Article

Gendered Triple Standard and Biomedical Management of Perinatal and Maternal Opioid Use Disorder in the United States

Investigating Bodily, Visceral, and Symbolic Violence

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Abstract

Despite trends towards treatment versus punitive-based approaches to addressing opioid use disorders (OUD) in the United States, pregnant and parenting women with OUD remain highly stigmatized, their maternal fitness routinely contested. Biomedical conceptions of OUD as a chronic, relapsing condition often run counter to the abstinence-based models enforced across the myriad institutions that manage OUD, particularly for women whose maternal status is contingent on treatment enrollment and adherence. Exposure to trauma is considered to be nearly universal among women with OUD; biomedical classifications of trauma primarily center on the interpersonal (i.e. adverse childhood [ACEs] and lifetime experiences). This work responds to a call to ‘gender addiction’ (Campbell and Ettorre 2011) and examine the ‘epistemologies of ignorance’ (Tuana 2006) around notions of ‘risk’ by advocating for a broadened definition of trauma that incorporates the institutional violence imbedded into policies and procedures specific to the biomedical management of OUD. Drawing on an 18-month ethnographic investigation of pregnant and parenting women with OUD living in the Northeastern United States, this article argues that the intertwined institutions (e.g. medical, legal, and social services) that manage OUD according to biomedical dictates enact a converging constellation of violence on women; this in turn becomes a form of embodied trauma, directly influencing perinatal and maternal opioid use trajectories. Key findings include: (1) civil commitment to treatment as a form of direct bodily violence, (2) loss of maternal status as visceral violence, and (3) institutional erasures (i.e. intergenerational family separation) as symbolic violence.

Keywords

opioids, maternal substance use, perinatal substance use, institutional violence, visceral violence

Introduction

Pregnant and parenting women who use opioids are a rapidly growing population in the United States (Centers for Disease Control and Prevention [CDC] 2019). Although there is a trend away from punitive towards treatment-based approaches to addressing opioid use in the U.S., pregnant and parenting women with opioid use disorders remain highly stigmatized, their maternal fitness routinely called into question. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma is an ‘almost universal experience’ (SAMHSA 2019, 2) shared by people with substance use disorders. Biomedical conceptualizations of trauma refer to adverse childhood and lifetime experiences, including direct and indirect exposure to physical, sexual, and emotional violence, as well as the traumas associated with war, combat, and natural disasters (SAMHSA, 2019). This article broadens current definitions of trauma to extend beyond the interpersonal and the structural (e.g. lack of transportation, income, or insurance coverage) and takes a pointed look at the role of the institutional violence imbedded into policies and procedures specific to the treatment and management of perinatal and maternal OUD in the U.S. This article argues that the intertwined institutions that manage OUD according to biomedical dictates enact a converging constellation of violence on pregnant and parenting women. In turn, this becomes a form of embodied trauma, directly influencing opioid use trajectories among this population.

Scope of Opioid Use in the U.S.

Opioid use and opioid-related fatalities in the United States have increased drastically. It is currently estimated that every day 130 Americans die from an opioid overdose. Between 1999-2017 over 400,000 people in the U.S. died from an opioid overdose. There are three notable spikes in opioid-related fatalities during that time. The first, from 1999-2009, wherein the bulk of overdoses were attributed to prescription opioids. The second, from 2010-2012, wherein most overdose deaths were attributed to heroin. And the third from 2013-2017 (and continuing beyond the time of this writing) where the bulk of opioid-related fatalities involve synthetic opioids, particularly illicitly manufactured fentanyl (CDC 2019).

Women in the U.S. with opioid use disorders are a rapidly growing and vulnerable population. Between 1999 and 2015, mortality rates from prescription opioid overdoses among women increased by 471% as compared to 218% for men; mortality rates for heroin overdoses among women during that same period were double that of men (U.S. Department of Health and Human Services [USDHHS] 2017). Concomitantly, rates of perinatal opioid use and neonatal opioid withdrawal syndrome more than quadrupled between 1999-2014 (CDC 2018). Women with opioid use disorders have higher rates of mental health comorbidities (e.g. depression, anxiety, post-traumatic stress disorder [PTSD]), poor self-concept, sexual trauma, intimate partner violence (IPV), and poverty as compared to men (Crandall et al. 2003; Kremer and Arora 2015).

Biomedical Conceptualization and Management of Opioid Use Disorder

Medical and public health discourse around opioid use primarily centers around the diagnosis of opioid use disorder (OUD). According to the most current Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-V), OUD refers to patterns of opioid use that interfere with multiple aspects of life, such as the ability to maintain employment and positive social relationships; it is classified as either mild, moderate, or severe (Substance Abuse and Mental Health Services Administration [SAMHSA] 2017). As defined by the National Institute on Drug Abuse (NIDA), OUD is a

chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences. It is considered a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control, and those changes may last a long time after a person has stopped taking drugs (NIDA 2019).

This ‘brain disease’ biomedical model of addiction represents an important departure from a moral model of addiction, which points to notions of moral frailty as the true roots of addiction.

Some of the critiques harbored at the ‘brain disease’ biomedical model of addiction point to a silencing of structural factors that contribute to addiction, as well as minimizing concepts such as brain plasticity (i.e. capability of the brain’s capacity to change and reorganize), existing evidence of people who ‘age out’ of problematic substance use patterns, and those individuals who use opioids but do not meet the criteria for diagnosis (Hall, Carter, and Forlini 2015). Guided by a biomedical model, current research goals in the U.S. specific to OUD primarily center on investigations related to neuroscience, epigenetics, pharmaceutical development, and prescription monitoring programs (NIDA 2018). With this focus the risk of somatic reductionism (Lock 2015) looms large, wherein the focus on biology and molecular processes overshadow the larger political-economic processes that shape ‘the environment’ and other ‘risk factors’ (Cadet 2014; Leatherman and Hoke 2016).

Under the biomedical model, OUD is categorized as a chronic health condition (commonly equated to other chronic illnesses, such as type two diabetes) that is best managed by sustained engagement with medications for opioid use disorder (MOUD), such as methadone, buprenorphine, naltrexone. Health experts largely view long-term treatment with medications as the ‘gold standard of care’ that improves health and psychosocial outcomes for people with OUD. However, approximately 90% of individuals living with OUD do not access MOUD; for those that do, treatment retention remains low. Furthermore, treatment rates are lower for women versus men (SAMHSA 2017).

In the field of maternal and child health, the perinatal period is often considered a ‘window of opportunity’ (Daley, Argeriou, and McCarty 1998, 240) for intervening in a multitude of health conditions among populations that might otherwise remain outside of the health care system, as is often the case with women who are active substance users. In pregnancy, women become a captive audience and routine prenatal visits present a unique opportunity to develop relationships with a clinic or hospital and health care providers, and to address health concerns. However, this notion is neither simple nor straightforward in the context of substance use. Interactions between care providers and women with OUD can be fraught with tension, judgement, and miscommunication, exacerbated by legitimate fears of punitive interventions that can divide mothers from their children and families (Holbrook 2015; Lupton 2012; Terplan, Kennedy-Hendricks, and Chisolm 2015). Additionally, while routine prenatal visits do indeed present an opportunity, the singular focus on this point in time remains mechanistic and shortsighted, evidenced by the reality that within six months of giving birth, treatment retention among mothers with OUD drops by over 50% and overdose rates spike dramatically (Wilder, Lewis, and Windhusen 2015).

The official position of the American College of Obstetricians and Gynecologists (ACOG) is that OUD is a chronic condition which requires routine care and maintenance, and women with OUD seeking prenatal care should not face criminal or civil penalties *including* loss of custody (ACOG 2016). In reality, however, stigmatizing public discourse inhibits care-seeking among this population. Complete withdrawal from opioids during pregnancy is not recommended; it can cause miscarriage, preterm birth, low birth weight, and stillbirth (ACOG 2016; Kremer and Aurora 2015). Yet, many women attempt detoxification before initiating prenatal care, and some avoid care altogether due to fears (often substantiated, and most definitely location dependent) of provider-stigma, mandatory reporting, social service involvement, and losing custody of children.

While considering OUD as a chronic condition has created space for a treatment versus punitive-based focus, this ‘trope of chronicity’ (Garcia 2010, 12) has reshaped moral notions of addiction by positioning MOUD as the sole option, particularly for women whose maternal status is contingent on treatment enrollment and adherence. Biomedical conceptions of addiction as a chronic, relapsing condition run counter to an abstinence-based model instituted across the myriad of managing institutions that mothers interact with, fear, or avoid on a daily basis, e.g. medical, legal, and social service entities (Holbrook 2015; Terplan, Kennedy-Hendricks, and Chisolm 2015). For example, as observed during the fieldwork for this project, many direct-care staff making decisions about a woman’s maternal status remain aligned with a moral model of addiction and were strictly unforgiving of ‘relapse’. And though the definition of ‘abstinence’ within some institutions increasingly includes the use of MOUD, failure to adhere to treatment protocols had multiple punitive implications, such as court-mandated stipulations for maintaining custody and accessing government-funded housing

Perinatal and Maternal OUD: Shifting Discourse and the Gendered Triple Standard

Current approaches to the management of OUD represent a departure from a War on Drugs approach from the 1970s that favored criminalization over treatment and drove the flagrant and dramatic rise of the incarceration of people of color in the U.S. (National Research Council 2014). As part of a series of legislation passed under the War on Drugs, the Comprehensive Drug Abuse and Prevention and Control Act of 1970 sought to lower rates of substance use and the violence associated with unregulated markets, allowing law enforcement to conduct ‘no knock’ searches, which primarily targeted low income communities of color. In response to the ‘crack epidemic’ of the 1980s, then President Reagan signed The Anti-Drug Abuse Prevention Act into law in 1986, creating funding for drug treatment, abstinence-based substance use education programs, *and* increased construction of prisons. Mandatory minimum sentencing for drug possession was central to The Anti-Drug Abuse Prevention Act, a policy that has been widely critiqued for promoting racial disparities in sentencing, and discriminant surveillance of low-income communities of color (Netherland and Hansen 2016). The majority of incarcerated individuals are men of color serving time for non-violent drug offences; females are the most rapidly increasing incarcerated population in the U.S. (National Research Council 2014).

Current policy efforts and public discourse around OUD have rapidly shifted from punitive-based legal interventions that focus on individual responsibility, to a call for compassionate treatment efforts that draws instead on a whitewashed narrative that depicts ‘good kids’ addicted because of the overprescription of legitimized medicine (Netherland and Hansen 2016). As a stark contrast to legislative efforts during the U.S. ‘crack epidemic’ the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act was passed in October 2018 with nearly unanimous, bipartisan support – a notable feat during the current combative political landscape in the U.S. In addition to providing funds for expanded access to MOUDs and lifting insurance restrictions, the SUPPORT Act specifically earmarks increased funds for the treatment of pregnant and postpartum women with OUD (Library of Congress 2018). It should come as no surprise then to read researchers Julie Netherland and Helena Hansen refer to the opioid ‘crisis’ as the ‘war on drugs that wasn’t’ (Netherland and Hansen 2016, 664).

Building on what Sanders refers to as the ‘gendered double standard’ (Sanders 2014) faced by women with substance use disorders, I characterize the intersecting identities of female and pregnant/mother as a *triple* standard. Being held to this gendered triple standard intensifies the stigma faced by pregnant women and mothers with OUD as they navigate medical, social service, and legal institutions. Although there *is* a trend away from punitive towards humanistic approaches to OUD, pregnant and parenting women with OUD remain one of the most stigmatized groups in society, routinely judged as being unfit to parent and uncaring of their child(ren) (Terplan, Kennedy-Hendricks, and Chisolm 2015). Messaging and

discourse surrounding OUD in pregnancy shape conceptions of who is deserving of empathy and care, with pregnant women expected to adhere to ‘reproductive asceticism’ (Ettorre 2009, 246) by controlling and managing their bodies according to medical dictates, inscribing the notion of ‘pregnancy as an ethical practice’ (Lupton 2012, 4) and pregnant women as having a moral obligation to keep themselves and their growing child healthy. According to the collective discourse, pregnant and parenting women with OUD are not only harming themselves, but also their reproductive potential, threatening their socially prescribed ‘purpose.’

Image taken less than 1 mile/km from a methadone clinic in Springfield, MA. September 2018, by author.

With a rising focus in the U.S. on addressing perinatal OUD and preventing neonatal opioid withdrawal syndrome, it is particularly important to consider the concept of a gendered triple standard as experienced by mothers with OUD who no longer fall into the perinatal and postpartum window. Although policies that address increasing rates of perinatal OUD and neonatal opioid withdrawal syndrome have importantly prioritized treatment access, in the first year postpartum many of these programs and supports taper. Mothers with OUD are most likely to die from a fatal opioid overdose during the ‘4th trimester’ (i.e. the first year postpartum; Schiff et al., 2018). Because of parental substance use, the demand for foster care placements has spiked nationally (MADHHS 2018), disrupting families and contributing to intergenerational patterns and a negative feedback loop of substance misuse and trauma.

Theoretical Framework: Threads of Violence

This work responds to the call from Nancy Campbell and Elizabeth Ettore to ‘gender addiction’ (Campbell and Ettore 2011) by bringing a critical feminist lens to the fore to examine the ‘epistemologies of ignorance’ (Tuana 2006) around notions of ‘risk’ that remain ‘resistant to acknowledging the... power differentials that structure the lives of drug-using women’ (Campbell and Ettore 2011, 1). This article is informed by foundational ethnographic work that examines the threads of violence – structural, symbolic, and every-day (Bourgeois 2009; Farmer 1996; Scheper-Hughes 1993) – which are woven throughout the lives of women and mothers with opioid and other substances use disorders in the U.S. In particular, Angela Garcia’s work, examining the violences of intergenerational material, cultural, and geographic dispossession in the context of indigenous heroin use in the Southwestern U.S. (Garcia 2010); Kelly Knights visceral depictions of structural vulnerabilities and violence inherent to the concurrent temporalities navigated by pregnant and addicted women living and working in low-rent hotels (Knight 2015); and Alison McKim’s work highlighting structural violence as played out across private and public substance use treatment programs, and the racially discriminate policing of addicted women through the medical and criminal justice systems (McKim 2017). Building on this rich ethnographic work, this article takes a pointed look at the role of institutional violence imbedded into policies, programs, and procedures specific to the treatment and management of perinatal and maternal OUD. A notable contribution of this article is the concept of visceral violence, which remains underexplored in the violence literature, and yet is key when examining the intimacy of pregnancy and mothering.

Institutional violence is made possible by structural violence (Farmer 1996), and pointedly refers to institutional policies and practices that are considered part of a larger system that is perceived to be fixed (Curtin and Litke 1999; Foucault 2002). As with structural violence, it is the illegibility of institutional violence that is most problematic. The first example of institutional violence presented in this article is of direct bodily violence, an experience most aligned with exposure to interpersonal physical violence. The most pronounced example of bodily violence cited here is the use of physical restraints and withholding of MOUDs as part of standard procedures utilized in civil commitment of individuals into substance use treatment. Yet, unlike interpersonal acts of bodily violence such as intimate partner violence and childhood sexual abuse which social mores do not outwardly condone, interpersonal acts of bodily violence as standard institutional practices are accepted as ‘business as usual’ or even ‘best practices.’

The second example of institutional violence presented here is of visceral violence. In one of two publications discussing visceral violence, Sarah de Leeuw examines the biopolitics of colonialism, and the visceral violence of being displaced from home and family for indigenous women and children in British Columbia (de Leeuw 2016). In the second, Clisby and Holdsworth explore the concept of visceral violence as relates to women’s mental health over the lifecourse (Clisby and Holdsworth 2014). However, they conceptualize visceral violence as a syn-

onym for interpersonal experiences of gender-based violence, specifically the experiences of sexism and sexual violence for school-aged girls. While de Leeuw's conceptualization may be most closely aligned with the notion of visceral violence as set forth here, it draws on a decolonial perspective that, while critical and relevant to mental health and substance use among pregnant and parenting women, contains a specific set of biopolitical factors that are not universally applicable to all women with OUD.

The last example of institutional violence in this article is of symbolic violence. Drawing on Bourdieu (2001), symbolic violence refers to daily enacted 'gentle violence' that reinforces and internalizes socially patterned and hierarchical raced, classed, gendered, sexed, and othered ideologies that are 'exercised upon a social agent with his or her complicity' (Bourdieu and Wacquant 2002, 167). Symbolic violence is best identified via the silences or absences — of topics or people — woven throughout this project. As one example, nearly every woman interviewed for this project had been separated from their family and placed in a foster home for at least some length of time as children. Yet the role of intergenerational family separation was never discussed by women or clinicians or staff or administrators or policy makers as a potential risk factor for problematic substance use.

Methods

Situating the Project Locally

This project was conducted across the Northwestern region of Massachusetts (MA), an area with one of the highest rates of opioid-related fatalities and opioid exposed newborns in the U.S. MA stands out in the U.S. as a state that has instituted considerably progressive policies, such as expanding access to naloxone (an opioid overdose reversal drug), prioritizing treatment access for pregnant women, and developing systems and processes to prepare women for the inevitability of having a case opened with the Department of Children and Families (DCF) upon delivery. MA is one of the few states that has seen a reduction in fatal opioid overdoses from 2017-2018 (MA Department of Health and Human Services [MAD-HHS] 2018).

This research was carried out across two counties in Western Massachusetts. County X is rural and predominantly white (70,000 residents that are 91% non-Hispanic White, 4% Latinx, and 1.5% Black or African American). Approximately 10% of the population live below the poverty line. County Z is more urban and larger in size (estimated population in 2017 was 470,000) and is more racially diverse (approximately 63% non-Hispanic white, 25% Latinx, and 11% Black or African American); 25% of households speak a language other than English. Approximately 17% of the population in County Z live below the poverty line (U.S. Census Bureau, 2018), and it ranks in the top quartile of the most racially segregated metropolitan areas in the U.S (Baystate Medical Center 2016). Because of the stigma associated with OUD the decision not to name specific counties is a purposeful choice to protect the anonymity and privacy of project participants.

Data Collection and Analysis

While research around pregnant women and mothers with OUD is growing, the bulk of data on this marginalized population consists of population-level survey data. In contrast, findings presented here consist of an intersection of qualitative methods that center the voices and experiences of women themselves. Data were collected in clinical treatment spaces, community-based organizations, women-only residential recovery facilities, participants' homes, and coffee shops. A total of 30 in-depth interviews were conducted, including 20 life history interviews with mothers with OUD and 10 in-depth interviews with physicians, clinicians, social workers, and staff working directly with mothers with OUD. Ethnographic data were collected from March 2017 through September 2018 and include participant observation and field notes from: (a) two digital storytelling projects with mothers 'in recovery' from OUD (one with peer mentors that support women newly in recovery and the other with women who had children under 12 months); (b) local and regional public meetings, symposia, lectures, and conferences convened around perinatal OUD; and (c) in and around clinical, residential, and community treatment and support service settings for people with OUD. Data analysis was guided by constructivist grounded theory (Charmaz 2010) and assessed the ways in which each of these narratives speak to, resist, silence, and position themselves in relation to each other, and to what end.

All women interviewed had the lived experience of heroin and other substance use prior to, and during, pregnancy. All women self-identified as being 'in recovery' – a complex concept that does not have a standard clinical definition but is routinely used; a detailed discussion of the nuances inherent to this concept is beyond the scope of this article. For some women being 'in recovery' meant abstaining from heroin and other substances; for others it meant being maintained on an MOUD. Recovery can be considered as both a state of being (i.e. being abstinent or maintained on MOUDs) and key to belonging in the 'recovery community.' Women interviewed ranged from being 'in recovery' for five months to five years. All women had experienced 'relapse' at least once during and after pregnancy. The majority of women interviewed were unemployed; all but two estimated their household earnings at $\leq \$20,000$ per year, and half either lived in a homeless shelter or a residential recovery home (colloquially referred to as a 'halfway house'). At the time of their interviews, thirteen of the twenty women did not have custody of at least one (of their) child(ren).

Liminal Complexities and the Biomedical Management of Maternal OUD

Rather than simply critiquing the biomedical management of perinatal and maternal OUD however, it is important to analyze the liminal complexities of how OUD is managed and navigated across multiple institutional settings. Wherein the use of the word liminal pushes us to consider states of being in spaces of ambiguity, the notion of *liminal complexities* asks us to take a step further and contemplate the ethical conundrums and complexities held in these spaces. For example, par-

ents who civilly commit their children to mandated treatment against their will often do so out of love and a true fear their child may fatally overdose. Yet this route to treatment often means being physically restrained with shackles, refused MOUDs, or being sequestered to a jail cell for ‘safety’ reasons. Additionally, while a ‘brain disease’ model of addiction leaves us to understand the brain to be ‘hijacked’ and incapable of autonomous thought or action among people with OUD, how do we interpret when women in recovery refer to the concept of ‘readiness’ as key to treatment engagement, particularly those with a long history of substance use? Does this signal autonomy and opposition to a ‘brain disease’ model of addiction, or an internalization of a moral model of addiction that remains imbedded in OUD programs and services? Furthermore, how does ‘readiness’ align with the notion of ‘non-chaotic’ opioid use, a concept referenced by two staff members that refers to individuals that use opioids intermittently, but would not be classified as addicted according to the biomedical definition of OUD?

Institutional Violence: Key Findings

Key findings from this project identify three forms of institutional violence as experienced by pregnant and parenting women with OUD, discussing the liminal complexities inherent to each form of violence: (1) civil commitment to treatment as a form of direct bodily violence, (2) loss of maternal status as visceral violence, and (3) institutional erasures as symbolic violence.

Civil Commitment to Treatment as A Form of Direct Bodily Violence

Civil commitment to a treatment facility is increasingly utilized in MA, driven largely by the dramatic rise in opioid-related fatalities. Colloquially referred to as ‘sectioning’ or ‘being sectioned’ (a reference to Section 35 of Chapter 123 of MA state legislation specific to Public Welfare, Title XVII) civil commitment to treatment results in up to 90 days of state-mandated detoxification and clinical support services. Access to MOUD as part of treatment is not standard. A person cannot ‘section’ themselves. The process must be formally initiated through the legal system by a spouse, blood relative, guardian, police officer, physician, or court official (Commonwealth of MA 2019). Once a petition is filed with the court, a warrant is issued and the person is then remanded to a holding cell and evaluated by a court appointed official prior to a court hearing. The decision to civilly commit an individual is based on the co-presence of an alcohol or substance use disorder *and* imminent ‘likelihood of serious harm’ to oneself or others due to their substance use. Recent updates to Section 35 require that the court report the person’s name, social security number and date of birth to the state Department of Criminal Justice Information Services, barring access to firearms for up to five years and making their record of civil commitment publicly available, a process historically reserved for people convicted of a criminal offence (Commonwealth of MA 2019).

Although it is not standard for pregnant women in MA to be ‘sectioned,’ a life course approach (Hser, Longshore and Anglin 2007) asks us to consider how a lifetime of experiences influence health in the present moment; specifically, how the

experience of being ‘sectioned’ may influence a pregnant and/or parenting woman’s decision to access OUD services. Nationally, women who are actively using when they get pregnant typically engage with the medical system only in the final trimester of pregnancy; this was the case for all women in this study who, like Aimee, were using heroin until close to their delivery date. The case of Aimee illustrates how the experience of being sectioned can be traumatic, resulting in fear and avoidance of institutions that can offer potential support. She tells me that being sectioned makes ‘you feel like a criminal. You’re thrown in handcuffs, put in a paddy wagon, and shackled with people who are getting dropped off at the jail on the way.’ ‘You’re shackled’ I ask? I’m incredulous. Aimee goes on: ‘yeah, to each other. It’s a nightmare. Hands and legs shackled. It’s not fun.’ Aimee describes the treatment facility as ‘horrible,’ recalling that there were ‘50 people in one room at a time, [and] four people in the bedroom.’ It is not surprising then, when Aimee tells me how important it is for her to feel ‘safe’ in order to access clinical care.

I meet Aimee through Kathleen, a recovery coach who offers support to women and mothers with OUD. Aimee was 30 at the time we met. Her small and tidy apartment was in the back of a housing complex tucked off of a main road. Although her parents currently have custody of her nine-month old son, his presence was everywhere - toys stacked neatly under the TV for when her father would bring him to visit, a push-bike behind the couch, and a high chair pulled up to the kitchen table. The wall art was a combination of her son’s drawings and framed inspirational quotes. At age 16 Aimee was prescribed benzodiazepines to manage her anxiety. Following an abortion at age 18 when she remembers being ‘literally forced out of the car and told [by her mother she] had to do it,’ Aimee described a ‘spiraling moment’ of substance use that lasted from ages 19 to 28. Starting with non-medical use of prescription opioids at age 24 then heroin at age 26, Aimee describes that period as a chaotic cycle of heroin use, voluntary treatment, civil commitment, and mixing heroin and MOUDs. At the time we spoke, Aimee had been stable on methadone for nearly one year.

MA state guidelines identify civil commitment as a ‘last option,’ yet in 2016 over 6000 people were civilly committed via Section 35 (Commonwealth of MA 2019). ‘Sectioning’ is indicative, in part, of the lack of available resources for loved ones who may feel like they have no other option, and for whom the potential of biomedical treatment through any means necessary offers hope. Prior to being ‘sectioned’ by her parents, Aimee had voluntarily entered into detoxification and 30-day treatment programs a few times yet was unable to abstain from heroin for any substantial length of time. We can imagine the desperation felt by her father when he finds her ‘in the bathroom. By that point I had overdosed quite a few times... I think that kind of scared the shit out of him. [T]he next day I was sectioned.’

Women who had been sectioned were fundamentally opposed to it. When I ask if she thinks mandated treatment is effective, Aimee touches on the concept of readiness that was repeated throughout the project: ‘I had literally just started us-

ing heroin at that time, so it was still new to me. I wasn't done experimenting. I knew I was gonna leave this place and literally use again. Like, that's just all I had in my mind for that whole time. I just wasn't ready.' Yet this notion of readiness comes into direct conflict with a brain disease model of addiction, which excludes notions of individual autonomy and points to 'physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavior control...[that] help explain the compulsive nature of addiction' (NIDA 2019). How, then, do we reconcile this definition with what Aimee tells me about her process of recovery after nine years of 'spiraling' and chaotic use: 'you have to like want it. If you're not at that point you're just gonna keep using, 'cause I know I did for years until I really wanted to stop.'

Loss of Maternal Status as Visceral Violence

In this article, visceral violence refers to acts of institutional violence that result in loss of custody, and are experienced by mothers as deep, physical emotions. The Merriam-Webster dictionary (2019) defines visceral as an adjective with three meanings: (1) as if in the internal organs of the body, (2) not intellectual, and dealing with crude or elemental emotions. Extending this definition to the sensory, we can imagine the complimentary definitions to be (1) deep, and below the surface; (2) of the heart, not the head; and (3) felt as anguish, perhaps expressed aurally through caterwauling or internalized; deep into the bones and gut.

A biomedical model of OUD recognizes relapse as part of its chronicity; as such, treatment 'success' typically requires multiple attempts (NIDA 2019; USDHHS 2016). However, in many of the institutions that mothers with OUD interact with routinely (e.g., medical, legal, social services), relapse often runs counter to expectations of maintaining or regaining child custody. In MA, substance use that impacts what DCF workers refer to as 'parental capacity to care' (MA Department of Children and Families 2018) is the primary reason that social service organizations remove children from their homes and place them into foster care (MADHHS 2018). However, the determination of who has the right to parent is highly subjective. Women talked regularly about how *hard* they work each day to prove their maternal fitness (Lupton 2012), tracked by checking off varying tasks from an ever-present, perpetually shifting, and seemingly insurmountable to-do list. Tanya describes

literally walking hours, to take one bus to another bus, to take a bus for an hour here to go to IOP (intensive outpatient treatment), to go to my appointments, to come here to do whatever I needed to do to make my recovery work. Because I could not mess up. There was *no* way. If I did, I'd never see my kids again. I need them. I live and breathe for them. They're my life.

Marina, the regional substance abuse coordinator for the MA Department of Children and Families reinforces this sense of how hard women work: 'I don't know how we expect people with substance use disorders, and mental health, and

lack of resources, and a lack of support to get to 17 different appointments in one week every week for a period of time.... I don't know [if] I'd be able to do it.' Yet, she almost seems to catch herself, and quickly reverts to institutional speak when I ask about women's reports of the inconsistencies between workers who are charged with determining their 'parental capacity to care':

what we say at [Department of Children and Families] is: 'we don't have substance use cases, we don't have intimate partner violence cases, we don't have mental health cases. We have impact cases.' So it's a case by case; there's no straight guidelines... [B]ut what it comes down to is decisions are made very differently in different area offices even within the same region.

It is these inconsistencies that reproduce inequalities along lines of race, place, and poverty, and require us to pay close attention to the intersectional layers of perinatal and maternal OUD. For example, women of color are more likely than white women to be reported to social service and legal authorities and subjected to punitive rather than supportive treatment approaches, dictating patterns of inequitable outcomes around determination of custody rights and access to support services (Holbrook 2015; Lyons and Rittner 1998; Netherland and Hansen 2016; Roberts 1995; Terplan, Kennedy-Hicks, and Chisholm 2015). During one afternoon at a community center that provides classes, resources, and childcare for low-income families of color in County Z, I meet Jamie, a recovery coach who has worked across the region for over five years. She illustrates these disparate experiences around the determination of 'parental capacity to care' when she tells me,

a family that lives over on Belmont Ave (African American neighborhood in County Z) who smokes pot, you know, there's got to be a [child] removal. [But] a family in [primarily White town in County X] who for lack of a better term is shooting dope seven ways to Sunday, [the discussion is about trying] to figure out [if they] need a parent aid. Sometimes I think [the case workers] don't even realize they're doing it.

But they do.

Addiction treatment literature and discourse cites the importance of having a 'sense of purpose' as crucial to treatment success (Polcin, Mulia, and Jones 2012). Becoming pregnant and mothering were consistently identified by women in this project as that sense of purpose, and the reason for them to maintain recovery. Take Linda, who recalls that after the death of her nephew from sudden unexplained infant death syndrome during her pregnancy: 'I don't know what prevented me from using other than being pregnant with my son. Like for me that was enough to not pick up, cause I wanted to. I *really, really* wanted to.' And Sarah, who identifies that her main motivation for going into treatment was 'to be healthy and alive and safe for my daughter.' And Aimee, who tells me that the birth of her son

‘just kept me at that point, like, I don’t want to use anymore. I had something better, I had a point of living clean - living the good life.’

Yet, one of the first things mothers along the substance use continuum lose is their right to parent. As Tanya tells it, you can see how clearly the process of taking a child is deeply visceral:

I was a mess, I was really not handling it well. They’re taking my kids, you know? They told me I was acting inappropriate, and if I wanted to see my children again, I needed to act appropriately for their sake. [I] needed to pull myself together because I was acting outrageous. And I’m like, ‘I’m crying because you’re taking my kids!’

For Marguerite, losing custody is visceral and embodied. When I ask if depression and anxiety is something she had experienced, or been treated for before, she says yes, ‘I have.... but it hit me hard when my kids were taken. It hit me really hard. I couldn’t eat, couldn’t sleep, all I do is lay around and look at the ceiling.’

The fear of losing custody drives women’s choices to avoid treatment late into their pregnancies, largely due to state mandates that require medical institutions to automatically report maternal substance use to the Department of Children and Families (DCF). Amy tell me she was ‘trying to use [buprenorphine] off the street ‘cause I didn’t want anybody to know. I didn’t want to get in trouble yet... I knew DCF was coming no matter what.’ Even when women do seek treatment and prenatal care, Emily, a nurse midwife, comments that ‘the first question they ask when they come in is “are they [DCF] gonna take [my] baby?” And that’s a real fear.’

It is here in this examination of mothering and the right to mother that we again bump up against the liminal complexities of maternal OUD. Although loss of custody and maternal status was perhaps *the* most prominent and pivotal experience that negatively influenced women’s care seeking and substance using trajectories in this project, some mothers noted that having a break from the demands of parenting was critical to their early recovery and treatment success. And while leaving children at home when engaging in drug seeking is typically perceived as neglectful, some mothers identified leaving as a necessary act of care and protection that was far better than using and being high in front of their children. Furthermore, simultaneous to policy inconsistencies around custody determinations of ‘parental capacity to care’ is the reality that staff making these decisions are often new to the overall workforce, young, inexperienced, not parents themselves, underpaid, and likely to leave that position within their first year due to the emotional weight of the work. It is in examining these liminal spaces that we begin to know the complexities of how pregnant and parenting women with OUD navigate their many roles: as woman, as mother, as sister or daughter or partner, and not simply as ‘addict.’ In examining these complications, we may begin to reimagine how to best support women and families in humanizing ways.

Institutional Erasures as Symbolic Violence

In April 2018, the Trump administration enforced a highly controversial ‘zero tolerance’ policy at the Southwestern border of the U.S, forcibly separating children from parents as families were attempting to cross into the U.S. without documentation. There was an almost immediate proliferation of graphic imagery, protests and public outcry across multiple sectors critiquing the enforcement of the policy and the foot-dragging on the part of the administration to reunify families. In August of 2018 the American Public Health Association (APHA) released a public statement decrying the policy as ‘inhumane’ and setting the ‘stage for a public health crisis.’ The content of the statement is pivotal to my argument for the need of a critical interrogation of the field of public health, and bears repeating in its near entirety:

As public health professionals we know that children living without their parents face immediate and long-term health consequences. Risks include the acute mental trauma of separation... and in the case of breastfeeding children, the significant loss of maternal child bonding essential for normal development. Parents’ health would also be affected by this unjust separation. Furthermore, this practice places children at heightened risk of experiencing adverse childhood events and trauma, which research has definitively linked to some of society’s most intractable health issues: alcoholism, substance misuse, depression, suicide (APHA 2018).

Of course, what is striking, is that this exact statement could be made about the separation of children and families that occurs on a routine basis in the U.S. via the intertwined institutions that manage perinatal and maternal OUD. And while the APHA does link family separation to heightened risk of future traumas and health issues such as harmful substance use, much of the public health literature fails to conceive of family separation as a form of violence and trauma in its own right. Exposure to parental substance use and sexual, emotional, or physical violence in the home are considered risk factors for intergenerational patterns of substance use and are primary reasons for foster care entry (NIDA 2019). However, the violence of family separation is predominantly absent from biomedical conceptualizations of risk. Nearly all the women in this project had spent some length of time in foster care in their youth, yet this was never discussed voluntarily in any of the biomedical spaces that I entered during this project. When I did pointedly ask about the impacts of family separation during interviews with clinicians and administrators specifically, the question largely appeared to be surprising.

Maeve is a young, single mother early ‘in recovery.’ When I asked her to describe herself from ages one to seven, she remembers herself as ‘scared, um lonely, like, abandoned.’ She is placed into her first foster home at age six, and by the age of 16 has lived in five foster homes. In addition to the trauma from being separated from parents and home, it is standard for siblings not to be fostered together -

largely due to availability of space, as well as the training and preferences of foster parents. When I ask Maeve if she and her brother are close, she tells me

no. I [feel] really guilty [be]cause my brother's dad was in prison... I got to leave the foster home and go live with my dad, and my brother had to stay in the foster home because he had nowhere else to go. So sometimes I feel like my relationship with my brother is the way it is because he feels like, you know, I left him there.

Taking a step back from the lifelong impacts of the separation of Maeve's family of origin and speaking again to the liminal complexities of maternal OUD, removing children from an unsafe home and placing them in foster care can be a necessary decision. The deeper challenges come with the inconsistencies around which families get separated and which receive services, as well as the lack of appropriate support for children and parents to process an experience that has lifelong impacts. As Marina tells it:

we're setting kids up for all sorts of problems. We're taking children from unhealthy environments where who knows what has happened thus far, and we're putting them in a different kind of unhealthy environment that doesn't necessarily support them healing or... moving forward.

When I ask Maeve to describe motherhood, she pauses for a full five seconds, sighs deeply, and tells me 'it's hard.' Although Maeve's mother and brother live within short distance, because of their separation their relationships are strained. Maeve has little tangible support. As I look around her apartment, I notice there are few personal items, minus a hand drawn sign that has the name David written in cursive letters. I realize as the interview progresses that David is the father of her child. As she talks about him with her head back and eyes closed, I look closer at the sign and see there are dates, realizing long before she gets to it that he has recently died from a heroin overdose. I count the months in my head as she talks. Only seven. And her daughter has just turned one. As I leave her apartment, I keep returning to her description of herself as a young child: scared, lonely, abandoned.

Conclusion

This article has presented findings on the lived experiences of pregnant and parenting women as they navigate the myriad institutions (medical, legal, and social services) that manage OUD in the Western region of Massachusetts (MA). The contribution of this article is to make legible the institutional violence enacted upon mothers with OUD, largely in the name of 'fetal victimhood' (Knight 2015) wherein 'reproductive asceticism' (Ettorre 2009) remains paramount. Returning to the notion of a gendered triple standard, more than other populations, pregnant

and parenting women with OUD have limited autonomy in the decision to engage with these systems. As such, exposure to institutional violence is nearly inescapable. The predominating approach to managing OUD that centers on ‘fetal victimhood’ continues to erase women with OUD as having needs that run concurrent to ensuring a healthy pregnancy and birth. This erasure is underscored for women whose maternal status may no longer be recognized by the biomedical institutions and policies that manage OUD: those that are no longer pregnant; whose children are no longer ‘cute’ babies; and those who may have lost custody of their child(ren), perhaps permanently.

It is important to note that MA is a state with considerably progressive policies around OUD. Although the passage of the SUPPORT Act in October 2018 does earmark funds for the treatment of pregnant and postpartum women with OUD, it does not overturn policies in 23 states and the District of Columbia (D.C.) that consider substance use in pregnancy to be child abuse. Nor does it call into question the three U.S. states that classify substance use in pregnancy as grounds for civil commitment to treatment (Gutmacher Institute 2019). We can imagine the experiences of institutional violence as identified in this article to be present, and likely magnified, in many of these states

While much of the addiction discourse is focused on the multiple forms of violence and trauma that contribute to disordered substance use, this article shifts that focus to make legible the violence interwoven into treatment itself. Each example of institutional violence discussed in this article – bodily, visceral, and symbolic – make the case that a robust critical public health agenda around perinatal and maternal OUD is crucial. Over the course of this project, conversations around structural violence (e.g. poverty, lack of housing and transportation) shifted to the fore. And although discussions did also touch on the impact of trauma on opioid use trajectories, the primary focus was interpersonal violence.

As part of a critical public health agenda I argue for the need to consider, envision, and categorize institutional violence as a distinct form of violence and trauma navigated and negotiated by pregnant and parenting women with OUD. The notion of visceral violence as explored here is an important contribution to the literature on forms of violence and is particularly relevant for any examination that considers the biopolitics of pregnancy and mothering. By erasing experiences of institutional violence, efforts to provide person-centered care, support families, and promote optimal health will remain incomplete and deficient. Lastly, the discussion around the liminal complexities inherent to the treatment and support of pregnant and parenting women with OUD is crucial to a broadened understanding of maternal OUD. Deep pondering of the quandaries held in these liminal spaces may then allow us to envision spaces of the ‘otherwise’ (Povinelli 2011) wherein the potential for intersectional notions of who has the right to mother and what constitutes humane approaches to the treatment of maternal OUD might simultaneously co-exist.

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