



Essay

Recovery in the US ‘Opioid Crisis’

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Dave, a Euro-American man in his early 30s and a newly admitted resident at Sunrise¹ drug treatment center, could not escape thoughts of death as we sat in a cold, dim group therapy room in the winter of 2014. ‘If I use, I will die, because I OD’d seven times. If I don’t quit, I will *die*,’ he told me. ‘I wanna live a little longer,’ he continued, ‘I just gotta do it right. It’s not an option.’ Dave entered treatment devastated by the recent heroin overdose death of his mother. The loss intensified his conviction to save his own life by making the ‘right’ treatment choices. Yet treatment at Sunrise was far from straightforward; it was filled with contradictions and ambivalence intensified by the recent rise in opioid use and overdose death.

Addiction and its treatment are now central concerns in the United States. In the last decade, public concern has mounted with the highly publicized opioid overdose deaths of socially privileged individuals. The spectacles of suburban White prom queens in recovery, parents overdosing in cars with children present, and ‘mobile morgues’ used to manage the overwhelming number of dead bodies have escalated moral panic surrounding what is now commonly referred to as the ‘opioid crisis.’ In 2017, the *National Academies of Sciences, Engineering, and Medicine* released a report on opioid use, stating:

Not since HIV/AIDS epidemic has the United States faced as devastating and lethal a health problem as the current crisis of opioid misuse and overdose ... Current national trends indicate that each year more people die of overdoses—the majority of which involved opioid drugs—than died in the entirety of the Vietnam War, the Korean War, or any armed conflict since the end of World War II. (NAS 2017, 187).

¹ The center and all resident and staff names are pseudonyms to protect participant confidentiality. This research protocol was approved by the Case Western Reserve University Institutional Review Board.

The magnitude of the problem is reflected in stark figures. From 2000 to 2014, the opioid-related overdose death rate increased by 200 percent (Rudd et al. 2016).

Carr, in a commentary in this special issue, challenges us to critically examine what is produced when we frame opioids in the language of ‘crisis.’ Crisis, she writes, demands a certain temporality—an urgency—in which there is, ‘No time for deliberation,’ we must, ‘do now, think later. This or that. Right or wrong. Yes or no’ (Carr 2019, 2). What, she asks, is foreclosed and inspired by thinking of opioids through the lens of crisis?

In this essay, I draw on in-depth ethnographic research conducted in and around Sunrise, a treatment center located in a US state that has been characterized as the ‘overdose capital of America’ (Soboroff 2017), from 2014 to 2015. Inspired by Carr’s call to question the work of ‘crisis,’ I explore the meanings, experiences, and stakes of recovery for Sunrise residents in the context of the ‘crisis.’ The urgency to intervene in the ‘opioid crisis,’ I will argue, intensifies the stakes and dilemmas of treatment for individuals like Dave, who are attempting to recover the ‘right’ way under the threat of death. This urgency exacerbates tensions between co-existing, and often contradictory, biomedical and 12 Step models of recovery rooted in disparate ways of framing the role of medications and relapse in recovery.

Recovery is often an unquestioned good, yet it is an inconsistent construct. Questioning recovery presents a unique opportunity to examine lived experiences that are occluded by interventions undertaken under the urgency of a ‘crisis.’ In critiquing the very concept of recovery and illuminating lived experiences of it, I hope to create space to imagine alternative models.

What Is Recovery? Biomedical and 12 Step Models

Under the impetus to intervene in response to the ‘opioid crisis,’ a so-called ‘gentler approach’ to the War on Drugs has emerged. This approach emphasizes a biomedical model of addiction as a ‘chronic, relapsing brain disease’ (McClellan 2002). It draws on a definition of addiction as a disease of dysfunctional neurological circuits responsible for reward, motivation, and memory (ASAM 2011) and promotes the use of Medication Assisted Treatment (MAT) that is purportedly blameless and designed for the promotion of public health and social integration versus surveillance and punishment (Hansen 2017; Netherland and Hansen 2016).

Yet this ‘gentler’ approach exists uneasily alongside the 12 Step model of recovery that has been the foundation of treatment in the US since the mid-20th century (Valverde 1998). In the 12 Step model, addiction is understood as a ‘spiritual disease.’ The goal of recovery is abstinence from all ‘mind altering substances’ achieved through adopting a primary identity as an ‘addict,’ accepting powerlessness over alcohol and other drugs, and progressing through a series of spiritual and pragmatic steps of self-transformation with the support of peers. Twelve Step

meetings, the central platform of this mode of recovery, are organized around social acceptance and mutual exchange of personal experiences. In meetings, participants share their most stigmatized experiences of drug use and its costs, as well as everyday struggles, in a community of peers who are expected to provide non-judgmental support. The use of MAT medications, such as methadone and buprenorphine, however, has traditionally been considered continued drug use in the 12 Step recovery community, and individuals who take these medications risk stigmatization as they may be seen as ‘dirty,’ ‘active users.’

As opioid use and overdose has intensified, policymakers, scholars, and activists have advocated for the use of MAT, with increasing urgency (Volkow et al. 2014; NAS 2019). With this shift, biomedical and 12 Step interventions increasingly co-exist in the same therapeutic landscapes, presenting individuals in treatment with double-binds: How does one recover when its very meaning is contested? By accepting MAT and faithfully taking one’s medications? By eschewing pharmaceutical treatment for a life free of ‘all mind-altering substances,’ focusing on self-transformation through 12 Steps practices? How does one navigate these contrasting models in social settings steeped in death, where no less than one’s life is at stake?

Recovery in the Shadow of Death

Each day at Sunrise, residents² attended group sessions including lectures and discussions on the neurological, psychological, and social dynamics of addiction. While multiple models of addiction were presented, the 12 Step model had long been the program’s foundation. Twelve Step is particularly significant at Sunrise because it is located near the birthplace of Alcoholics Anonymous (AA), not far from where the first meetings took place. There is strong local pride in ‘the program.’ All residents were required to participate in several onsite 12 Step meetings daily, and offsite meetings several evenings a week.

Twelve Step offered participants much sought-after social inclusion. Many residents became intensely involved in 12 Step recovery, finding social connection that seemed out-of-reach as they felt judged by and excluded from mainstream society, and socially isolated by the loss of friends, family members, and peers to overdose. At 12 Step meetings, residents often remarked that they recognized themselves in the ‘war stories’ of alcohol/drug use told by their peers (Singer et al. 2001). They admired 12 Step group members who had been ‘clean and sober’ for 20-, 30-, 40-years. They were comforted by often-repeated mantras: ‘There is a solution,’ ‘One day at a time,’ and ‘I just need to not put one [alcoholic drink/drug] in me.’ At the best meetings, they felt emotional warmth, elusive love, and social acceptance.

Knowledge derived from direct experience among members of the 12 Step community garnered precious social status elusive to ‘addicts.’ Experience generated

² While most administrators encouraged use of the term ‘patient’ to promote the biomedical addiction model, the majority of treatment staff and individuals in treatment used the term ‘resident.’ In this essay, I adopt the most commonly used term ‘resident.’

authority that competed, and largely outweighed, biomedical authority on matters of recovery. Residents often saw the ‘experience, strength, and hope’ (a common 12 Step mantra) of 12 Step members as more convincing evidence that a life worth living is attainable compared to biomedical explanations. This significantly challenged biomedical explanations of recovery delivered by treatment professionals, focused on individual brains and behavior change, and MAT adherence. MAT remained controversial in treatment, as it was viewed by staff, peers, and 12 Step recovery fellows as continued problematic drug use. Yet many residents were on MAT³, often at the urging of judges and parole officers. They were often ambivalent about their medication use due to concerns that they would be stigmatized as being ‘dirty’ and using MAT as a ‘crutch.’

Risk, Relapse, and Certain Death

Death loomed over this tense therapeutic setting. As opioid-related overdose death rose sharply in the region, reporting the number of overdoses residents survived became common practice when introducing oneself to the therapy group: ‘once, and never again,’ (Tina), ‘five times,’ (Aaron), ‘seven,’ (Dave), ‘I’ve lost count’ (Linda). In formal and informal group discussions, residents recounted near death by overdose, overdose deaths of intimate others, and fears of relapse (i.e., returning to alcohol/drug use), which was increasingly framed by residents, treatment staff, and members of the local 12 Step recovery community as inevitable death. In Dave’s words: ‘If I don’t quit, I will *die*.’ Residents came to understand themselves as perpetually at risk of death.

How do individuals understand their risk of relapse—and by extension, overdose death—in the urgency of the ‘opioid crisis’ when contrasting biomedical and 12 Step models of recovery co-exist? Rose asks scholars to think diagnostically about risk: ‘To ask where risk thinking has emerged (in which problem field?); how it has emerged (in relation to what knowledge and expertise?); and with what consequences (under new technologies of power and relations of authority, what new ethical dilemmas are generated?)’ (Rose 2002, 214). How can we think diagnostically of risk in relation to recovery and its contradictions intensified by the ‘opioid crisis’?

In the biomedical model, relapse is understood as rooted in biological craving, with the addicted brain hypersensitive to drug-related stimuli (Vrecko 2016). Relapse is a chronic risk to be expected; an accepted, if unfortunate, part of a chronic disease process that is managed pharmaceutically. In the 12 Step recovery model, relapse is also understood as an ongoing threat, but one that is to be avoided through 12 Step recovery processes of self-transformation. Relapse is explained as failure to ‘work a good [12 Step] program’; if one follows the dictates of the program, they will avoid relapse. As members of the 12 Step community say, ‘the

³ MAT was dosed at an off-site clinic administered by the same organization that operates Sunrise.

program is perfect’ (Christensen 2017). Residents who adopted the 12 Step recovery model often repeated the phrase, ‘relapse is not a part of *my* recovery,’ challenging the biomedical model of recovery and positioning themselves in opposition to it.



Rally for Recovery at the Ohio Statehouse on September 29, 2017, Columbus, Ohio. Image credit: Karen Kasler, Statehouse News Bureau, Ohio Public Radio and TV.

Treatment staff also challenged biomedical framings of recovery, adding to residents’ ambivalence toward it. As we discussed the recent rise in people seeking services related to opioid use, Derrick (African American man, 40s), a case manager⁴, clearly described his belief that relapse is a *failure* to recover:

Derrick: I think the treatment needs to be precise and definite. Needs to be corrective. It has to be immediately corrective. It can’t be, ‘Okay. We’re gonna play this out. We’re gonna play this out. We’re gonna play this out.’ You play it out, play it out, play it out, because then you have a constant stream of individuals who utilize [services].

Allison: What do you mean by that?

⁴ While many Sunrise case managers identify as ‘in recovery’ following the 12 Step model, Derrick did not.

Derrick: You can play it out because you don’t have to be—maybe it doesn’t get corrected this time. It gets corrected on the fourth time. Ain’t really a sense of urgency. Again, it’s based on the individual. If it’s serious to you, it’s gonna happen. I don’t believe that relapse is part of the recovery process, personally.

Allison: You don’t?

Derrick: No [*firm tone*]. It’s the relapse process. It’s a failure to recover.

Derrick’s comments reflect a stance toward relapse common among treatment staff, many of whom critique the acceptance of it in the chronic brain disease model. Recovery, in their view, should not include relapse. If you are ‘serious,’ you will not return to drug use.

In discussions among residents and staff at Sunrise, in 12 Step meetings, at the MAT clinic, and in everyday social life outside of treatment, relapse became a lightning rod for the politics of recovery. Residents carefully negotiated their allegiance to 12 Step and biomedical models to position themselves socially. These negotiations were framed by tensions between how the two models regard the role of medications and relapse in recovery.

Navigating Competing Models of Recovery

Residents attempted to negotiate 12 Step and biomedical models in this high-stakes and morally-charged therapeutic context, yet their engagement with these models was ambivalent. Many sought MAT as treatment staff and peers framed medications as the most effective way to manage cravings and prevent relapse. Other peers and staff adherent to the 12 Step model, however, challenged relapse as a part of recovery. To manage cravings, they promoted stronger adherence to the 12 Steps instead of medications.

Rather than choose either 12 Step or biomedical models of recovery, most residents attempted to engage both. Dave, who was sure he would die if he did not ‘do it [recovery] right,’ became a vocal proponent of 12 Step recovery and also went on MAT (methadone). By the time he entered Sunrise, he had lost all but one family member to drug-related deaths. He was court-mandated to treatment, and his parole officer (PO) strongly suggested he go on MAT. Dave described ‘intense cravings’ in his early days in treatment: vivid dreams in which he injected heroin and repetitive thoughts and sensations of injecting that were constant reminders of his risk of relapse. They further influenced him to begin MAT, which he saw as ‘life-saving.’

Yet Dave was also highly critical of MAT, especially at doses he believed induce euphoria associated with illicit drug use. He suspected other residents were ‘drug

seeking’: attempting to use MAT to ‘get high.’ Dave was careful to distinguish himself from these individuals who were socially marginalized in treatment as they visibly struggled to remain awake in groups due to sedation attributed by residents and staff to MAT (Schlosser 2018). Instead of viewing methadone as a ‘drug,’ Dave re-framed it as a ‘medication’ taken to avoid any chance of return to illicit drug use. In this way, he constructed his MAT use as consistent with the 12 Step belief that recovery excludes relapse. For Dave, both the 12 Steps *and* medications were necessary. ‘I’m gonna use every tool in my toolkit,’ he told me, ‘but I’m not going to be on it [methadone] forever.’ He often made this assertion in group sessions and research interviews, reflecting his ambivalence about the treatment and fear that he would be tethered to the MAT clinic for life.

Dave also took an active role in the 12 Step recovery community. He attended both AA and Narcotics Anonymous (NA) groups, but quickly focused his participation on AA as these groups had a reputation for being comprised of individuals of higher socioeconomic status with longer periods of abstinence from alcohol, and other drug use. ‘They have what I want,’ he explained. In the absence of kin, Dave relied on what he called his ‘AA family’ to weather the stresses of treatment and life after leaving the center. He grew up in a working-class family that tipped into poverty with the loss of local manufacturing jobs, and his lack of higher education and felony record limited his ability to access formal work. His AA sponsor gave him under-the-table construction work he desperately needed to pay transitional housing fees and bus fare to the MAT clinic post-treatment. Other AA members took Dave fishing to ease his anxiety from days filled with trips to the MAT clinic, appointments with his PO, and anxiety-inducing empty time.

Yet his acceptance in this community that he relied on for social, emotional, and instrumental support was tenuous due to his use of MAT. Dave carefully navigated his engagement with biomedical and 12 Step recovery models to access the support offered by 12 Step participation, and the medication he viewed as lifesaving. He negotiated a fine line in his mind, and within the Sunrise and broader 12 Step communities, between MAT as relapse preventive and MAT as illicit drug use.

This tenuous position led Dave to hide his MAT use from his 12 Step recovery network, fearing judgment. While he was able to re-frame his methadone as ‘medication’ in his own mind, he did not attempt to do this within the social world of 12 Step recovery. He does not lie about it, he explained, but does not discuss it either. This comes at a psychic cost because by withholding this information Dave is breaching the central AA decree to be fully ‘honest’ in recovery. ‘The secrets keep you sick,’ is often said in 12 Step recovery circles. But Dave tells me he will do ‘anything that keeps me off the needle.’

How Does One Recover? Imagining Alternative Models

In the moral panic swelling with the rise in opioid-related overdose death, and the language of ‘crisis’ framing the problem, biomedical intervention is promoted with

ever-greater urgency. Yet biomedicine is no all-powerful monolith. It takes shape in particular socio-historical moments, in local communities, and in lives with unique histories and stakes. It intersects with extant and longstanding models for understanding the meanings ‘addiction’ and ‘recovery.’ It is delivered through a fractured treatment system and broader cultural context that continues to divide individuals along moral lines of ‘clean’ or ‘dirty,’ and place substances in contested categories of ‘drug’ or ‘medicine.’

What is uncovered by examining this urgent response from the ground up, contextualizing it in the everyday lives of individuals who must live in and through the ‘crisis’ at hand? Experiences of Dave illustrate how individuals subject to distinct and contradictory recovery discourses engage multiple models at once within a system that inconsistently promotes and discourages them. Residents were positioned, and positioned themselves, in relation to these models in ways that shaped their standing within the communities that matter most to them—families, friends, and peers—as well as in relation to powerful institutions with power to grant them freedom from incarceration and access to essential resources. Residents like Dave initiated MAT to live in the wake of the deaths of loved ones, easing fear that they would meet the same end, yet largely hid their treatment from 12 Step recovery communities to maintain longed-for belonging in these social worlds in which they could find rare social acceptance. All the while, they struggled under the affective burden of the largescale panic of the ‘opioid crisis,’ and an uncertain path to recovery.

These experiences provide a window into the ways in which various models of recovery are entwined with everyday politics. They reflect the fluid and fraught distinction between ‘bad’ drugs and ‘good’ medicines, which scholars have long critiqued as socially-mediated categories defined in particular social, cultural, and political-economic contexts (Montagne 1996; Singer 2008). The dynamics the body of ethnographic research highlighting how lived experiences of (il)legal drug use defies the social categorization of these substances (Bourgois 2000; Fraser and Valentine 2008; Luhrmann 2010; Schlosser and Hoffer 2012). This knowledge is critical and is enabled by time for deliberation and careful consideration that ‘crisis’ may preclude.

I have attempted to suspend an understand of opioids as ‘crisis’ to delve deeper into the meanings and local articulations of recovery, the moral good of which is often taken-for-granted. By ethnographically tracing the cracks in recovery in local treatment landscapes, anthropologists have the opportunity to resist the ways in which this concept may obscure the voices and subjectivities of individuals most affected by the problem. I hope to have contributed to this work by throwing the meaning of recovery into question and contextualizing its expression in a community where opioid use and overdose death weighs heavily.

Questioning recovery lays essential groundwork for imagining alternatives obscured in the urgency to respond to the ‘crisis.’ Perhaps intervention in the context

of recovery is not the answer. Perhaps there are alternative spaces more suited to supporting the social inclusion and moral recognition desired by individuals labelled ‘addicts.’ Can we, as anthropologists of the extreme, resist the moral panic of the ‘opioid crisis’ to find and foster such alternative spaces?

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