickly addicted. But soon, it became a site of conversation. Those in need would come in, grab a coffee, and sit down on the couch to talk with us, absently messing with the puzzle pieces to move their hands and work through anxiety.

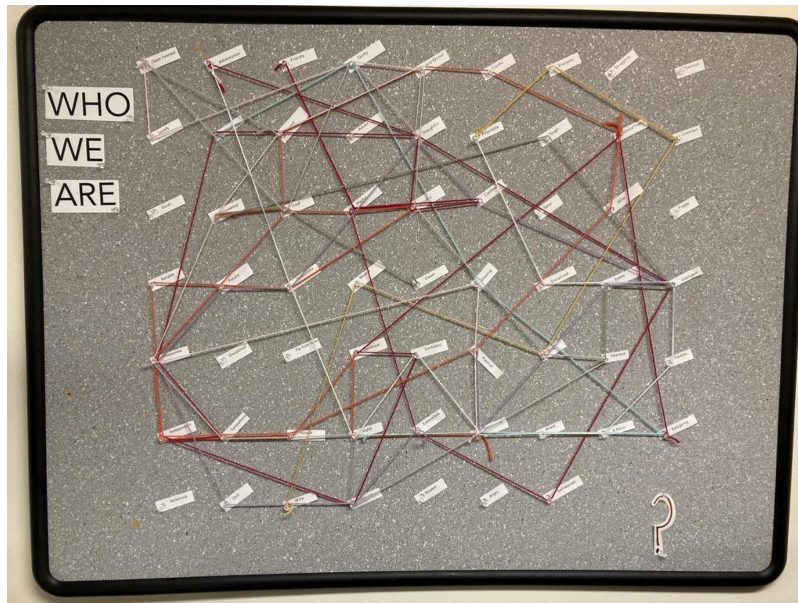


On one slow Friday afternoon, I asked my boss if there was anything that needed to get done. She said not really and encouraged me to look around and try to figure out what kinds of art we could do. We recently had the opportunity to expand into the other section of the building which was previously inhabited by the building's owner, so we needed more things to put on the wall as well as projects to get people engaged with during an open house. Having grown up with a crafty DIY single mom, I knew the first place to look for ideas would always be Pinterest. So, I searched for community art ideas, and school art projects. I quickly compiled a list of coloring pages, painted rocks, black out poetry, and a handprint wall where the prints formed different pictures such as butterflies or trees.

But the one that I quickly became attached to was an identity wall. It was first done in a museum, and the concept was to have pegs with labels that could relate –in a variety of ways– to identity, and then there was yarn available to thread through and around the pegs. The intent was to create art that visually represents interconnectedness. Once I latched onto it, I started looking for other ways that this had been created. There were other ones such as a "what makes me:" wall where different colors represent emotions or states of being, as well as data projects that visually represented demographics like age, gender, and occupation.

I emailed a Notability pdf around to all the staff to get opinions on all of the ideas I had compiled, heavily emphasizing and bringing up the identity wall during many subsequent conversations. It was finally agreed that we would create one and I was tasked with determining what would go on it. When I looked at the other ones online the artists discussed their deep research on the local communities in their efforts to create not just an exhibition but one which was tailored to the people in the place and their lifestyles. So I started by making a list, I imagined how large the wall would be, knowing that the building wasn't that large and that we intended to put it on a large corkboard so it didn't damage the actual walls. My assumption was that we would do 10 by 10 pegs or 12 by 10 depending on the size. So I set about trying to create tags for 100-120 pegs. I created category headings such as demographic information, community partners, and positive characteristics and then started creating lists of terms or titles that I felt could fall into those categories. I ended up getting more labels than could reasonably fit, and it was completed just at the end of my internship. So, I sent this document to the programs director along with my boss in order for them to implement it for the open house after I had left.

When I returned to the Recovery Center during my Thanksgiving break some of my coworkers gave me a tour of the extended version of the facility. In our new section there was a large conference table and at the head of it was the cork board with a "Who We Are" title on the left and a grid of thumbtacks threaded through with multicolored pieces of yarn.



Once again Imagistic Care is a discussion of the image as another form of knowledge production and how we discover avenues for people to create their own voice when they have historically been unable to. It's an issue of representation as much as it is a discussion of healing. In the vignette we see an image of people who don't fit the mold prescribed by society that people with SUD are "dangerous to the community" rather these people are creatives, engaged in recovery and a brightening of their lives. At the same time we get a sense of the way in which the people of the recovery center are "held" by art.

People at the center are not particularly concerned with statistics and the world writ large, unlike many of the speakers at the Opioid forum in Chapter Two who used these statistics to show evidence of accomplishment. Rather, the people at the center, like Tyler our Assistant

director communicated through his own speech, are more concerned with the interplay of emotions, of seeing themselves in one another, and the incredible need to help when granted the opportunity. Even when I asked in interviews how the staff measures progress or accomplishment, how do they know if a program "works" or not, none of them really knew how to answer me. Numbers don't mean anything there, rather if it causes one person to reach out to them, they would consider that a form of success. The peer model is an imagistic one: it's not entirely decipherable and rather than challenging that, it accepts indecipherability, "expression without formulation" (Stevenson 2014). Yet, Tyler's speech became the one which was repeatedly mentioned, it stuck with people, and changed the landscape even after Alyssa's parents derailed it. He stuck with people, the image of the person with SUD in the emergency room, lonely and suffering, yet being offered care through the recovery center became central to the event and to the ways that some people discussed SUD in the future.

Bridging the Gap, a Manifesto for Art in SUD

Having worked with the amazing people at the Recovery Center and learned so much from them, it has helped me to envision a potential future. Looking toward that future I contend that:

- Art provides a voice for people who have lost theirs.
- Locations of art and art therapy function as a respite and create community connection.
- Art is a form of social justice, it promotes individual agency.
- Art can be utilized as a form of psychological first aid.

Over the next several pages I will expand upon these points in order to discuss the ways in which art can change the landscape for people with SUD, especially in rural communities like the one I researched. Art is already influencing people's lives, this is simply an explanation combined with a desire for continued change, a belief I have in a better future.

Art Provides a Voice

One of the most critical aspects of art is that it allows for suffering and experience to enter into the realm of shared discourse outside of purely medical contexts. Elaine Scarry believes in the value of narratives and poems in doing this work, calling on the work of author Virginia Woolfe who complains about "a lack of literary representations of pain" (Scarry 1985). Juxtaposed by a seeming surplus of suffering shown in art, to the extent that they have become considered the "most authentic class of sufferers[10]" (Scarry 1985).

As mentioned earlier, visualization is the most authentic way of understanding for people to understand pain, this is the same for suffering. Scarry said that pain is "unreal" to people who cannot feel it, when explained they get the sense of it but cannot feel it and it cannot be proved (1985). Art makes pain tangible and undeniable, it is visual, and the attributes of the art allow for understanding of the attributes of the pain that cannot be expressed or transferred verbally.

One of the benefits of making suffering real and entering it into the sphere of the public discourse is that it can be utilized for a political project. Visualizations have been used for obtaining aid for many years. The humanitarian aid system is largely based on the optics of disaster and violence of crisis. Art work helps elevate the experience of people with SUD from

[10] Scarry also warns that because of the fact that artists are so incredibly able to communicate their suffering through art they may draw attention away from those who are still in need of assistance. I recognize this as an important and valid argument, however my belief is that people who are in need of assistance, should turn to art due to the way that it is so radically communicative, thus reducing the number of people not using art who are thus overlooked.

something mundane to something that can be understood more clearly as a violence in need of address. This work can then be promoted through social media and through exhibitions. For example, The All Genders Photo Project held an exhibition in Yukon Canada of art produced through an art therapy program for transgender and two-spirit individuals (Brown and Omand 2022). The people in the program curated the contents and audience of the exhibit in order to show what would be the most critically important of what they were trying to communicate (Brown and Omand 2022). They also invited policy makers and teachers who they could talk to and hopefully show work that would influence future policies to focus on the experiences and needs of the community (Brown and Omand 2022).

Artists have used art for social protests. For example, Georgette Powell from New York City took part in the Harlem Hospital Muralists program early in her career, as well as introducing a new program "Art in the Park" at Malcom X park which was an annual event for 30 years. Her work was centered on the civil rights movement, and aimed to produce art that showcased the racially and economically diverse populations of the area.

Artists have also been crucial for other forms of social change. For example: the promotion of organ donation. Margaret Lock (1997) reports that after the 1994 international conference on organ transplantation, this treatment "started to capture the imaginations of the media and the Japanese public" (Lock 1997). As a result, Kyoto held an art exhibition using pictures of children who had received organs alongside their medical histories. This art exhibition was able to jumpstart a shift in beliefs, where organ transplantation began as something taboo and breaking the laws of human function, living off of the dead; it now began to characterize continuity and life (Lock 1997). Art has shown its ability to facilitate these changes. It is my belief that it can continue to do so in substance use contexts to reduce the understanding

of SUD as taboo and its sufferers as inherently criminal or "dangerous to the community," and instead promote them as people who are simply human.

Art exhibitions can also provide a sense of longevity, continuity, and solidarity. In the book, *Museum Objects, Health and Healing: the Relationship Between Exhibitions and Wellness* by Brenda Cowan, Ross Laird, and Jason McKeown, Chapter 10 focuses on health and healing in the museum setting, specifically in the context of The War Childhood Museum (2019). One of their interlocutors says that "The museum is a time capsule and you are part of the time capsule. I can come here and feel a satisfaction that I am a part of here" (Cowan et al. 2019) another stated that:

> They fight; this is our scream with all others united. My scream [object] is a small scream. Together with the other objects it's one big message to never do this again. The things, they scream so people – the decision maker – don't do this again. This is a process of waking up this empathy (Cowan et al. 2019)

Here, the donor/interlocutor places value on the object which has been donated to the collection as part of a historical project of violence and suffering, but also on the ability of the object to become a bigger movement. They use the word "scream" as though the object itself has a personal voice, it is in and of itself communicative to others. And I believe that it very much performs this role. The object means something, it is a marker of a specific history and of a person's suffering. It symbolizes that struggle and places it in the realm of discourse, as the donor says, the aim here is for this exhibition to change social understandings and policy by using art in order to elevate the voices of people who are unable to speak into the collective public consciousness.

It is also possible to look at the value of art and speech on a more individuated scale. In *Museum Objects, Health and Healing,* the authors invite us to share their interest in the therapeutic value of objects in and of themselves, like how people feel having surrendered objects into a museum collection or seeing that object in the completed exhibition. The emotional resonance experienced by an individual who has a personal stake in both object and collection. In a section entitled "The theory of psychotherapeutic object dynamics," Jason McKeown discusses the work that he does as a wilderness therapist, through the emphasis he places on objects and their symbolic meanings (Cowan et al. 2019). One example is of a boy who experienced major depression. Having gone through various other therapeutic treatments, the boy continued to struggle. McKeown told the boy to pick up a rock that he felt accurately represented his depression (size, shape, level of physical burden) and to carry it around. The boy carried it for a bit over a week, during which he was able to use the rock to communicate the way that his depression affected him, how it physically took up his time and energy. The way he described it began to change as well as he began to think of it as something separate from himself, something that he was in control of rather than simply a victim of. Later on as he continued to feel the way that the rock (symbolizing his depression) impeded his ability to move around and exist in the world, he decided "I want to let it go! I don't need it anymore" - and he threw the rock off of a ridge and into the darkened void below (Cowan et al. 2019).

This story shows the way that objects - in this case a rock, but also other objects that we may create - can be symbolic and change the way that we think about our experiences and pathologies. As previously mentioned, it creates an undeniable representation of something that is invisible. Utilized in this format however it can also be a treatment for people facing acute suffering in order to facilitate language creation and personal knowledge making about an

experience. It allows us to catalog the experience and transition from the status of a victim to that of a survivor. In an SUD context, this could be utilized after situations like an overdose when the recovery coaches program goes into the Emergency Department in order to talk to the people there and experience meaningful discussions with them that may influence their frame of thought about their experience.

Community Connection

In this way we can see that art has the power to remove stigmatized and suffering people from positions of isolation into situations of relation. The book *Contemporary Practice in Studio Art Therapy* by Christopher Brown and Helen Omand emphasizes the studio as a location for art and practice to exist. They do so with respect to the roots of art therapy's history with psychiatry and later the antipsychiatry movement, and the transition from studios in hospitals and asylums into community spaces. They recognize the need to prove that art therapy is a useful intervention in the current health climate, while also resisting the idea of the "studio" as a location is in any way a formal artistic space. Instead, they reference "the communal dining area of a homeless shelter to a table in a refugee encampment, a hospital warm or a graffiti wall" (Brown and Omand 2022). **In this way we are able to see the location of the Recovery Center as a respite, a safe space for people to go through and address their lives, behaviors, and histories in order to begin to heal from them. It is a form of a studio.**

The utilization of art therapy places the agency with the person as they can choose how much they engage and at what pace. Brown and Omand say that "a studio is a way of being together on your own terms, making or not making art, talking or not talking." It's a radical departure from clinical spaces where just *being* is impossible and treatment runs against an

emergency focused clock powered by the ideology of triage (Brown and Omand 2022). Art therapy is fundamentally the opposite of triage: it is a recognition that everybody needs care, but that care may look different and may exist on different timescales for different people. It is a dedication to include all without overlooking, free of deadlines.

Returning one more time to a conversation I had with one of my interlocutors:

She explained, people with substance use need a community. She gestured with her hands animatedly, nearly dropping her phone as she tried to put it into star-patterned leggings that lacked any. She used the analogy of a car, that you can't just stop using substances, it's like when you try to use hard breaks on a snowy road. You just keep doing it, and you probably end up in a ditch. You need people in that car and you need to be able to trust them to speak up before it gets so bad and to do so repeatedly.

Here, she highlights the need for people who have a shared need and agenda, who will keep you accountable and who are invested in your growth toward recovery. Art therapy and studio places create a location where these people can gather, discuss, and share history.

Brown and Omand also contend that studio spaces, where people gather, are also valuable spaces for sharing resources that people may need (Brown and Omand 2022). The Recovery Center in particular is first and foremost a referral agency. It functions largely as a location where resources are collected and consolidated in order to help people access things like gas money, food stamps, education, entrance into rehabilitation programs, medical and legal support. By creating a location, like the Recovery Center, where art and support services intersect it creates structures of support that act on both immediate emotional suffering (through art), as well as longer term resources that help people to move towards lifestyle stability.

Social Justice and Agency

In the previous two sections I have highlighted the way that art has the ability to visualize invisible injustices, but it also has the ability to combat the social imbalances between individuals and clinicians. Mary-Jo and Byron Good(2000) as well as Cheryl Mattingly (1994) have argued for the importance of clinical narratives in understanding contemporary doctor-patient relationships. These discussions can be expanded to include art as potentially fundamental to this process.

In her article "The Concept of Therapeutic Emplotment," Cheryl Mattingly discusses the way in which occupational therapists use "emplotment," a form of narrative writing in which one tracks their progress through time (1994). When discussing the value of emplotment Mattingly quotes social psychologist Erving Goffman who says that "We have a need not only to make sense, but to *create* sense out of situations" (1994). Mattingly then follows this up by saying that "A fundamental way we create sense is by shaping the 'one thing after another' character of on-going action into a coherent narrative structure with a beginning, middle and end" (1994). In this way, emplotment is about creating a coherent narrative, it doesn't depend on temporal time and necessarily what happened one second to the next, but rather on the vividness of lived experience, its reverberations, and various actors with motives (Mattingly 1994). It allows us to see outside factors in more depth, issues like discussed in the last chapter regarding social suffering becomes more clear when it is seen within a narrative that moves toward an end goal. For clinical narratives within the sphere of occupational therapy that Mattingly researched, the task, she says, then becomes: "to create a plot in which the 'ending' toward which one strives invokes a sense of what it means to be healed when one will always be disabled" (Mattingly 1994). Art, imagery, and narrative in this sense are about representation of progression, but more

crucially they are about constructing agency and meaning in one's life when it exists outside of the norm; it is about empowering oneself to continue to exist and to exist loudly.

Good and Good believes that these clinical narratives, which unfold in the medical encounter, shape the understanding of illness, treatment, and the doctor-patient bond. This relates to discussions in Chapter Two regarding medical treatment for patients with SUD, where the power between doctors/nurses and those in need of care is greatly imbalanced and individuals are not able to advocate for themselves. Good and Good emphasize that clinical narratives need to be co-constructed by both doctors and patients. As a result, the way these narratives are told and interpreted significantly influences the diagnostic process, treatment decisions, and the overall therapeutic relationship. Thus illness narratives are able to place a person in a human context rather than a clinical one, or in the case of SUD away from a combined legal and medical context into a purely human one.

Illness narratives can be written accounts as they often are, but they can also be artistic renderings. One of the clubs that I am on the board for here at Mount Holyoke is called Students for Health Humanities and we recently held a "Zine and Collage Making Workshop" in the Fimbel Makerspace. Here, participants were able to use a variety of materials (old textbooks, magazines, stickers, colored paper, markers, etc) in order to make graphic stories in the form of Zines or Collages about their experiences and associations with the medical system. Some of the highlights from this were feelings of anxiety, an insecurity about options especially regarding childbirth and women's reproductive rights, as well as more emotional zines from people who had conditions that left them feeling "not long for this world."

Additionally, I mentioned earlier an art project I worked on in the Recovery Center utilizing a large corkboard, tacks, and strings. This project was exhibited at the Open House that

was held after the building was expanded. Every single peg/tag was referencing states of being that are not inherently pathological, things like: “I am genuine” “I am joyful” “I am a good friend.” In this way the project worked to flip the narrative from people with SUD who have symptoms, to people who have SUD who are inherently *people*. Additionally it was intended to recontextualize people who feel isolated. Several of the people I met with during my research mentioned to me the way that they felt alone before using substances and then felt in some ways even more alone while using them. They felt unmoored and without a support system. The imagery of this was intended to be a web, where people are connected at points and disconnected at others, as a result it showed that although people were different, we share important aspects of ourselves and nobody is alone.

Psychological First Aid

Dr Carla Van Laar, referenced in Contemporary Studio Art Therapy, performed and filmed a workshop on how she uses art therapy as a form of psychological first aid. She begins by having everyone create a “mandala installation” where participants form a geometric figure out of pieces of fabric or other small items that they brought along with them; she does this in order to create a safe space (Van Laar 2020). It requires the participants to work together cohesively as well as creates a physical piece that is an embodiment of their interconnectedness. Following this she asks everyone to pull out their sketchbooks and colorful drawing utensils to create a “body map.” This is a sketch of a body that has additional marks and annotations that – rather than indicating specific body parts as we may see in a textbook – index emotions, feelings within the body and where people feel them. Things like anxiety, pain, and distress. This allows them to create a benchmark for the emotions before art has been utilized as well as to create a

plan for how to address specific feelings and tailor the program to the community it is being utilized with.

Van Laar then explains that psychological first aid is not debriefing to go over the past trauma, treating, diagnosing, or counseling. Rather, it is a process of making people feel safe, connected to others, and helping people to be able to access support so that they feel like they are able to help themselves (Van Laar 2020). Van Laar says that not everybody needs psychological first aid, however the risk factors, or groups most likely to need it are: people who have had previous traumatic experiences, underlying mental illness, have experienced a life-threatening situation, or have experienced the death of a friend, family member, or pet (Van Laar 2020). These characteristics are incredibly prevalent within the substance use and recovery community which makes this kind of treatment valuable as well as applicable.

Applying the process of psychological first aid to art therapy, Van Laar says that it is critical to begin by asking "what do you need" and then attending to whatever that need may be, such as "I need to charge my phone," "I need clean clothes," "I need a cup of tea." This helps people to feel more in control of their situation (Van Laar 2020). The first thing is to offer services and resources to encourage individual resilience and the ability to cope with whatever is going wrong in their lives. Only then can you offer art therapy activities, during which it is important to emphasize that participation is voluntary and it is a choice that they are able to make, again promoting self-determination and agency. Simply present it as something that may help people to feel calm or hopeful.

Art projects should be bright and colorful to help attract attention and encourage participation as well as promote hope within participants. Additionally, tactile projects such as clay, or building materials that create sculptures help people feel more grounded. She suggested

including prompts like “let's make a superhero” that help to guide people into questioning things like “what does a superhero look like for me today” “what would help me most today” that help them to inventory their resources and what potential actions can help to alleviate their needs.

Although psychological first aid is largely marketed as a program to engage in in the aftermath of a crisis, as it was utilized in summer of 2023 after the devastating flooding in Vermont, or as we planned to use it when I worked at the Northampton Department of Health on their Resilience Hub project. I propose that it is a valuable way to address everyday crises. In Chapter Three I drew upon Elizabeth Povinelli to mention a distinction between what we call a crisis and the everyday “Quasi-events” of normalized suffering. It is my belief that simply because it is normalized these instances of inequality and structural injustice remain harmful and people should have the opportunity to be treated with arts based psychological first aid in order to promote individual and community resilience. As people go through cycles of psychological first aid, they begin to see their strengths and abilities beyond the immediate scope of their struggle, as a result they will be more able to take care of themselves and continue to move forward in the face of larger instances of suffering and reduce the need for *“self-medicating, burying that stuff.”*[11]

Concluding Thoughts

This thesis as a whole is intended to show a way of life, to unpack and understand the stakes in community based healing work in rural areas, its challenges and its triumphs. I wanted to highlight that institutions – like biomedical and police systems – intended to care for people in many ways instead cause damage to specific people in ways that are reified in the community.

[11] This is part of a larger quote from an interview I had with one of the people at the Recovery Center. I used it in Chapter One and the full quote is: “A high percentage of people also have mental health problems and are self-medicating, burying that stuff, it’s too bad. In that way, substances are serving a need.” What I am pointing to here is an increased personal resilience that eliminates the need to self medicate in the first place.

Despite this, people find their way to one another in the Recovery Center and they work together to create new ways of support, utilizing existing institutions and building their own at the same time. People with SUD are people who have been systematically discounted throughout history, while suffering from a disease that cannot simply be addressed with one pill or one treatment. Properly treating SUD requires a complete transformation of the care landscape.

Ultimately, this manifesto is one that recognizes another form of knowledge production and communication. It encourages us to invest in a kind of cultural change aimed at reducing the damage that is done to people with SUD and similar conditions. We live in a world with many kinds of suffering and struggle, but there are ways to alleviate that struggle, from everyday psychological first aid to promoting resilience to personal and political advocacy. Art changes the landscape, reducing stigma and isolation by disrupting systems that perpetuate social suffering, while creating a kind of language for people whose suffering may feel impossible to convey.

Epilogue

In the 2019 book *Imagistic Care: Growing Old in a Precarious World*, edited by Cheryl Mattingly and Lone Grøn, anthropologist Rasmus Dyring writes a section "On the Silent Anarchy of Intimacy: Images of Alterity, Openness, and Sociality in Life with Dementia." It opens with a vignette like many that I included in this very work, he calls it "Image #1, Morning Coffee at a Dementia Unit in Denmark, February 8, 2018." Later on he calls his vignettes "ethnographic resonance images." The aim of his introduction is similar to the introduction of this very chapter, he references Judith Butler to claim that human life itself is linguistic life. Those who are unable to speak thus enter into a status of ethico-political vulnerability. Thus vulnerability within the wider context of bio and necropolitics within Agamben's view positions these silent people as "still life," people whose lives are able and allowed to be characterized by suffering but who cannot be "sacrificed." (Agamben 1998, Mattingly and Grøn 2019).

Throughout this thesis I have worked to explore the ways that SUD as both a diagnosis and a social status is inherently isolating and systemically violent. Digging into lived experiences as well as pre written works in order to find commonality, the commonality I found was voicelessness. I then started to look for alternative avenues, if the structures, people, and policies that are in existence are not helping or even actively harming, what do we do instead. And instead I envision a future where art is commonplace in recovery and health care spaces as both an individual tool as well as a larger political project working towards social justice and agency.

In the meantime however, this thesis provides "ethnographic resonance images," photographs and discussions of critical moments I experienced working with people in recovery in rural Vermont. These images are a form of art, a form of advocacy, and a way for me to show the people whom I worked alongside that they are real and they exist. Their love and care for one another is not invisible, I saw them just as they saw me, and together we work(ed) on a liberatory project to change the landscape of Substance Use Disorder in Vermont. We push toward a future in which people are able to access care, they are not triaged into nonexistence. A future where legislation properly serves the people it intends and fewer daughters overdose from deals made with men who shouldn't be dealing. A future in which our voices are colorful and our experiences are shared, where stigma cannot relegate people into dismal corners, but rather we invite people in, we chat, and we build something together, reducing our fear or the other and paving the way for a community where people's lives do not have to be characterized by suffering.

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