

DOCTOR OF MINISTRY PROJECT:
“DEVELOPING A COMMUNITY MENTAL HEALTH CHAPLAINCY MODEL IN CARTER
COUNTY, TENNESSEE IN RESPONSE TO THE OPIOID ADDICTION CRISIS”

Deo Volente

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March 2023

Acknowledgements

In memoriam Emma Beatrice Townsend-Fisher

I want to offer my sincerest gratitude to Dr. Jack Holland, who has advised and guided me through the entirety of my Doctor of Ministry program. He has modeled a ‘non-anxious presence’ and always acted with great gentleness and grace.

Likewise, I thank Dr. David Kiger for his assistance as second reader, but more importantly for his boundless intellect, curiosity, knowledge, and humor. He has been an encouraging figure throughout this process.

Dr. Kiger grooms a wonderful seminary library, which has been crucial to my studies. I also wish to thank Welshimer Library, and in particular, the InterLibrary Loan staff who have helped me immensely.

I remember and thank my father-in-law, Dr. G. Richard Phillips, for allowing me to be an intellectual sparring partner over our thirty-year relationship.

To all the teachers and professors who have shaped and informed me.

To the Glory of God

Table of Contents

Notes: In an effort at brevity, throughout this work I will refer to “those addicted to opioids” as “the population.” I have interspersed cultural artefacts in the form of songs, my own photos, poems, and novels. I have done this in part to demonstrate that the problems discussed here, from the legacy of slavery to socioeconomic injustice have been testified to all along by artists. It is also my intent to use these examples to personalize the tragedies discussed here.

| | |
|--|------------|
| Foreword: Autoethnography..... | 4 |
| <i>Part One: Opioid Addiction in America.....</i> | <i>17</i> |
| Introduction..... | 18 |
| Chapter One: The Crisis of Opioid Addiction in America..... | 29 |
| Chapter Two: On Pain..... | 55 |
| Chapter Three: How Opioid Addiction Operates..... | 66 |
| Chapter Four: Long-Term Effects of Chronic Opioid Use..... | 87 |
| Chapter Five: Medical Treatment for Opioid Addiction | 93 |
| | |
| <i>Part Two: Other Perspectives.....</i> | <i>119</i> |
| Chapter Six: Perspective..... | 120 |
| Chapter Seven: Opposing Forces..... | 136 |
| Chapter Eight: Control..... | 151 |
| Chapter Nine: Racism..... | 169 |
| Chapter Ten: Appalachia and its Discontents..... | 180 |
| | |
| <i>Part Three: A Pastoral Theology of Addiction.....</i> | <i>100</i> |
| Chapter Eleven: The Practical Theology of John Swinton..... | 201 |
| Chapter Twelve: Implications of the Opioid Crisis for Pastoral Theology..... | 226 |
| Chapter Thirteen: A Pastoral Theology of Addiction..... | 240 |
| Chapter Fourteen: Healing..... | 262 |
| Chapter Fifteen: Qualitative Research: The Opioid Crisis in Carter Co. TN..... | 280 |
| Chapter Sixteen: Conclusion..... | 307 |

Foreword

Autoethnography: An Essay in Reflexivity

The purpose of this foreword is to offer an essay in reflexivity using the format of autoethnography. I do this at the outset as an exercise in academic transparency regarding the ways in which my interests and values may affect this project. Swinton and Mowat define reflexivity as “the process of critical self-reflection carried out by the researcher throughout the research process that enables her to monitor and respond to her contribution to the proceedings.”¹ The *Oxford Handbook of Qualitative Research* refers to autoethnography as the “research, writing, stories, and methods that connect the autobiographical and personal to the cultural, social, and political.”² Following this method, this essay will have two tracks. The first is an attempt to locate myself within the complex world of qualitative research theory. The second is an attempt to locate myself within Appalachian culture. This, then, is my best effort at academic honesty and transparency regarding culture and experience.

Theory

In *Handbook of Qualitative Research*, Maurice Punch writes:

The personality of the researcher helps to determine his or her selection of topics, his or her intellectual approach, and his or her ability in the field, but often we are left in the dark as to the personal and intellectual path that led researchers to drop one line of inquiry or to pursue another topic. We require more intellectual autobiographies to clarify.³

¹ Swinton, John and Mowat, Harriet. *Practical Theology and Qualitative Research, 2nd Edition*. (Norfolk, England: SCM Press, 2016), 57.

² Ellis, Carolyn and Adams, Tony E. “The Purposes, Practices, and Principles of Autoethnographic Research.” Chapter 13 in *The Oxford Handbook of Qualitative Research*. Edited by Patricia Leavy. (Oxford: Oxford University Press, 2014), 254.

³ Punch, Maurice. “Politics and Ethics in Qualitative Research.” Chapter Five in *Handbook of Qualitative Research*. Edited by Norman Denzin and Yvonna Lincoln. (Thousand Oaks: Sage Publications, 1994): 83.

Responding to the idea of why a researcher determines the selection of topics, theories, and methods, I am reminded of Michael Polanyi's anecdote of the dog owner who is always successful in training his dog. "There was a story of a dog owner who prided himself on the perfect training of his pet. Whenever he called: 'Here! Will you come or not!' the dog invariably either came or not."⁴ The dog owner was a master of probability who expertly controlled the outcome of his experiment. Perhaps we choose methods because we are attempting to control the outcome of a process.

When considering how theory has affected my work and why, I have come to believe that 'choosing' a theory, is not so much a choice as it is a pre-determined exercise of contingency and experience. In reviewing my academic career, I acknowledge that I was deeply affected by four years of graduate school at another institution. Most influential was the program in *Historical and Critical Theories of Religion*, where I was profoundly influenced by the works of Karl Marx and Sigmund Freud. The bulk of my work in graduate school was an exploration of psychoanalytic theory.

The second major influence was that of the field of Bioethics. I attended the weekly Bioethics Seminar, while working as a chaplain at the Vanderbilt Medical Center and Children's Hospital. This seminar, which used a Socratic method to approach understanding, changed the way I approach problems and the ways in which I understand the medical community.

In the final analysis, the principle behind this project is epistemological. How does one know what one knows, and what is the relationship between the knower and the known? I approach 'knowledge' of any kind with a degree of suspicion, recognizing that knowledge and

⁴ Polanyi, Michael. *Personal Knowledge*. (Chicago: University of Chicago Press, 1958): 21.

understanding are perhaps the sum of negotiation between interested parties. Knowledge, it seems, is always political, in that we are forever negotiating our own deeply held world views with the deeply held worldviews of others. I am somewhat leery of saying ‘I understand,’ so, as I gingerly attempt knowing, I fear looking into a murky mirror and seeing only my own distorted image in return.

Regarding theories of qualitative research, while I appreciate the academic prowess on display, I cannot help walking away with the feeling that I have encountered “turtles upon turtles.” In considering the history of this rather brief endeavor, we encounter a multiplicity of theories, criticisms, and countercriticisms. Rather than despair at the complexity, I have kept in mind Geertz’ remark that “(s)tudies do build on other studies, not in the sense that they take up where others leave off, but in the sense that, better informed and better conceptualized, they plunge more deeply into the same things.”⁵

In a deep plunge into qualitative research theory, Guba and Lincoln envision four competing paradigms in the theoretical environment: positivism, postpositivism, critical theory, and constructivism.⁶ Within the bounds of these broad paradigms, I tend to end in the constructivism corner. I believe that everyday life, understanding, and relationships are socially constructed, to use a postmodern term. I would term this as environmentally constructed, in that I believe location, place of birth, and site of work all matter in our construction of that which we call reality.

⁵ Geertz, Clifford. *The Interpretation of Cultures*. (New York: Basic Books, 1973): 25.

⁶ Guba, Egon G. and Lincoln, Yvonna S. “Competing Paradigms in Qualitative Research,” Chapter Six in *Handbook of Qualitative Research*. Edited by Norman Denzin and Yvonna Lincoln. (Thousand Oaks: Sage Publications, 1994): 109-111.

Guba and Lincoln describe the hallmarks of the constructivist position: “Constructions are not more or less ‘true,’ in any absolute sense, but simply more or less informed and/or sophisticated.”⁷ Knowledge, particularly in a research setting, is based on an interactive interchange between participants, to the degree that, understanding is “*literally created*” in the process⁸

This intricate process of creating understanding between two parties can be seen in the psychoanalytic exchange between analyst and analysand. As psychoanalyst and physician Donald Spence writes: “We have seen how the patient must continuously translate the private sensations he has experienced into the common language of speech.”⁹ Spence emphasizes three procedures that must occur before an analyst can say that she ‘understands’ what the analysand has attempted to convey. First, the analysand has an image of an experience that is non-verbal. The analysand must translate that visual image into a verbal expression that conveys her truth. Second, the analyst must take that verbalized language and analyze the expression, not only for the content of what was said, but, perhaps equally important, for what remained unsaid. If the transfer is successful, then the analyst can ‘paint’ those words into a verbal image in her own mind. Last, the analyst has the task of creating that transferred image into her own verbal expression. Thus, the follow-up by the analyst is important: “What I hear you say is that...”

This example from psychoanalysis serves to illustrate the difficulty in understanding what we mean by ‘understanding.’ This psychoanalytic illustration gives some insight into the ways in

⁷ Guba and Lincoln, “Competing Paradigms in Qualitative Research,” 111.

⁸ Ibid.

⁹ Spence, Donald P. *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis*. (New York: W.W. Norton, 1982): 86.

which two people create meaning. This process is replicated in any serious exchange of ideas. When we later conduct research interviews in Part Three of this project, we will keep in mind the intricacies of understanding another's life experiences.

Having established a relevant paradigm, constructivism, we can then discuss a research approach that would be an appropriate fit for our worldview. Since this project is a work of pastoral theology, I valorize lived experience and hold a high theological anthropology. Within philosophy this approach falls within the sphere of phenomenology. The phenomenological approach is defined by "the description of appearances."¹⁰ Husserl moved the field of phenomenology from a study of experience to a study of the objects of experience, which he termed phenomena.¹¹ Another approach, Participatory Action Research (PAR), grew out of the critical theory paradigm. This approach is like constructivism in that PAR places an emphasis on interaction between participants, as participants are an essential part of a research team. One feature of this approach is that PAR is "a form of action research anchored in the belief that the research process itself serves as a mechanism for *social change* (my italics)."¹² The type of social change that PAR has historically emphasized is perhaps not a pure fit for this project, but the emphasis on participatory experience and the eye toward change are both shared values.

We must consider one last feature of this project, which is an attempt to understand and bridge four cultures: Appalachian culture, the culture of the medical community, the culture of

¹⁰ Proudfoot, Michael and Lacey, A.R. *The Routledge Dictionary of Philosophy*. Fourth Edition (London: Routledge, Taylor, and Francis, 2010): 300.

¹¹ Ibid.

¹² Spencer, Renee, Pryce, Julia M., and Walsh, Jill. "Philosophical Approaches to Qualitative Research." Chapter Five in *The Oxford Handbook of Qualitative Research*. Edited by Patricia Leavy (Oxford: Oxford University Press, 2014): 91.

the church as expressed in Upper East Tennessee, and the culture of those addicted to opioids. My premise is that through understanding, deep listening, apostolic friendship, and communication perhaps we can bring those cultures closer together to better the lives of the population. I envision a Community Mental Health Chaplaincy (CMHC) as serving a bridge function between those who are addicted and other parts of society, such as church and medical providers. I will explain this model in the introduction to this work.

Culture

As the second part of this autoethnography I want to acknowledge and address my own embeddedness in Appalachian culture. This is more autobiographical in nature, but I believe this attempt will aid in academic transparency. I do not approach an understanding of Appalachia as an impartial observer or as an ‘armchair’ anthropological observer; rather, I am deeply influenced by experience in my understanding.

My roots in Upper East Tennessee run deep. My forefathers, the Taylors, Townsends, and Jones, were some of the first Ulster-Irish, British, and Welsh frontiersman to settle in this region. The Taylors were already wealthy when they arrived in America from County Armagh. Originally, they settled in frontier Virginia, and later migrated into what is now Carter County. Several of my forefathers formed part of the Watauga Association, the first majority-rule system of democracy in the nation, and the Overmountain Men, who marched over the mountains into the Carolinas in 1780 to defeat the British in the Battle of Kings Mountain.

The Taylors owned thousands of acres in modern-day Carter and Unicoi counties, stretching into southwestern Virginia. My fourth-great uncle,

“Aunt Jo” Taylor was a slave in the cookhouse of the Taylor Plantation. Photo by author May 20, 2022.



Gen. Nathaniel Taylor, owned Sabine Hill, a vast plantation, and accompanying mansion in Elizabethton. Sabine Hill has been restored and is now a state historic site. Unfortunately, I discovered late in life that the Taylors were slaveholders, and this knowledge has deeply impacted me. The Taylor slave quarters were on the site of the current Elizabethton Municipal Golf Course. The slave quarters were bulldozed to construct the golf course, and the history of those slaves remains untold. In a search to know more, I discovered the Taylor slave cemetery located just off Gap Creek Road – less than a mile from where I grew up.

This knowledge of the slave history in my own family has affected me personally. The knowledge has also led me on a voyage of discovery as I reconsider our New Testament for the faint echoes of slave stories. The concept of slavery is pertinent to this project, because one of my driving *metaphors* to describe an addicted population has been that of slavery. This knowledge of my family history with slavery has deepened the metaphor as I consider the ways in which persons, metaphorically, become slaves of opioids.

This concept of opioid slavery, as I have come to realize through my research, is an inadequate metaphor. I formed this opinion of slavery, I now realize, because for eleven years I worked with the worst cases of addiction. That experience of acute addiction shaded my understanding of the problem. What I did not see was that for every person I could describe as a slave to opioids, there were many more who were using opioids without dire effect. Some of those used occasionally without incident, some became dependent but not addicted, and then there were those cases I witnessed, in which opioids had created the worst addiction problems possible.

My childhood was almost idyllic. We loved the outdoors and explored the local mountains and farms. We moved into Johnson City so that I could attend South Side Elementary, but my real attachment was to my grandmother, a Taylor, and her farm on Big Springs Road in Carter County. My grandmother, a simple country woman, had a profound effect on me. I never saw any other book in her home except for a well-worn bible. She instilled in me a devotion to the bible and the faith that has lasted me a lifetime. I was baptized in the Stone-Campbell tradition at Locust Street Church of Christ in Johnson City. Later I became Anglican, but I consider myself a fellow-traveler with the Stone-Campbell tradition.

My association with Milligan is also deep. My great-grandmother, Nola Fagan-Fisher, is buried in the cemetery behind the faculty office building. Her father, William Fagan, owned 450 acres in the Buffalo Valley, including land in what is today Okolona Road in Unicoi County. The Fagans were early supporters of the new Milligan College.

Not all was idyllic, however, as I gradually witnessed the darker side of Appalachia and the incursion of the opioid trade. All three of my grandmother's children, including my mother, died a violent death in Carter County. After my mother's murder in 1995 and my father's subsequent

imprisonment at the Northeast Correctional Complex in Johnson County, I began to see the area and Appalachia with new eyes. I became more and more aware of the violence, particularly that of femicide, the crushing socio-economic conditions of the people, and the devastation of addiction.

I attended middle and high school in Piedmont North Carolina. In the early 70s my family and I lived in the town of Sanford, which was only seventeen miles from the vast Army and Air Force bases at Fort Bragg. The sprawling base, one of the largest military installations in America, is home to the famed 82nd Airborne Division and Special Operations Center. There was only a three-year difference in age between me and some of the soldiers serving at Ft. Bragg, so several paratroopers and Green Berets became my friends. The father of my best friend in middle and high school served a thirty-year career in the 82nd and retired as a Sergeant Major. These military influences affected my own decision to enlist and serve a twenty-year career.

During the 70s, Ft. Bragg was a hubbub of activity as soldiers and airmen rotated from service in the Vietnam War. Harlem-based crime boss, Frank Lucas, masterminded a drug smuggling operation using Vietnam-based soldiers, especially two non-commissioned officers who ran the export operation from their bar in Saigon. As soldiers rotated home, they would be paid or extorted into bringing Asian heroin (named 'Blue Magic' on the street) into the US in their luggage. As a result, the area where I lived was a virtual drug (and weapons) bazaar with the most common drugs being marijuana and LSD, along with heroin and hashish imported from Asia. By the year after I graduated high school, three classmates had died of heroin overdose. Two years after my graduation, my cousin also died of a heroin overdose in Elizabethton.

I enlisted in the United States Air Force in 1980 and retired in 2001. I was selected to be trained as a cryptologic linguist (Russian) and entered the military intelligence community. I

served eight years overseas in England, then in Berlin during the crisis of the Fall of the Berlin Wall. After I retired, I worked as a special education teacher in California for two years, before heading to seminary at the University of the South (Sewanee). After seminary I entered a PhD program in Religion, Personality, and Culture at Vanderbilt University, but left before dissertation. While at Vanderbilt I worked as a chaplain at the Vanderbilt Medical Center and Children's Hospital. I later accepted a job as hospice chaplain for Solari Hospice in Las Vegas. While there I was 'attached' as an associate pastor to Grace in the Desert Episcopal Church. Later I accepted a call to a parish in Vermont, then to a parish in New York City.

After leaving the Episcopal Church in 2013, I took a job as a social services manager in a 76-bed Single Residency Occupancy (SRO) in central Harlem. The SRO was part of the supported housing program of New York City and operated under city and state grants. The facility was a housing program for formerly homeless persons living with substance abuse and Severe Mental Illness (SMI). I consider this experience as one of the most formative of my life and I refer to it as a crash-course in the culture of Harlem.

One Friday evening as I was packing up to head home, a resident came to my office. He, rather sheepishly, told me that a resident neighbor, Betty, had "maybe overdosed." I knew most of the residents well, but not Betty. She was a 64-year-old African American who seemed to keep to herself. I knew that she had been homeless and that she suffered issues with depression, but that was all.

After the report, I went up to the sixth floor to check on Betty. When I arrived at her room the door was standing open. I entered the room and found Betty, lying dead on the floor. The neighbor had said that Betty had been using heroin. I later came to suspect that the neighbor was in fact supplying the building with heroin. I made some phone calls to my boss and to

appropriate city authorities. When I called the Office of the Chief Medical Examiner (CME), I was told that it would be about two hours before he could arrive. I pulled a chair out of Betty's kitchen and sat by her corpse, waiting for the examiner to arrive.

As I sat next to her, I wondered about Betty, whether she had friends or family who cared about her. I wondered how a 64-year-old woman could be involved with heroin. She had a kind, grandmotherly face and was dressed in a conservative blue cotton dress.

As promised, the CME arrived two hours later. He was not what I had expected, not like anything I knew from TV. He was a white man in his 40s, with a light, fun air about him. I soon discovered that, like me, he had a wicked sense of humor, so we bonded quickly. He was respectful of Betty and treated her with great care. After he had examined her, he demonstrated how to search the room and what to look for. Under her desk we found empty glassine bags, each enough for one dose of heroin. We then found several bags with the heroin still inside. Searching under her bed, we found 'works,' a kit of hypodermic needles. The CME gave me a lesson in heroin use since I was working with a vulnerable population. After that experience, I was trained to use NARCAN, an anti-overdose drug, and carried a kit with me wherever I went.

I later moved from that job to another in Harlem as Director of Veterans Services, working for another non-profit, with the same population of people who were also veterans. My office was in a storefront on 125th Street in Harlem – the central boulevard of the neighborhood. I frequently had to travel through the intersection of 125th and 7th Avenue, where there was located an immense drug bazaar. Through these experiences I gained an understanding of the problems of addiction in our country. After nine years working in the city, I decided to retire home to Tennessee.

When I relocated back to East Tennessee, I expected my experience with drug bazaars to be over. One beautiful day in May 2018, I drove to Roan Mountain, a favorite spot. As I drove back home, I was confronted with an odd sight. I am accustomed to seeing bare-chested boys and men in pickup trucks, but what I saw caught my attention. I took out my phone and took a picture, in part to convince myself that what I saw was real.



“Shoot Your Local Heroin Dealer” Photo by author, May 2018.

I had wanted to return to the idyllic scene of my youth. What I found quickly, however, was that my homeland was awash in heroin and other opioids. A few months later I took a position as a manager in a new methadone clinic in Gray, Tennessee, where I administered the State Opioid Response grant (SOR) for northeast Tennessee.

Being back home reminded me of a brief conversation I had once with my father-in-law. I had been serving in Europe on active duty and came home on leave to visit my father. My father-in-law, a Stone-Campbell scholar, picked me up at the local airport. We drove in silence for a long time, while I gazed out at the land I had known and loved as a boy. To break the silence,

Dick asked me, “Well, is it as you remember it?” I thought for a moment and replied, “I never knew we were so poor.”

I feel a passion for this land and for its people. I see many problems – addiction, poverty, underemployment, and violence to name a few. But this passion is part of what led me to studies at Emmanuel Christian Seminary. That same passion drives this DMin project, which I see as one attempt to offer a form of healing to this troubled land.

Part One

Opioid Addiction in America

“The problem of chronic opium intoxication...is so extremely complex and far-reaching, so intimately interwoven with public health, commerce and trade, and social customs, and has been evolved so insidiously that we may well ask if the use of opium ever was confined to its sole valuable function, namely, that of a therapeutic agent.”¹³

Charles E. Terry, MD

The Opium Problem

1928

¹³ Terry, Charles E. and Pellen, Mildred. *The Opium Problem*. (Montclair, NJ: 1928). Publication No. 115 in the Patterson, Smith Reprint Series In Criminology, Law Enforcement, and Social Problems, Reprinted in 1970.

Introduction

A brutal opioid addiction and overdose crisis¹⁴ has gripped our nation, with more than 100,000 persons dying of opioid overdose every year. The crisis has affected millions of Americans, either directly, from addiction, or indirectly, as addiction affects entire communities. The roots of this vast problem are deep and complex, but the epicenter of the crisis, which began roughly in 1996, is in Appalachian America, including the communities surrounding Milligan University and Emmanuel Christian Seminary. To date, this health crisis has cost the nation trillions of dollars, which does not begin to reflect the effect on the lived experience of those who suffer from addiction and that of their families, other loved ones, and friends.

The subject of opioid addiction is complex. How does addiction work? How does it affect the neural pathways of the brain to produce humans whose only concern is for their next dose? How is it possible that opioids could have affected so many people? What is the treatment for opioid addiction and is it effective? Can we save lives, and what would saving lives look like?

Because of these complexities and more, the church has either been slow to respond to this crisis in the lives of millions of people, or, more likely, the church simply has not known *how* to respond in a way that does not damage the church and its congregants. The contention of this project is that the church not only can but must respond, through proper training and community planning. No one community and no one person is the answer. Together, however, as one people of the one Lord Jesus Christ, through the blessing of our baptismal covenant, we are in a unique

¹⁴ Although the opioid crisis is frequently referred to as an ‘epidemic,’ to date it does not meet the medical criteria of epidemic. The Department of Health and Human Services has officially declared it an ‘emergency.’

position to help – to help in ways that the medical and recovery communities cannot. In this project I will offer and test *one* model of care. I will now outline the purpose of this project.

Problem and Purpose

The purpose of this Doctor of Ministry qualitative research project is to respond to the lived experience of chronic opioid addiction by studying the feasibility of developing a *Community Mental Health Chaplaincy* Model in Carter County, Tennessee. This model will be explained in detail below (beginning at page 25). My founding premise is that before we can respond to persons living with chronic opioid addiction, we must first understand how the current crisis spread and how such addiction works in our community. My approach has been to consider those who live with opioid addiction in Carter County as if they were my congregation.

In Part One I will provide a history of the current opioid crisis, as well as an overview of the mechanics of addiction, how it affects the lived experiences of those who are addicted, as well as treatment options. This is what I refer to as the *standard account* of addiction. In Part II we will look at other perspectives on addiction in a deliberate effort to complexify the standard account. Scattered through this project we will consider artefacts from the culture in the form of songs, poems, and novels, as I believe these have provided a prophetic action alerting us to the deep problems of our society. We will seek to understand this lived experience of our population through Participatory Action Research and by adopting the best principles of qualitative research. Findings of this research will be shaped into a final report at the end of this written project.

Training and raising community consciousness of the crisis is important, but I realize that working with congregations and helping to train congregations in opioid addiction is a years-long process. I would hope over time to develop a network of pastors and congregants who are willing to formulate a response to the crisis both at the local level and in the communities of Upper East Tennessee. The church has the power to respond to the crisis and could be a major force in defeating the opioid crisis. This, of course, takes training, prayer, reflection and – action.

Ministry Context

In 2017, the Department of Health and Human Services declared that our nation is undergoing a public health emergency.¹⁵ From the year 2000 to 2019, nearly 460,000 Americans died of an opioid overdose. In the year 2019 alone, 70,630 persons died of an opioid overdose. The rapid spread of illicitly made fentanyl, a synthetic opioid, has drastically increased the number of overdose deaths since 2019. In 2022 over 107,000 Americans died of opioid overdose, frequently due to fentanyl use. This health crisis had its beginnings in Appalachian America and its ramifications are felt acutely in this region of the country. In fact, “Tennessee ranks third in the nation for opioid prescribing with a regional rate of 112 per 100 people.”¹⁶ Put another way, physicians in the state write enough opioid prescriptions to provide every Tennessean – man, woman, and child – with their own opioid prescription, with remainder.

¹⁵ Hargan, Eric D. Acting Secretary of the Department of Health and Human Services. “*Determination that a public health emergency exists*,” *Memorandum* of the Department of Health and Human Services. Accessed on January 22, 2022, at the Website archive at <https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf>.

¹⁶ Clements, Andrea D et al. “Initial Validation and Findings from the Willing/Ready Subscale of the Church Addiction Response Scale,” *Frontiers in Psychology*, Volume 12 (October 2021). Accessed online January 12, 2022, at <https://doi.org/10.3389/fpsyg.2021.733913>.

Carter County, in Upper East Tennessee, is one of the communities most affected by the opioid crisis. Elizabethton, with a population of nearly 14,000 is the county seat. The county itself is home to approximately 58,000 persons. Carter County borders North Carolina to the east. Residents of the county have access to I-81, a north-south artery that transverses Appalachia. The county has deep roots. I-81 itself roughly follows an ancient buffalo migration trail. The county is of historic importance in the state, as the Watauga Association, founded in 1772, was the first majority-rule system of democracy in the nation. In 1780 local men, who came to be known as the Overmountain Men, launched an expedition over the mountains to engage and defeat British Forces in the Battle of Kings Mountain during the Revolutionary War.

The county is almost idyllic in its beauty. The Appalachian Trail runs through the county, while the Watauga Lake and surrounding mountains offer a scenic landscape, as do the farms of the county. The mist-covered mountains seem to offer a mystic experience for one who has the good fortune to explore the region.

Elizabethton is a proud, close-knit community. One point of pride is Elizabethton High School, which is one of seventeen schools nationally to be ranked a super school. The team has fielded a state championship football team, and sports remain central to the county's identity. Many churches, primarily evangelical, serve the region.

Unfortunately, the opioid epidemic has ravaged the local community. Those who seek treatment for opioid addiction may do so at Overmountain Recovery, a methadone treatment program in Gray, Tennessee, or at several physician's practices that offer suboxone treatment, although distance and transportation are a problem for this rural county. Typically, such treatment is accompanied by social services and therapeutic services support. There are efforts at abstinence-based treatment (without methadone or suboxone treatment) underway in the county, and a

residential abstinence-only facility is planned for Roan Mountain, on the premises of a former annex facility of the Northeast Correctional Center.

There are several community efforts intended to address substance abuse in the community. The *Carter County Drug Prevention Coalition* sets its mission to reduce substance abuse through community planning and action. Its efforts are aimed primarily at the county's youth. *Red Legacy Recovery*, which is located in Elizabethton's downtown area, offers recovery services for women who live with substance abuse or domestic violence. *Families Free* also operates a branch office in Elizabethton. *Elizabethton Health Service*, located at 405 Hudson Dr, is a large suboxone practice that was kind enough to offer office space and access to patients for my research interviews.

While Narcotics Anonymous (NA) meetings are available online for those who have technological resources, the nearest in-person meeting is located seven miles from the city. Typically, though, Narcotics Anonymous frowns on those who are in medication-assisted treatment (methadone or suboxone), under the premise that these persons still are using narcotics and are therefore not in recovery. NA recommends an abstinence-only response to opioid addiction, although recovery rates through a 12-step or abstinence-based approach are not encouraging. There are other treatment options in the area for those who have means. These include in-patient, crisis, and Intensive Outpatient Programs (IOP). The State of Tennessee, through grants provided by the federal government, may be able to assist some with the financial burden of treatment.

There are many Protestant churches in the area. Elizabethton is also served by one Catholic and one Episcopal parish. Some churches, as well as local social service agencies, may offer support in the form of thrift stores, food giveaways, or temporary lodging. Churches in the greater Upper

East Tennessee area may sponsor 12-step programs. There are three *Celebrate Recovery*¹⁷ meetings within driving distance, although transportation remains one of the biggest obstacles for those living with opioid addiction.¹⁸ One of these groups at a church in Gray, Tennessee was the subject of a previous Doctor of Ministry Project at Emmanuel.

Theological Challenges

The problem for pastoral theology is this. Despite hundreds of thousands of deaths nationally and the ravages addiction has left behind for family, friends and loved ones, the church's profile in this ongoing crisis is low.¹⁹ Throughout the execution of this project, I wish *to make it clear* that it is not my intent to attach shame or blame to the church. Churches and parishes have their own institutional goals set by church leadership. Typically, those driving goals are for growth, formation of youth and young adults, and biblical literacy, to name a few. Addressing the opioid crisis is simply not programmed.

Churches are not prepared to work with this population, for several reasons. The population is notoriously difficult to serve. The population over years of addiction has learned and embedded negative tactics for personal interaction, to include manipulation, prevarication, and triangulation. By *definition*, those who are addicted to opioids engage in criminal behavior, and members of the population may have a record of multiple incarcerations. By definition, opioid addiction is a mental health disorder.²⁰

¹⁷ <https://www.celebraterecovery.com/>

¹⁸ Hereafter, for the sake of brevity, persons living with opioid addiction will simply be referred to as 'the population.'

¹⁹ See literature review on page 16 of the DMin Proposal at attachment 1.

²⁰ *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. American Psychiatric Association. (Washington: American Psychiatric Publishing, 2013): 541-542. The DSM-V assigns the code 304.00 to Opioid Use Disorder.

Having personally worked for years as a social services manager on the streets of Harlem and the Bronx with a homeless population that lives with substance abuse and serious mental illness, and later as a manager in a methadone clinic, I am acutely aware of the many difficulties of working with this population. To do so effectively requires years of experience and training to understand the history of addiction, how addiction works, the effect that it has on lives, and what treatment options are available. Although a developed sense of empathy is necessary, caregiver fatigue is common. The people with whom we work have a high mortality and disease rate, a high incarceration rate, and frequent relapses. Measuring ‘success’ is difficult, realizing that for some, treatment for opioid addiction may be a lifelong endeavor. For all these reasons and more, I completely understand why the church has not engaged effectively with this population.

But it should. If our frequently and proudly proclaimed and expounded theologies are true even in the slightest degree, then the church has a *duty and obligation* to engage this population. We proclaim that all human beings, even in their most fallen state, are made in the icon of God (Gen. 1.26). Every human being bears the spark of divinity and is worthy of Christian regard. The art of healing was one of the most prominent forms of the ministry of Jesus Christ. He healed those at the very extreme margins of society, to include the blind (Mark 10: 46-52), lepers (Mark 1: 40-45; Matt 8. 1-4; Luke 5. 12-16), paralytics (Mark 2: 1-12; Matt 9: 1-8, Luke 5: 17-24), women (Mark 5: 21-43, Matt 8: 1-4, Luke 5: 12-15); the deaf mute (Mark 7: 31-37), and children (Mark 5: 41). Our Lord also performed multiple exorcisms. Jesus the Good Shepherd would leave ninety-nine sheep behind to find the one that had gone astray (Matt. 12. 11; 18.12). Additionally, the Holy Scriptures offer a broad commentary on the value of friendship. The Holy Trinity serves as an icon of love in relationship. All these ideas and more compel us to engage the most lost of sheep.

I offer a few clarifications. By “church” I am *not suggesting or advising* that churches immediately swing their doors open to this population unless the leadership and congregation alike are educated, formed, and trained to do so. I also am not suggesting that even if we do find a way to engage, that addicted persons will become ideal Christians who attend church regularly, take up leadership positions, join the choir, and fill out pledge cards. What I *am suggesting* is that the church has an evangelical duty and theological responsibility to formulate strategies that will allow effective Christian ministry with this population. Once that engagement has occurred, then we leave the future of this population in the hands of the Holy Spirit.

The purpose of this project is to develop a model for a Community Mental Health Chaplaincy (CMHC) in Carter County. I am deeply influenced by and in gratitude to the Scottish practical theologian, John Swinton.²¹ I will review Swinton’s theology in Chapter 11. Swinton, a professor at the University of Aberdeen, has a distinguished career in developing a theology of disability and of chaplaincy with persons living with the description of mental illness.²² I propose to adapt and adopt his model for a CMHC as explained in his book *Resurrecting the Person*.²³ In developing this model Swinton recognizes that there may be congregational resistance to such a ministry and proposes to develop a CMHC that offers training and supervision for congregations, that reframes illness and personalizes ‘the patient’ by developing a theology of friendship, and by experiencing advocacy as a ministry of prophecy. It is this model that I would seek to

²¹ I have even adopted and adapted Swinton’s outline for a proposed qualitative research project as developed in: Swinton, John and Mowat, Harriet. *Practical Theology and Qualitative Research, 2nd Edition*, (Norfolk, England: SCM Press, 2016).

²² Although ‘mental illness’ is an accepted term in our society, it is not one I prefer, for reasons that will become clear.

²³ Swinton, John. *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*. (Nashville: Abingdon Press, 2000): 191. Chapter Ten, 165-191, Swinton lays out a plan for the development of a CMHC.

develop, not as a ‘lone ranger’ ministry, but with the support of community agencies and churches. I would hope that this exploratory work could be developed in the community after the completion of this research phase.

The Community Mental Health Chaplaincy Model

Swinton notes the changing face of chaplaincy.²⁴ In the traditional model, a chaplain is an ordained minister who has been vetted by a denomination and who is an ‘offshoot’ of a local church or parish. In my colorful tradition, we say that a chaplain is ‘attached to an altar.’ By this it is meant that a chaplain is not a free agent but is anchored to a particular church. While this may be true in an ecclesial sense, in fact the bulk of the chaplain’s work is performed in an institutional setting such as in a hospital, school, or jail. In reality, the chaplain is responsible to the institution and meets the institution’s standards. What the chaplain actually *does* may vary from institution to institution. In some settings, such as in a Catholic medical center, the chaplain is expected to perform the sacramental rites of the church. In other settings, the chaplain may work with the broad term ‘spirituality,’ in which she is attempting to help a patient find and utilize spiritual resources for healing or recovery.

In the CMHC model, the chaplain functions more in the role of community organizer. The model, which Swinton refers to as “Friendship in Action” has three components.²⁵ First, is to enable persons who live with mental health issues to find “an accepted and personally acceptable place within the life of a local church community.”²⁶ Second, is to develop forms of education for local churches, which may include advocacy and empowerment as key goals. Third, is to

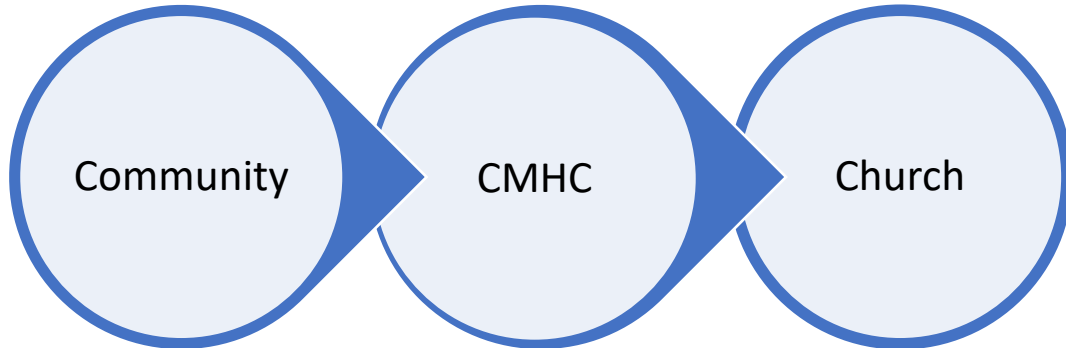
²⁴ Swinton, John. *Resurrecting the Person*, 147.

²⁵ Swinton, 148-149.

²⁶ *Ibid.*

develop a network with other agencies that may also offer services to persons living with mental health issues. The CMHC relies upon a multidisciplinary approach to chaplaincy, using the skills of community organizers, members of the medical community, as well as agencies that perform the functions of advocacy and education. In this model, Swinton sees the chaplain’s task as “a bridge between the hospital and the community.”²⁷

The CMHC reaches out to and includes family support organizations, volunteers, mental health professionals, day centers, and recovery organizations. The driving force behind this model is Swinton’s concept of ‘radical friendship.’ I would also term this as apostolic friendship. The concept of the model is generally presented in this diagram:



My purpose then is to begin to develop such a chaplaincy model in Carter County. While the third component of the model, developing a network of community providers, is essential, I realize that it can take years to develop such close and effective relationships. The qualitative

²⁷ Swinton, 150-151.

research process of this project will seek to explore what beliefs the population has, whether there are prior relationships with specific churches, and what spiritual resources would be meaningful to the population. The result is to find that “accepted and personally acceptable” place for the population within the church community.

The Plan of this written project

This project consists of three parts. *Part One* addresses the opioid crisis in America. We will discuss the status of the current opioid crisis, and the association with the experience of pain and pain management. From there we proceed to a technical discussion of how opioid addiction works and consider the long-term effects of addiction. Last, we will discuss treatment options.

This account is what I refer to as the Standard Model or NIDA (National Institute on Drug Addiction) model of addiction, which sees addiction as a medical problem. In *Part Two* we will look at other perspectives, including those who are opponents of the Standard Model. We will look closely at the issue of control in the medical model. Racism is blatantly embedded in our drug policies, so we will discuss that issue separately in Chapter Nine. We close by taking up the cultural perspective of Appalachia.

In *Part Three*, we will express a theology of pastoral care to those living with addiction and will discuss qualitative research with the local community. We will begin by reviewing the Practical Theology of John Swinton, because his work is vital to this project. I will then make a personal statement of pastoral theology, with the hope of rendering informed pastoral care to our population.

Chapter One

The Crisis of Opioid Addiction in America

“The American vice of modular repetition, combined with what is perhaps our basic search: to find something that can kill intense pain without causing addiction.”

Gravity’s Rainbow

Thomas Pynchon

In this opening chapter we will consider the history of the Crisis of Opioid Addiction in America, 1996-2023. We should begin by noting that this is the deadliest opioid crisis in our nation, but it is not the first, nor will it be the last crisis. As we will see, three precipitating factors generated a tidal wave of pain and destruction in the current opioid crisis: the marketing of Oxycontin, the rapid growth of pain management as a medical sub-specialty, and the incredibly successful export of Mexican black tar heroin to the United States. We will explore these three factors below.

A thorough knowledge of the history is important for at least three reasons. The first is that the project participants with whom we will work not only know this history, but many have lived through it from the beginning. They know the history and its tragic consequences. To work effectively with this population, we must know as much of this, their story, as we can. If we do not, we run the risk of seeming uninformed or even naïve, and thus, of losing pastoral credibility.

The second reason is financial. The Trump White House Council of Economic Advisers estimated that the financial cost of the crisis from 2015 to 2018 alone was \$2.5 trillion.²⁸ That staggering financial cost to the nation continues. The economic calculations include “the value of

²⁸ Council of Economic Advisors, The Trump White House Archives. “The Full Cost of the Opioid Crisis: \$2.5 trillion over years.” Accessed online on February 16, 2022, at <https://trumpwhitehouse.archives.gov/articles/full-cost-opioid-crisis-2-5-trillion-four-years/>.

lost lives, as well as increases in criminal justice costs, and reductions in productivity.”²⁹ The report acknowledges the devastation from “America’s very human crisis next door,” an apt phrase for what we face as a nation.³⁰ In this project we wish to consider closely this “very human crisis next door.”

Third, is the cost numbered in lives lost and loved ones affected. While the financial cost of the crisis is astounding, the number of those who have died from opioid overdose, who have lost employment and careers, who have broken families, and those who grieve the totality of this devastation is heartbreaking and unacceptable. Those affected are those who sit in our pews, are our cousins, nephews and nieces, parents and grandparents, co-workers, and neighbors. Opioid addiction and the path of destruction it leaves behind is a silent, secretive killer. One reason for writing this project is to call the church’s attention to that destruction, as well as its history and causes.

Manufacturing a Crisis

On December 12, 1995, the Food and Drug Administration (FDA) approved a new opioid painkiller, OxyContin. In 1996, Purdue Pharma of Stamford, Connecticut, patented, marketed, and began introducing OxyContin to the market. Purdue Pharma was owned by three psychiatrist brothers, Arthur, Mortimer, and Raymond Sackler. OxyContin (Contin stands for continuous) is a time-released opioid agonist that acts on the opioid receptors in the brain and spinal cord and is an equal substitute for heroin.³¹ OxyContin is made by modifying thebaine, an alkaloid present in

²⁹ Ibid.

³⁰ Ibid.

³¹ National Drug Intelligence Center, Department of Justice. *OxyContin Diversion and Abuse, 2001*, <https://www.justice.gov/archive/ndic/pubs/651/backgrnd.htm> Accessed 22 Jan 2022.

opium.³² The resultant product acts as a central nervous system depressant with a high potential for addiction and abuse. Purdue Pharma aggressively marketed OxyContin with massive, well-paid sales teams and sophisticated tactics.³³ Sales of the product grew from forty-eight million dollars in 1996 to nearly 1.1 billion dollars by 2000 – this growth in only four years.³⁴ The growth in the use of the product was made possible both by the increase of patients suffering from pain and by eagerly participating physicians, who prescribed the drug in massive numbers. The prescription of opioids hit its peak in 2012. In that year, 255,207,954 total prescriptions were written nationwide, with a dispensing rate of 81.3 prescriptions per 100 persons.³⁵ By the year 2017 drug overdose had become the leading cause of death for Americans under the age of 50.³⁶

| Most Commonly Found Opioids |
|--|
| Hydromorphone |
| Morphine |
| Heroin |
| Oxycodone (Oxycontin) |
| Hydrocodone |
| Codeine |
| Methadone |
| Fentanyl |
| Buprenorphine |

The growth was not only in healthy profits, but in a chain of devastation eventually felt across the United States. In response to the crisis, on December 17, 2020, the House of Representatives,

³² Van Zee A. “The promotion and marketing of OxyContin: commercial triumph, public health tragedy,” *American journal of public health*, no. 2 (Issue 99, 2008): 221–227. Accessed online on January 2, 2022, at <https://doi.org/10.2105/AJPH.2007.131714>.

³³ Reyes, Sean. Office of the Utah Attorney General. “*Opioids have killed at least 460,000 Americans*,” Press Release, October 25, 2019. Accessed online on January 22, 2022, at <https://attorneygeneral.utah.gov/tag/opioid-epidemic/>

³⁴ Van Zee. “The promotion and marketing of OxyContin,” 221.

³⁵ Centers for Disease Control and Prevention. “U.S. Opioid Dispensing Rate Maps.” Available from the CDC website at <https://www.cdc.gov/drugoverdose/rxrate-maps/index.html> Accessed online on February 10, 2022.

³⁶ Wakeman, Sarah E. “Why it’s Inappropriate not to treat Incarcerated Patients with Opioid Agonist Therapy,” *AMA Journal of Ethics*, Vol. 19, No. 9, (September 2017): 922. Accessed online on April 26, 2022, at <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/stas1-1709.pdf>.

Committee on Oversight and Reforms met in session to discuss the Sackler family's role and responsibility in the crisis. The Committee's Chairwoman, Rep. Carolyn B. Maloney, made this opening statement:

Since 1999, nearly half a million lives have been cut short by opioid overdoses in the United States alone. These lives were taken from us too soon. They were taken unnecessarily, and they were taken unfairly. For each life lost, there have been many other family members -aunts, siblings, children, and loved ones- left to pick up the pieces. And right there in the middle of all this suffering was Purdue Pharma, the manufacturer of a highly addictive painkiller, OxyContin. This company played a central role in fueling one of America's most devastating public health crises. Purdue has generated more than \$35 billion in revenue since bringing OxyContin to market.³⁷

The Appalachian Region of the United States, in an area roughly paralleling the north/south Interstate-81, was the initial bomb crater in an explosive epidemic.³⁸ In the peak year of 2016, the states with the highest level of opioid prescriptions were West Virginia, Kentucky, Tennessee, Alabama, Louisiana, and Oklahoma.³⁹

In 2017, in a terse one-paragraph memorandum, the Acting Director of the Department of Health and Human Services, Eric D. Hargan, declared that the opioid crisis in America is a public health emergency.⁴⁰ From the year 2000 to 2019 nearly 460,000 Americans had died of

³⁷Maloney, Carolyn. B. Chair. Committee on Oversight and Reform, House Hearing of the 116th Congress, Second Session. "The Role of Purdue Pharma and the Sackler Family in the Opioid Epidemic." December 17, 2020. Accessed online on February 10, 2022 at <https://www.govinfo.gov/content/pkg/CHRG-116hhrg43010/html/CHRG-116hhrg43010.htm>.

³⁸ Macy, Beth. *Dopesick: Dealers, Doctors, and the drug company that addicted America*, (New York: Little, Brown and Company, 2018), 8.

³⁹ Centers for Disease Control and Prevention. "U.S. Opioid Dispensing Rate Maps," Available from the CDC website at <https://www.cdc.gov/drugoverdose/rxrate-maps/index.html> Accessed online on 10 Feb 2022.

⁴⁰ Hargan, Eric D. Acting Secretary of the Department of Health and Human Services. "*Determination that a public health emergency exist*," Memorandum of the Department of Health and Human Services. Website archive, accessed online on January 22, 2022, at <https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf>.

opioid overdose.⁴¹ The Office of the Utah Attorney General notes that these deaths were more than the number of Americans who died in World War II and the Vietnam War combined. In the year 2019 alone, 70,630 Americans died of opioid overdose.⁴² This number represents the deaths from all opioid overdoses, including heroin.

Why did such a rapid increase in addiction and deaths happen, specifically in this period from 1996 to the present? After all, the Western world has known of the effects of opium since at least 2100 BCE, its usage attested on a Sumerian clay tablet.⁴³ In May of 1805, a twenty-one-year-old German pharmacist, Friedrich Wilhelm Adam Sertuner, isolated an alkaloid compound from the resin of opium poppies.⁴⁴ The resultant product was named Morphine, after Morpheus, the Greek god of dreams, due to the dreamy state (known as twilight by modern-day addicted persons) the drug produces. Morphine was highly effective at controlling pain. In the 1850s the first reliable hypodermic syringes were developed, making the

“In 1864, the ‘Lancet’ published a number of articles pointing out the danger of the use of morphin as an addiction. This was probably the first warning note against its use.”

T.D. Crothers

Morphinism

1902

⁴¹ Reyes, Sean D. Office of the Utah Attorney General. “*Opioids have killed at least 460,000 American,*” Press Release, October 25, 2019. Accessed online on January 22, 2022, at <https://attorneygeneral.utah.gov/tag/opioid-epidemic/>.

⁴² The Department of Health and Human Services. *What is the U.S. Opioid Epidemic?* Accessed online on January 25, 2022, at <https://www.hhs.gov/opioids/about-the-epidemic/index.html>.

⁴³ Norn S, Kruse PR, Kruse E. Opiumsvalmuen og morfin gennem tiderne [History of opium poppy and morphine]. *Dan Medicinhist Arbog*. 33 (2005); 171-84. Danish. PMID: 17152761. Made available by the National Institutes of Health. Accessed online on January 26, 2022, at <https://pubmed.ncbi.nlm.nih.gov/17152761/>.

⁴⁴ The University of Chicago, College of Medicine. *At the Forefront*. “As Morphine turns 200, drug that blocks its side effects reveals new secrets,” May 19, 2005. Accessed online on January 26, 2022 at <https://www.uchicagomedicine.org/forefront/news/as-morphine-turns-200-drug-that-blocks-its-side-effects-reveals-new-secrets> Accessed 26 Jan 2022.3.

administration of morphine effective and accurate.⁴⁵ Morphine was used widely during the American Civil War for relief from gunshot wounds and amputation pain. By 1900, an estimated 300,000 persons in the United States lived with morphine addiction; most of that number were Civil War veterans and female patients.⁴⁶ This was the first opioid crisis in our history – a crisis only resolved by the eventual deaths of those who were addicted.

In the late nineteenth century, The Bayer Corporation of Germany, working on medications for pain, discovered that by the acetylation of morphine, a new product was obtained, which was stronger than morphine. Calling it the “Hero of Pain Treatment,” Bayer named the product Heroin.⁴⁷ In 1898 Bayer started production, using it at first for cough suppression. By the early 1900s, Bayer had realized the



devastating effects of addiction to heroin and withdrew the product from the market. By 1938 the medicinal use of the product was greatly curtailed, but the production of heroin went underground. A 1962 study of heroin at the Harvard Medical School found that the narcotic was approximately four times stronger than morphine.⁴⁸ Bayer eventually succeeded in bringing an alternative to heroin to market, Aspirin. In fact, almost all our known pain relievers to date derive from two plants: the willow and the opium poppy. Aspirin, derived from the willow, gave

⁴⁵ Ibid.

⁴⁶ Meier, Barry. *Painkiller: An empire of deceit and the origin of America's opioid epidemic*. (New York: Random House, 2018), 25.

⁴⁷ Hosztafi S. A heroin története [The history of heroin]. (No pagination.)

⁴⁸ Claus W. Reichle, Gene M. Smith, Joachim S. Gravenstein, Spyros G. Macris and Henry K. Beecher “Comparative Analgesic Potency of Heroin and Morphine in Postoperative Patients,” *Journal of Pharmacology and Experimental Therapeutics* 136, no. 1 (April 1962): 43-46. Accessed online on January 22, 2022, at <https://jpet.aspetjournals.org/content/136/43>.

birth to a wave of NSAIDS, still commonly used, while the opium poppy has launched the careers of synthetic opioids.

In the 1940s, German scientists synthesized methadone as a pain reliever, but methadone would later be widely adopted as a treatment for addiction.⁴⁹ In the 1960s, a chemist, John Lewis, working at the University of Bristol discovered buprenorphine, an opioid that, along with methadone, due to its metabolic properties, could be used in the treatment of persons addicted to opioids.⁵⁰ Finally, in 1959 another synthetic opioid product, Fentanyl, became available, primarily for intravenous surgical use. Fentanyl is approximately 100 times more potent than morphine and *50 times more potent than heroin*.⁵¹ To be clear, these narcotics, except for heroin, have a licit and beneficial medicinal use. They are used extensively for surgical and cancer pain. Used appropriately, they are an important tool of medical care. It is the illicit use that has created a crisis in our nation.

In America, we have of course been aware of opioid addiction, primarily of addiction to heroin. The blockbuster movie, *The French Connection*, released in 1971, as well as popular 1970s television series, such as *Kojak*, brought the issues of heroin abuse to national attention - although heroin use for most still seemed a ‘far-off’ problem. By the 1920s heroin addiction was seen as an ‘inner city,’ urban problem. The Harvard-educated writer, William S. Burroughs, published *Junky* in 1953 and *Naked Lunch* in 1959. In both Burroughs writes in a narrative memoir style, documenting the seamy side of heroin addiction in America. Popular jazz

⁴⁹ Quinones, Sam. *Dreamland: The true tale of America’s Opiate Epidemic*, (New York: Bloomsbury Publishing, 2015/2019): 63.

⁵⁰ Quinones, Sam. *Dreamland: The true tale of America’s Opiate Epidemic*, 56.

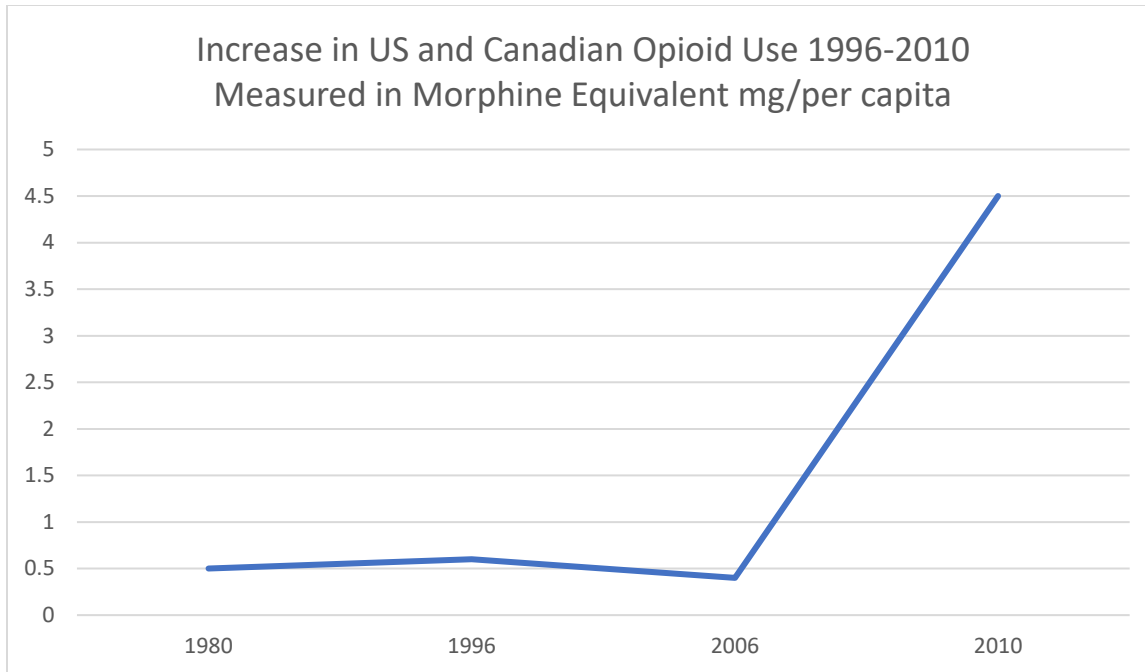
⁵¹ Department of Justice and Drug Enforcement Agency. “Drug Fact Sheet: Synthetic Opioids.” Fact sheet released in April of 2020. Accessed online on February 9, 2022, at <https://www.dea.gov/sites/default/files/2020-06/Synthetic%20Opioids-2020.pdf>.

musicians, such as Charlie Parker, and the virtuoso guitarist Joe Pass, were known to favor heroin. Heroin abuse peaked in the 1970s but would later make a jolting comeback. But it was on Super Bowl Sunday 2014 that the reality of the current opioid crisis caught national attention.

On February 2, 2014, Tony and Oscar-nominated actor, Philip Seymour Hoffman, died of a heroin overdose in his New York City apartment. Suddenly, white celebrities were dying of opioid addiction, which was once seen as only an ‘inner-city’ problem. In April 2016, the acclaimed musician, Prince, died of a Fentanyl overdose. In October 2017, Rock and Roll Hall of Fame singer/songwriter, Tom Petty, died of an overdose from a combination of OxyContin and Fentanyl. The publication of two books, *Dreamland* by Sam Quinones, published in 2015, and *Dopesick*, by Beth Macy, published in 2018, raised public awareness of the opioid crisis. Suddenly, the addiction problem had reached the mainstream news.

But it was the year 1996 that serves as a watershed year in the explosion of addiction that seized the country. Purdue Pharma’s aggressive marketing campaign made OxyContin a highly prescribed medication for the treatment of pain. Although prescriptions were required, OxyContin was easily diverted to an illicit market. Purdue Pharma maintained that OxyContin was virtually free of the risk of addiction because it contained a time-release coating that would thwart the drug’s diversion to illicit use.⁵² West Virginians were among the first to disprove this corporate claim. They found that if they dissolved the tablet with saliva, they could extract the core of the pill, which was pure hydrocodone, which is equivalent in strength to heroin. By then crushing the extracted hydrocodone, they produced a substance that could either be snorted or added to water to form an injectable solution.

⁵² Van Zee A. (2009). The promotion and marketing of OxyContin: commercial triumph, public health tragedy, 223.



Graph modified from Hastie, Barbara A. Gilson, Aaron M. Maurer, Martha A, and Cleary, James F. “An Examination of Global and Regional Opioid Consumption Trends 1980-2011.” *Journal of Pain and Palliative Care Pharmacotherapy*, (September 1, 2014): 265. Accessed online on April 9, 2022, at DOI: 10.3109/15360288.2014.941132. Opioids are measured according to a morphine standard, so that all opioids are rated in morphine equivalents (ME).

By the early 2000s, the Food and Drug Administration (FDA) began to note a spike in opioid overdoses and deaths, with OxyContin always at the center of the suffering.⁵³ By 2009 the FDA had recorded 1.2 million emergency department visits due to the misuse of opioids, again prominently, OxyContin. This number of visits represented a ninety-four percent increase in emergency room visits since 2004, when most drug-related visits were for the abuse of heroin and cocaine.⁵⁴ Generally, the initial governmental response was to issue warnings to

⁵³ Food and Drug Administration. “Timeline of Selected FDA Activities and Significant Events Addressing Opioid Misuse and Abuse,” (2018). Accessed online on March 11, 2022, at FDA website <https://www.fda.gov/media/106638/download>.

⁵⁴ *Ibid.*

manufacturers and to improve patient packaging and labeling to clarify the dangers of OxyContin.

On January 17, 2003, the Department of Health and Human Services issued a severe Warning Letter to Michael Friedman, Chief Operating Officer (COO) of Purdue Pharma regarding false marketing claims.⁵⁵ In the letter the Department found that its marketing claims were in violation of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C., section 331 and 352. The letter clearly lays out the Department's position on Purdue Pharma marketing activities, specifically advertisements that had appeared in the prestigious *Journal of the American Medical Association* (JAMA). I wish to quote the findings verbatim.

Your journal advertisements omit and minimize the serious safety risks associated with OxyContin and promote it for uses beyond which have been proven safe and effective. Specifically, your journal advertisements fail to present in the body of the advertisements any information from the boxed warning in the approved product labeling (PI) for OxyContin regarding the potentially fatal risks associated with the use of OxyContin and the abuse liability of OxyContin, which is a Schedule II controlled substance, and make unsubstantiated efficacy claims promoting the use of OxyContin for pain relief. Your journal advertisements also understate the minimal safety information that is presented.

Your advertisements thus grossly overstate the safety profile of OxyContin by not referring in the body of the advertisements to serious, potentially fatal risks associated with OxyContin, thereby potentially leading to prescribing of the product based on inadequate consideration of risk. In addition, your journal advertisements fail to present in the body of the advertisements critical information regarding limitations on the indicated use of OxyContin, thereby promoting OxyContin for a much broader range of patients with pain than are appropriate for the drug. The combination in these advertisements of suggesting such a broad use of this drug to treat pain without disclosing the potential for abuse with the drug and the serious, potentially fatal risks

⁵⁵ Department of Health and Human Services. "Warning Letter from Thomas W. Abrams to Michael Friedman, COO of Purdue Pharma." (January 17, 2003). Accessed online on March 11, 2022, at <http://wayback.archive-it.org/7993/20170112065652/http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/EnforcementActivitiesbyFDA/WarningLettersandNoticeofViolationLetterstoPharmaceuticalCompanies/UCM168946.pdf>.

associated with its use, is especially egregious and alarming in its potential impact on the public health.⁵⁶

The Department further advised Purdue Pharma that OxyContin has an abuse potential like morphine; that it was intended to be swallowed whole, not crushed; that the narcotic was never approved for ‘as needed’ (PRN) use, and that the narcotic was not approved for post-operative use for patients who had not been prescribed the drug previously (not for opioid naïve patients).

The warning was perhaps late in coming. By 2004 OxyContin had become a leading drug of abuse in the US.⁵⁷ In 2001 alone Purdue Pharma spent \$200 million to market its product.⁵⁸ One of the primary sales tactics was to invite prescribers to all-expenses paid conferences at resorts in Florida, Arizona, and California. More than 5,000 physicians and nurses were known to have attended.⁵⁹ Purdue ran a program to identify the highest prescribing physicians nationwide and targeted those physicians for aggressive marketing.⁶⁰ Marketers were highly paid. In addition to their salary, they could earn sales bonuses from 71,500 to 245,000 dollars a year.⁶¹ Purdue increased its marketing force from 318 sales representatives to 671 to meet the demand. At the height of its marketing campaign, Purdue had a physician call list of 94,000 physicians. Purdue freely distributed ‘swag’ – free items to remind physicians and patients of Purdue’s presence. This included a swing-music CD “*Get in the Swing with OxyContin.*”⁶² The cover (below)

⁵⁶ Department of Health and Human Services, Warning Letter: 1-2.

⁵⁷ Van Zee A. (2009). The promotion and marketing of OxyContin: commercial triumph, public health tragedy, 221.

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ Van Zee A. (2009), 222.

⁶¹ Ibid.

⁶² Khazan, Olga. “Whatever happened to pharmaceutical swag?” *The Atlantic*. Nov 7, 2014. Accessed online on January 27, 2022, at <https://www.theatlantic.com/health/archive/2014/11/whatever-happened-to-pharmaceutical-swag/382419/>.

portrays senior citizens dancing pain-free to swing music, presumably because of their opioid use.

Purdue targeted primary care physicians, who were the least likely to have the time or specialization to administer pain management programs.⁶³ Perhaps most egregious was Purdue's deliberate misrepresentation of the risk of addiction in patients not being treated for cancer pain (termed non-malignant pain) and consistently misrepresented the risk of addiction.⁶⁴ Rep.

Maloney continued her opening statement:

At the behest of the Sackler Family, Purdue targeted high-volume prescribers to boost sales of OxyContin, ignored and worked around safeguards intended to reduce prescription opioid misuse, and promoted false narratives about their products to steer patients away from safer alternatives and *deflect blame toward people struggling with addiction*. And most despicably, Purdue and the Sacklers worked to deflect blame for all that suffering away from themselves and *onto the very people struggling with OxyContin addiction* (my italics).⁶⁵

In litigation, Purdue Pharma was charged with using non-population specific and non-research based and peer-reviewed studies to misrepresent the danger of addiction. In fact, in its marketing literature, Purdue Pharma claimed that OxyContin had a low or nonexistent risk of addiction. Purdue Pharma, in an out-of-context use, pointed to a one-paragraph letter to the editor that Dr. Hershel Jick and Dr. Jane Porter had submitted to the *New England Journal of Medicine* on January 10, 1980 – sixteen years before OxyContin hit the market. The letter was intended to point to findings from database surveillance *only* of inpatient hospital patients in the City of Boston who had been treated with opioids for pain. The letter pointed out that the findings discovered only four patients who had become addicted because of in-patient care.

⁶³ Van Zee, 223.

⁶⁴ Ibid.

⁶⁵ Maloney, Carolyn. B. Chair. Committee on Oversight and Reform, House Hearing of the 116th Congress, Second Session. "The Role of Purdue Pharma and the Sackler Family in the Opioid Epidemic."

While it may have been a fine letter to the editor, its research value was the equivalent of a Google search. In 2017, Dr. David Baker of the Joint Commission would note that this letter to the editor had been cited over 1,000 times in medical literature to support the notion that addiction from narcotics is rare.⁶⁶ Later investigation of Purdue Pharma found that the company had “blatantly disregarded standards of bioethics,” and that “ulterior financial motives led certain companies to prioritize transactional values above the health of customers.”⁶⁷ The misbranding of OxyContin and the subsequent rapid spread of addiction led to thousands of lawsuits filed by local, state, tribal, and federal agencies against Purdue Pharma, other pharmaceutical makers, large pharmacies, to include Walgreens and Walmart, and even small “good neighbor pharmacies.”

In 2018 the Attorney General of the State of Tennessee brought a lawsuit against a wholesale drug distributor, AmeriSourceBergen, for knowingly contributing to the epidemic. So flagrant was the abuse that the plaintiff affirms: “Between 2006 and 2014, Amerisource distributed over 712 million opioid dosage units in Tennessee, more than any other distributor. It not only knowingly kept pharmacies where diversion was occurring, or was most likely to occur, supplied with opioids—it actually sought out their business.”⁶⁸ In a section of the lawsuit addressing the opioid problem in the Tri-Cities, the plaintiff continues:

⁶⁶ Baker DW. History of The Joint Commission’s Pain Standards: Lessons for Today’s Prescription Opioid Epidemic, *JAMA*. 2017;317(11):1117–1118. doi:10.1001/jama.2017.0935: 1118.

⁶⁷ Alonso, Jason Sanchez. “Purdue Pharma Deceptive Research Misconduct,” In *Voices in Bioethics*: Feb 2021. (Columbia University Press, ISSN: 2691-4875). Accessed online via DOAJ: Directory of Open Access Journals on January 28, 2022 at <https://doaj.org/article/2b81338150b1493390edb87e56bc135d>.

⁶⁸ *State of Tennessee ex re Herbert H Slatery III, Attorney General and Reporter v. AmerisourceBergen Drug Corporation*. Sixth Judicial District, Knoxville. (October 2019): 5. Accessed online and downloaded in PDF on March 2, 2022, at <state of tn v amerisource.pdf>

284. This Tri-Cities region, much like Knoxville, is notorious for prescription pill abuse. Amerisource had ample knowledge of this abuse and diversion yet continued to oversupply these communities with tens of millions of opioids anyway.

285. Amerisource not only took advantage of this area's appetite for opioids by supplying it with oxycodone and hydrocodone, but it also supplied huge quantities of buprenorphine. Of course, the irony is that buprenorphine is often used to medically treat opioid addiction but since it is itself an opioid, it is also susceptible to abuse and diversion, primarily because it can cause euphoria.

287. Among other things, Amerisource knew it was supplying buprenorphine pill mills. In the Tri-Cities' area alone, Amerisource had direct evidence that one Tennessee pharmacy was purchasing more buprenorphine than any other pharmacy in the country to dispense to large groups of doctor-shopping patients who were driving from places like Kentucky, Virginia, North Carolina, and West Virginia to go to a specific doctor, who only accepted cash payments and would write Buprenorphine-8 prescriptions for anyone willing to pay, and this pharmacy accepted what it knew to be medically illegitimate prescriptions for controlled substances in exchange for cash.⁶⁹

Four local pharmacies were cited, including a pharmacy in Johnson City, TN, Blankenship Pharmacy. Blankenship and Gray Pharmacies supplied 92% of the buprenorphine to Washington County. Blankenship has since been shuttered.



Despite withering criticism from those affected by the opioid crisis, from government agencies, and despite thousands of lawsuits, Purdue Pharma's position to this date is to deny responsibility and to 'blame the patient' by deflecting blame to those who had fallen to Oxycontin addiction. In the face of an onslaught of lawsuits from federal, state, local, and tribal

⁶⁹ *Tennessee v. AmerisourceBergen*, 110-111.

agencies, Purdue Pharma declared bankruptcy on September 15, 2019.⁷⁰ Plaintiffs moved quickly to prevent the Sackler family from protecting their assets under bankruptcy protection.

In the spring of 2022, legal proceedings against the family were finally settled, the result of which is that the Sackler family would pay up to six billion dollars, much of which will be redirected to states and tribal areas to address the cost of addiction recovery.⁷¹ One other feature of the settlement is notable. According to the agreement, three leading members of the Sackler family were to hear live testimony from the loved ones of those who had died because of addiction to opioids. Addressing the family's indifferent attitude to the suffering, family members did not restrain their language addressed to the family. According to Anne Andrews, an attorney for 70,000 relatives: "The Sacklers have to listen to the direct victims of their crimes, the stories of people who have died, who lost the potential of their lives. But for years the Sacklers painted them in their emails as slime, addicts, as low-lives, and that it was their fault they were addicted. But they are America. They are you and me."⁷²

While the introduction of OxyContin certainly impacted the addiction problem in the United States, the causes of the opioid crisis of 1996-2023 are complex. We will consider two other developments that coincided with the rapid distribution of OxyContin that contributed to this unique and massive opioid crisis: a revolution in the care of patients with pain and the amazing rise of the Mexican black tar heroin enterprise.

⁷⁰ Hoffman, Jan and Walsh-Williams, Mary. "Purdue Pharma, Maker of OxyContin, files for Bankruptcy," *The New York Times*, September 15, 2019. Accessed online on March 12, 2022, at <https://www.nytimes.com/2019/09/15/health/purdue-pharma-bankruptcy-opioids-settlement.html>.

⁷¹ Hoffman, Jan. "Sacklers and Purdue Pharma Reach New Deal with States over Opioids," *The New York Times*, March 3, 2022. Accessed online on March 3, 2022, at <https://www.nytimes.com/2022/03/03/health/sacklers-purdue-oxycontin-settlement.html>.

⁷² Hoffman, Jan. "'You Murdered my Daughter': Relatives of OxyContin Victims Confront the Sacklers," *The New York Times*, March 10, 2022. Accessed online on March 10, 2022 at <https://nyti.ms/3hUTh8Y>.

A revolution in pain care

The first development, beginning in the 1970s with the hospice movement, was a revolution in the care of patients in pain. The movement, begun by Cicely Saunders in England, insisted that patients dying from cancer be relieved of their pain in their final days with aggressive opioid treatment, primarily in the form of morphine.⁷³ This was and still is an emphasis on treating patients humanely, so the hospice movement spread. Eventually, the idea of relieving pain in cancer patients with aggressive morphine treatment was enshrined in the policies of the World Health Organization (WHO).⁷⁴ Further, WHO policy stated that “if a patient said he was in pain, doctors should believe him and prescribe accordingly.”⁷⁵

In 1960, Dr. John Bonica,⁷⁶ working as chief of anesthesia at the University of Washington School of Medicine, opened the first pain clinic in America.⁷⁷ Bonica undertook the management of pain through a multi-disciplinary approach, later dubbed the biopsychosocial model, being the first in the nation to do so. Bonica would go on to write a seminal work, *The Management of Pain*, which was a foundational text for those physicians taking up work in the new field of pain management. In this work Bonica wrote:

A number of studies have shown that house officers and some physicians prescribe narcotics at two-thirds or three-fourths of the dose required to relieve severe pain and that nurses under-administer drugs by another one-third to one-half. These studies revealed that the reasons for such underdosing included inadequate knowledge of the pharmacology of these drugs so that physicians underestimated the effective dose range and overestimated the duration of action and that both nurses and physicians had an exaggerated opinion of addiction potential and the dangers of respiratory depression. As

⁷³ Quinones, 80.

⁷⁴ Quinones, 81. Quinones explains the birth of the idea, which at the time was quite revolutionary.

⁷⁵ 82

⁷⁶ Quinones introduces the reader to Dr. Bonica in pages 86-88.

⁷⁷ 86.

will be emphasized in many parts of this book, these are *not* valid reasons for underdosing patients with pain.⁷⁸

In other words, pain patients had been undertreated because medical staff did not have the adequate education to dose properly. Bonica and his associate at the University of Washington, John Loeser, and others were champions of patient pain care.⁷⁹ Relief of pain is one of the objectives of medicine.⁸⁰ Bonica saw that medical officers were not doing enough to treat pain adequately. One result of his work was that all patients, not only those with cancer pain, but those suffering pain from all its causes (non-malignant pain) should be treated compassionately and aggressively for the pain condition.

Working at the Sloan Kettering Cancer Center in the 1980s, Dr. Russell Portenoy became a leader in the pain management movement⁸¹ and a developer of the concept of palliative care.⁸² By the time OxyContin was marketed in 1996, physicians had become convinced that treating patients in pain (based on their own statement) with opioids was the humane action. Because of what turned out to be dubious studies, including the now famous Jick letter, physicians were further convinced that patients treated with opioids were at low risk of addiction. Purdue Pharma consistently insisted falsely that the risk of addiction was “less than one percent.”⁸³

⁷⁸ Bonica, John J. et al. *The Management of Pain*. Second Edition, Vol. I. (Philadelphia: Lea and Febiger, 1990), 13.

⁷⁹ Loeser JD. Pain: disease or dis-ease? The John Bonica Lecture: presented at the third World Congress of World Institute of Pain, Barcelona 2004. *Pain Pract.* 2005 June (2):77-84. Accessed online on January 22, 2022, at doi: 10.1111/j.1533-2500.2005.05204.x. PMID: 17177753: 77.

⁸⁰ *Ibid.*

⁸¹ The most lucid history of the development of the field of pain management is found in: Meier, Barry. *Painkiller: An empire of deceit and the origin of America's opioid epidemic*. (New York: Random House, 2018).

⁸² Meier, Barry. *Painkiller*, 83.

⁸³ *Ibid.* The Veterans Health Administration had begun this practice in the 1990s.

In 1990, Dr. M.B. Max proposed a series of reforms in health care in an article in *The Annals of Internal Medicine*.⁸⁴ Many of these proposals were subsequently put into practice. Max suggested making pain signs visible at the bedside so that physicians are aware of the patient's pain level; providing physicians and nurses bedside guides of analgesics; and advising physicians “to work with narcotics control authorities to encourage therapeutic opioid use.”⁸⁵ In 2000, the Joint Commission emphasized the need for physicians and nurses to use an approved pain scale in assessing their patients. Caregivers screen patients by asking whether they are experiencing pain.⁸⁶ If the patient affirms pain, then they are asked to rate (subjectively) their experience of pain on a scale from 0-10, with zero representing no pain and ten representing the worst pain imaginable. This (subjective) assessment then becomes part of the data that inform a treatment plan.

By the year 2001, the revolution was complete. In that year the Joint Commission implemented a standard of care that considered pain to be “The Fifth Vital Sign.”⁸⁷ Traditionally in the practice of medicine there are four vital signs: temperature, pulse rate, respiration rate, and blood pressure. By making pain the fifth vital sign, The Joint Commission had raised the experience of pain and its treatment to the forefront of patient care. Pain was to be treated

⁸⁴ Max, M.B. “Improving Outcomes of analgesic treatment: Is Education Enough?” *Ann Intern Med.* 113, no.11. (1990): 885-889. Accessed online on January 22, 2022, at [Improving outcomes of analgesic treatment: is education enough?: Milligan OneSearch \(oclc.org\)](#).

⁸⁵ Baker DW. History of The Joint Commission’s Pain Standards: Lessons for Today’s Prescription Opioid Epidemic, *JAMA.* 2017; 317(11):1117–1118. doi:10.1001/jama.2017.0935: 1117. Accessed online on February 8, 2022, at [History of The Joint Commission's Pain Standards: Lessons for Today's Presc...: Milligan OneSearch \(oclc.org\)](#).

⁸⁶ Ibid.

⁸⁷ Ibid.

aggressively.⁸⁸ Only a year later, in 2002, the Joint Commission changed its implementation practices to suggest: “Pain *used to be* considered the fifth vital sign”⁸⁹ (my italics). By 2004 the suggestion had been retracted altogether.

But this was too late. One study had found that “75% of individuals who use heroin describe their first opioid abuse as a prescription drug.”⁹⁰ By 2019 the pain revolution was in reverse gear, as the medical community and government agencies became aware of the widening crisis of opioid addiction.

While the intentions of aggressive pain management are noble and in keeping with medical philosophy, the medical community had not found the fine balance between treating pain in a multidisciplinary fashion and the overzealous prescription of opioids. In fact, the omnipresence of ‘pill mills,’ unscrupulous practices run by rogue physicians who dispensed narcotics for cash, and of unethical pharmacies willing to dispense wildly inappropriate numbers and dosages of prescriptions, would leave a lasting stain on noble intentions.

After 2011, government regulatory measures were in place to decrease the rate of opioid prescriptions, which was necessary, but it had two negative consequences. First, was the effect

⁸⁸ Bertagnolli, Andrew. “Pain: The 5th Vital Sign,” *Patient Care*, Vol. 38, No. 9 (September 2004): 66-70. Accessed online on February 7, 2022, at <https://eds-s-ebscohost.com/milligan.idm.oclc.org/eds/pdfviewer/pdfviewer?vid=1&sid=647264d8-b7e6-4395-b321-d8d8702fa065%40redis>.

⁸⁹ Baker DW. History of The Joint Commission’s Pain Standards: Lessons for Today’s Prescription Opioid Epidemic: 1118.

⁹⁰ Chidgey, Brooke A., McGinige, Katherine L., and McNaull, Peggy P. “When a Vital Sign leads a Country Astray,” *Journal of the American Medical Association: Surgery*, Vol. 154, No. 11 (November 2019): 987. Accessed online on February 7, 2022, at PMID: 31411665 DOI: [10.1001/jamasurg.2019.2104](https://doi.org/10.1001/jamasurg.2019.2104).

on addiction. Persons who had become dependent on opioid prescriptions found that new regulations were in place to crack down on opioid prescribing. Pushed on by addiction, they found themselves attempting to supplement the decrease in opioids by turning to the black market.⁹¹ Second, legitimate prescribing for severe pain was impacted. So cautious had physicians become that even opioids dispensed for bone cancer metastasis patients who were enrolled in private insurance and Medicare Advantage actually declined between 2011 and 2017.⁹²

Cautioning that physicians need to take care in their management of pain conditions considering the opioid epidemic, Baker cautioned that “it is necessary to carefully acknowledge concerns that patients with chronic, painful conditions may be undertreated and stigmatized if they need adjunctive opioid therapy.”⁹³ In an interview with Sam Quinones, Dr. John Loeser, Bonica’s colleague, summarized the issue this way:

“There is a philosophy among many patients – ‘I’m entitled to be free of pain.’ People are entitled to healthcare. Health care should be a human right. Pain management must be a part of health care. But they are not entitled to pain relief. The physician may not be capable of providing them with pain relief... You’re not entitled to pain relief any more than you are entitled to happiness.”⁹⁴

⁹¹ This was the case with many clients in my own practice in a methadone clinic.

⁹² Zhang H. et al. “Prescription opioids dispensed to patients with cancer and bone metastasis,” *Oncologist*. 26, no. 10. (2021). Accessed online on January 30, 2022, at <https://eds-s-ebSCOhost-com.milligan.idm.oclc.org/eds/results?vid=0&sid=fb0e6dc9-f778-4297-a5d3-e8a0b930a4da%40redis&bquery=Portenoy%252c%2BRussell&bdata=JnR5cGU9MCZzZWZyY2hNb2RlPUFuZCZzaXRlPWVkcylsaXZlJnNjb3BIPXNpdGU%3>

⁹³ Baker DW. History of The Joint Commission’s Pain Standards: Lessons for Today’s Prescription Opioid Epidemic: 1118.

⁹⁴ Quinones, Sam. *Dreamland*, 87.

To this date, the medical community and patients continue to fine-tune this delicate balance between compassionate care and undertreating or overtreating with narcotics.

*The Xalisco Boys*⁹⁵

The second development that influenced the opioid crisis was the evolution of Mexican black tar heroin and the implementation of a retail sales effort that would be the envy of any Fortune 500 company. Heroin has been present in the United States since the narcotic was invented by the Bayer Corporation. Later banned for sale, the drug went underground into the illicit marketplace. This white-powder heroin was imported largely through Southeast Asia. As the heroin market centralized and the product passed down through a series of middlemen, this ‘brand’ of heroin was typically ‘stepped on,’ which is to say cut with other substances and diluted. Because of this, users never knew the purity of the product they were injecting. “The ‘Godfather of Harlem,’ Ellsworth Raymond ‘Bumpy’ Johnson, and Harlem-based Frank Lucas were responsible for the heroin market in New York City. Lucas made connections with servicemen in Vietnam to help bring back heroin from Southeast Asia.

The Asian importation summited during the Vietnam War, when heroin became a drug of choice for some, but its use was still largely limited to big cities. Baltimore became the acknowledged heroin capital of the country, but heroin also found a home in large cities such as New York City, Chicago, and Los Angeles. Heroin use was especially prominent in underground fringe groups, particularly among jazz musicians and writers. The year 1970 saw heroin overdose gain national attention in the deaths of three prominent rock musicians, all at the age of twenty-seven. The legendary guitarist, Jimi Hendrix, died on September 18, 1970, of a cocktail

⁹⁵ Xalisco, a metropolitan area in the small Mexican state of Nayarit, should not be confused with Jalisco, a large and influential state in the Mexican republic.

of polydrug abuse, including barbiturates, heroin, and alcohol. Less than a month later, the rock singer Janis Joplin died of a heroin overdose on October 4, 1970. Jim Morrison, front man for the popular group *The Doors*, died of a heart attack caused by excessive drug use, prominently including heroin, in Paris on July 3, 1971.

Beginning in the 1920s and peaking in the 1970s, heroin use was not known to the public at large. Heroin, we thought, was limited to jazz musicians and to ethnic groups, such as African Americans and Latinos. Heroin, however, made a comeback in the late 1980s and 1990s, but instead of the diluted white-powder heroin from Asia, this new heroin was distinctively different.

The major accomplishment of Samuel Quinones' book, *Dreamland*, is his investigative report of the black tar heroin trade. In investigating this 'brand' that was new to the market, Quinones also broke the story of the "Xalisco Boys," who developed the production and marketing of black tar heroin.⁹⁶ The Xalisco Boys were poor boys from the small pueblo of Xalisco in one of the smallest Mexican states, Nayarit.⁹⁷ The Boys grew up on ranchos in the Mexican countryside with few prospects, other than the traditional sugar cane farming, which was brutally hard work for low pay.

Beginning in the 1980s, the Boys realized that opium poppies, nurtured by indigenous people, grew extremely well in the mountains above Puerto Vallarta. The opium was converted to heroin in a black tarry substance that users could smoke or mix with water to inject. Over a decade the Boys perfected a system of exporting the heroin to the United States, developing a retail strategy

⁹⁶ Meyer, pps. 40-46. In this section on the growth of the heroin business, I am summarizing from *Dreamland*. This story is woven throughout the book but is introduced in Chapter Four *Delivered like Pizza*.

⁹⁷ The 2021 Mexican film, *Prayers for the Stolen*, translated as *Noche de Fuego*, offers a description of life in a remote, mountainous Xalisco village, where the villagers survive by milking locally grown opium poppies. The film addresses the effect this has on the village, especially the tragic effect on children.

for their product and marketing it to eager users. They invented an entirely new system of drug marketing.

Their marketing genius was this. Rather than forming a centralized, large cartel - like the Sinaloa, Cali, and Medellin cartels – the Boys worked by cells (as with terrorist groups or spy organizations.). Each cell (or *tienda*, store) was a small-scale operation based on three to four drivers and one dispatcher who sat in an apartment taking orders by phone. Starting out in the San Fernando valley of California, the Boys perfected their model. They were unique in the drug world. So as not to attract undue attention, they were clean cut, prompt and polite. They drove old, but serviceable used cars. They eschewed violence and feuds. They never carried weapons, as weapons brought serious jail time. They blended into the local Mexican community. They worked hard. Each tienda operated from 8:00 to 8:00. At first, they took advantage of existing addicts, but with their good product the sales base grew. Their product was superior. Unlike the stepped-on white powder back east, the black tar heroin, or *chiva*, was predictably 80% pure, thus allowing addicts to use the product with some assurance of a reliable, steady dose.

The tienda started out by going to the nearest methadone clinic to advertise their product, sometimes giving out free samples. They gave discounts and incentives to loyal customers. Word spread. With each product bag came a business card with a number to call for more product. Rather than an addict having to go to bad parts of town to search for drugs, the Boys delivered like *DoorDash*. The addict called the number provided and ordered. The dispatcher sent instructions to the driver via beeper. The driver delivered. Each driver carried small amounts, approximately one-tenth of a gram, in balloons that the driver stored in his mouth. The balloons allowed the driver to swallow the heroin if he was pulled over by the police. The amounts each

driver carried were so small, that even if a driver were arrested, he would likely just be deported and not sentenced to jail time.

At the cutting edge of the logistics business, the Boys perfected just-in-time delivery. They never smuggled heroin by the truckload as the big cartels did. Instead, they would smuggle one or two kilos of chiva, and break that down between various tiendas. The tiendas were not centrally owned and organized. Anyone with knowledge of the system could start a new cell. This introduced competition between cells. As competition increased, tienda owners looked for new markets on the advice of their customers. The Boys avoided large cities, where the trade was controlled by violent gangs and cartels. Rather, they spread to mid-sized cities in suburban America. By the middle of the 1990s, they operated ten cells in Denver.⁹⁸ They spread east to Columbus, Pittsburgh, Memphis, Nashville, and Charlotte.

Soon chiva was available in every part of the United States, even rural Appalachia, where only years before heroin was completely unknown. The Boys' system worked, and worked brilliantly, because a free-market economy is so effective. One other factor made the system effective. The heroin trade spread just as an opioid epidemic, caused by narcotic pills prescribed by physicians, had created a whole new class of opioid addicts. New addicts seeking to avoid 'pill sickness' – the severe effects of withdrawal - found a new, reliable way to meet their needs via the chiva sold by the Xalisco Boys.

These three developments - a well-intentioned revolution in pain care, the over-prescription and diversion of OxyContin and other opiates, and the ready supply of a new source of powerful and cheap black tar heroin from Mexico - all coincided to help create the opioid crisis. While

⁹⁸ Quinones, Sam. *Dreamland*, 45.

opioid prescriptions have seen a significant decrease since 2016,⁹⁹ our society was left with millions of Americans addicted to opioids. Unfortunately, fatalities from illicitly manufactured fentanyl increased from 26,666 in 2011 to 31,335 in 2018¹⁰⁰ – and our problems with fentanyl, a much more powerful and deadly opiate, it seems, are only beginning.¹⁰¹ We have seen already the intimate connection between opioid use and the human experience of pain. In the next chapter we will explore the issue of pain more closely.

⁹⁹ Centers for Disease Control and Prevention. “U.S. Opioid Dispensing Rate Maps.” Accessed online on February 10, 2022, via the CDC website at <https://www.cdc.gov/drugoverdose/rxrate-maps/index.html>.

¹⁰⁰ Department of Justice and Drug Enforcement Agency. “Drug Fact Sheet: Synthetic Opioids.” Fact sheet released in April of 2020. Accessed online on February 9, 2022, at <https://www.dea.gov/sites/default/files/2020-06/Synthetic%20Opioids-2020.pdf>.

¹⁰¹ On the day that I began writing this conclusion, CNN released a report of the phenomenon of fatalities among middle-school children who had perished from fentanyl overdose. <https://www.cnn.com/2022/02/18/health/fentanyl-fatal-overdoses-middle-schoolers/index.html>

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The advertisement features a central photograph of an elderly man and woman walking together on a golf course. The man is wearing a grey jacket and blue pants, while the woman is wearing a yellow suit. They are walking on a green path that curves through a grassy area. The background is a soft, out-of-focus landscape with trees and a blue sky. The overall tone is positive and active, suggesting that the medication helps maintain a quality of life that includes enjoying hobbies like golfing.

Chapter Two

On Pain

*For I am ready to fall,
and my pain is ever with me.*

Psalm 38.7

Pain has always been a part of the human experience. Pain is a democratizer in that it is a tribulation we all share. We as a species have accepted the fact of pain, from infant dental pain to end-of-life cancer pain. We have developed folk remedies, spells, salves, and concoctions, all to gain control of that which seems to control us – pain. As we saw in the last chapter, well-intentioned efforts to control pain with opioids contributed to our current opioid crisis.

It is relatively recent in our human story that we have begun to understand the mechanism of pain. This knowledge is new and evolving. Knowledge of the mechanism of pain has developed through neuroanatomical research, and more recently, brain imaging research, to identify the neural circuits of pain and to fathom how the body responds to pain. In fact, we could say that pain “is noncommunicable, but its effects are as far-reaching as a global pandemic given the magnitude of how it ravages lives.”¹⁰²

Because, as we will see, the body produces its own form of opioids to respond to pain and possesses receptors specifically designed to ‘marry’ the body’s organic opioids, an understanding of pain, organic opioids, and neural receptors is key to understanding how opioid addiction

¹⁰² Hastie, Barbara A. Gilson, Aaron M. Maurer, Martha A, and Cleary, James F. “An Examination of Global and Regional Opioid Consumption Trends 1980-2011,” *Journal of Pain and Palliative Care Pharmacotherapy*, (September 1, 2014): 259. Accessed online on April 9, 2022, at DOI: 10.3109/15360288.2014.941132.

develops. We will consider that cycle of addiction in the next chapter. We will recall from page 31 that in 2012 a total of 255,207,954 total prescriptions were written nationwide, with a dispensing rate of 81.3 prescriptions per 100 persons.¹⁰³ All of those prescriptions, ostensibly, were to treat pain. Many of the recipients of those prescriptions would develop an addiction to opioids.

There are two types of pain disorders: acute and chronic. Acute pain lasts for less than three months and is typically related to broken bones, surgery, dental care, childbirth, and so on. Chronic pain endures for longer than three months in such disorders as migraines, arthritis, cancer, neuropathy, and fibromyalgia. One study highlighted the importance of understanding the interaction between chronic pain and addiction. “The prevalence and incidence of chronic, relapsing conditions, such as chronic pain, have implications for policy development, resource allocation, and healthcare delivery.”¹⁰⁴ Chronic pain, as we will see throughout this work, has a close association with opioid addiction.

The cost for the treatment of pain in the US is enormous. A study by the US Institute of Medicine estimated the cost of pain care to total \$560-\$635 billion annually in 2010 dollars.¹⁰⁵ This reflects the cost of medical care, lost wages, underemployment, and unemployment. The study also found that approximately 100 million adult Americans suffer from chronic pain. Many

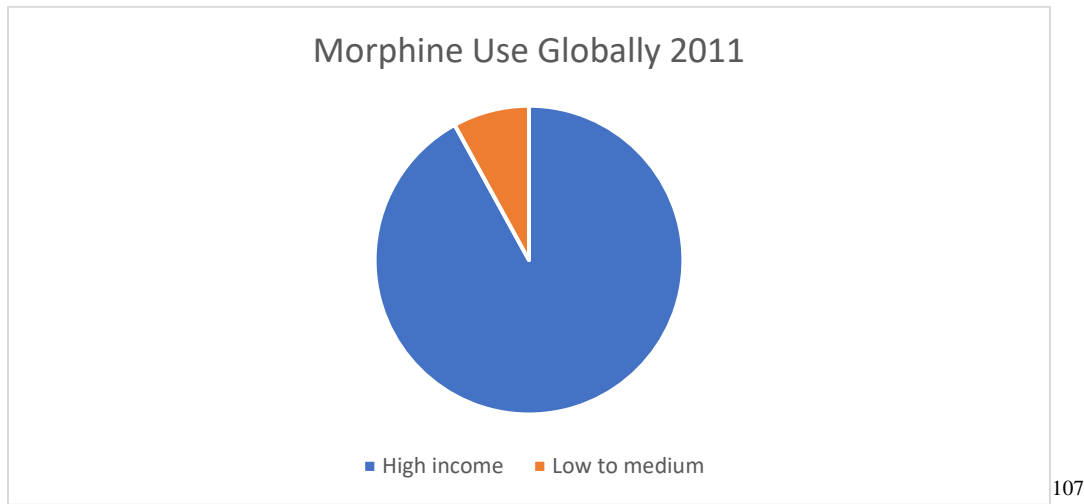
¹⁰³ Centers for Disease Control and Prevention. “U.S. Opioid Dispensing Rate Maps.” Accessed online on February 10, 2022, via the CDC website at <https://www.cdc.gov/drugoverdose/rxrate-maps/index.html>.

¹⁰⁴ Higgins, C., Smith, B.H., and Matthews, K. “Incidence of iatrogenic opioid dependence or abuse in patients with pain who were exposed to opioid analgesic therapy: a systematic review and meta-analysis,” *British Journal of Anaesthesia*, 120 (6). (2018): 1336. Accessed online on March 7, 2022, at doi: 10.1016/j.bja.2018.03.009.

¹⁰⁵ Gaskin, Darrell J. and Richard, Patrick. “The Economic Costs of Pain in the United States.” Appendix C in *Relieving Pain in America: A Blueprint for transforming Prevention, Care, Education, and Research*. Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. (Washington (DC): National Academies Press, 2011).

of these will be referred to pain management clinics for further care, which could include surgery, physical therapy, or opioid treatment in severe cases.

Pain, of course, is a global problem, but there is a global inequality in the distribution and availability of opioids to treat moderate to severe pain. Globally, morphine remains the gold standard among opioids. High Income Countries (HIC) (US, Canada, Scandinavia, and Europe) far and away have greater access to opioids than do Low to Medium Income Countries (LMIC), which account for 83% of the world population.¹⁰⁶



Although the International Association for the Study of Pain has declared access to pain management a global right, five billion people live in Low to Medium Income Countries with little or no access to opioids or other means of care.¹⁰⁸ In fact, a World Health Organization

¹⁰⁶ Hastie, Barbara A. Gilson, Aaron M. Maurer, Martha A, and Cleary, James F. "An Examination of Global and Regional Opioid Consumption Trends 1980-2011," *Journal of Pain and Palliative Care Pharmacotherapy*, (September 1, 2014): 259-275. Accessed online on April 9, 2022, at DOI: 10.3109/15360288.2014.941132: 259.

¹⁰⁷ Graph modified from Hastie, 261.

¹⁰⁸ Hastie, 259.

(WHO) study of 2010 found that sixty-six percent of the world’s population “had virtually no consumption of potent opioids.”¹⁰⁹

Gateways

The ancients explained the experience of pain in many ways, to include possession by demons. René Descartes (1596-1650) was the first to offer a scientific explanation of pain.¹¹⁰ He proposed that a source of pain, such as fire, met the skin and that a pain signal was sent from the source of pain directly to the brain, where, in effect, an alarm bell was rung. In this, the specificity theory of pain, which endured with modifications to the modern time, the brain played only a passive role in the pain process. The job of the brain was to receive the pain input. There was no ‘downward’ pathway afterward from the brain to the source of pain, neither did the brain coordinate a response to pain. In the specificity theory pain impulses met ‘pain receptors,’ which carried pain signals to the brain. This type of neurological system would be a fixed and direct communication from the pain source to the brain.

In a subsequent theory developed in the 1890s, the pattern theory, it was widely assumed that the intensity of the pain experience was a direct response to the intensity of the source of pain, for instance the reaction to the skin’s contact with fire. Beginning in the 1950s, however, several puzzling pain phenomena began to shape our understanding of pain. In a 1961 article in *Scientific American*, Canadian researcher Ronald Melzack explained the conundrum.¹¹¹ Because

¹⁰⁹ Hastie, 261.

¹¹⁰ Melzack, Ronald and Katz, Joel. “The Gate Control Theory: Reaching for the Brain.” Chapter One in *Pain: Psychological Perspectives*. Hadjistavropoulos, Thomas and Craig, Kenneth D. Editors. (Mahwah, NJ: Psychology Press, 2004): 13-14. Accessed online on April 7, 2022 and downloaded PDF from Ebook at <https://eds-p-ebshost-com.milligan.idm.oclc.org/eds/detail?sid=9d833952-3770-48e2-ba42-37b0370b90de@redis&vid=0&format=EB&rid=4#AN=104204&db=nlebk>.

¹¹¹ Melzack, Ronald., “The Perception of Pain,” *Scientific American*, Vol. 04, no. 2. (February 1961)” 41-49. Accessed online on April 7, 2022, at <https://www.jstor.org/stable/10.2307/24937349>.

of the neuroplasticity of the nervous system, the ability of the nervous system to in effect learn and reorganize based on experience, we do not all experience pain in like manner.

Melzack offers a consideration of unexplained pain events. Why is it in some cultures that childbirth is experienced through excruciating pain, while in others, the mother immediately returns to work? Based on observations of wounded combat veterans in WWII and later in Israel, why is it that some soldiers experiencing horrific wounds reported experiencing no or little pain? Why is it that amputees experience limb fatigue and ‘phantom’ pain, even though their limbs can no longer generate pain impulses?¹¹²

In 1965 Melzack, a research psychologist at McGill University, and Patrick Wall, a biologist working at the Massachusetts Institute of Technology, published a groundbreaking theory that revolutionized our understanding of pain. Their article, “Pain Mechanisms: a New Theory,” rejected both the specificity theory and the pattern theory by proposing a revolutionary Gate Control Theory of Pain.

Previous theories had hypothesized only an upward system of pain modulation, from pain source to the brain. Melzack and Wall proposed a pain modulatory system in which pain stimuli were transmitted to three spinal cord systems: substantia gelatinosa in the dorsal horn,¹¹³ dorsal column fibers that project toward the brain, and central transmission (T) cells in the dorsal horn.¹¹⁴ It is the substantia gelatinosa in the dorsal horn that performs the function of gate control

¹¹² For more information regarding phantom limbs, see Melzack’s 1992 article at: Melzack, Ronald. “Phantom Limbs.” *Scientific American*, Vol. 266, No. 4 (April 1992): 120-127.

¹¹³ The dorsal (posterior) horn is gray matter of the spinal cord. It contains interneurons that descend to the spinal column and ascends to sensory pathways in the brain. Interneurons transmit impulses between neurons. There are two arms of the dorsal horn, spinal and medullary.

¹¹⁴ Melzack, R. and Wall, P.D. “Pain Mechanisms: A New Theory,” *Science*, vol. 150, (1965): 974. Accessed online on March 8, 2022, at <https://www-jstor-org.milligan.idm.oclc.org/stable/1717891?seq=1>.

of pain, allowing neural networks to be activated in both downward and ascending modulation systems.¹¹⁵ Among other functions, the substantia gelatinosa acts as a control trigger that modulates brain processes. The T cells “activate neural mechanisms which comprise the action system responsible for response and perception.”¹¹⁶ The three spinal cord systems, then, determine pain phenomena. In other words, for the first time in human history we understood that the brain was not a passive receptor of information, but that the dorsal column modulates pain signals in both ascending and descending systems.

The gate control theory has, so far, stood the test of time and vigorous criticism. Still perplexing, though, was the instance of ‘phantom’ pain in paraplegics and amputees. If there was no limb, how could an amputee experience intense pain and fatigue in that limb? How could an arm amputee experience intense pain from a locked and gripping fist when the hand was no longer there? These phenomena did not negate the gate control theory, but it did force Melzack to reformulate the systems involved in pain.

His response, with colleague Joel Katz, was to envision the central nervous system (CNS) in a metaphor derived from the world of music. When we listen to a symphony, we are receiving complex sound signals – strings, brass, percussion all in concert. Were we to listen only to the cello section playing their role in the symphony, we could no longer call it a symphony. It is but one piece of the symphony. We only recognize the piece as a symphony when all sections play together harmoniously.

¹¹⁵ Melzack drew the initial idea of the gate control on a cocktail napkin over wine at a medical conference.

¹¹⁶ Melzack, R. and Wall, P.D. “Pain Mechanisms: A New Theory,” 974.

Likewise, Melzack and Katz see the CNS as a symphony, with many pieces playing many parts. This system, which they term the Neuromatrix Theory of Pain, was proposed in 2004.¹¹⁷ The theorists propose an elegant solution to the problem of phantom pain. Our CNS forms a Body-Self Neuromatrix – a schema of neural networks that establish in our consciousness an awareness of homeostasis, of our own self, of our own body, which we recognize as being distinct from the bodies of others.¹¹⁸ It is this neuromatrix, through a series of ‘neural signatures,’ that provides the brain an awareness of ourselves as one entire unity. Like our symphony, many structures play different parts in this neuromatrix and produce one harmonious work of music.

The neuromatrix provides a picture or image of the body to the brain.¹¹⁹ The brain has an awareness and memory of the entirety of our being, our senses, and our environment. Pain, then, is not so much a report of pain stimulus to the brain. Rather, pain is a disruption to the homeostasis of the whole. When an amputee loses a limb, the brain *still* perceives a threat to the homeostasis of the whole. Pain - like disease, infection, and trauma – signals throughout our entire system that damage has been done to our Body-Self Neuromatrix. The theory also accounts for factors that shape the experience of pain to include cultural responses to pain, anxiety, stress, depression etc. The brain is not just a passive receptor; the brain takes action to restore homeostasis.

¹¹⁷ Melzack, Ronald and Katz, Joel. “The Gate Control Theory: Reaching for the Brain.” Chapter One in *Pain: Psychological Perspectives*. Hadjistavropoulos, Thomas and Craig, Kenneth D. Editors. (Mahwah, NJ: Psychology Press, 2004): 13-34. Accessed online on April 7, 2022 and downloaded PDF from Ebook at <https://eds-p-ebscobhost-com.milligan.idm.oclc.org/eds/detail?sid=9d833952-3770-48e2-ba42-37b0370b90de@redis&vid=0&format=EB&rid=4#AN=104204&db=nlebk>: 22.

¹¹⁸ Melzack, Ronald and Katz, Joel. “The Gate Control Theory: Reaching for the Brain, 22.

¹¹⁹ Analogically, when we ‘search the internet’ we are searching a snapshot of stored memory of all items on the internet at a specific moment in time, down to the millisecond. Were we to return weeks later to our search, we may find that a ‘page is not found 404’ – the computer equivalent of reporting a missing limb. The search remembers that an entity used to be there and is reporting both the memory and the loss.

One other feature of pain is important to our work. This is in the linguistic expression of pain. “The psychology of pain reinforces the conclusion that pain is not just a brute fact or self-proclaiming state which, once it occurs, is simply recognized and reported on without the intrusion of interpretation and learning.”¹²⁰ Pain, especially chronic pain, is an experience in which we must *tell someone* about our experience. We all have experienced a minor pain, such as a paper cut, and have kept that experience to ourselves. The pain is trivial and is ignored. More intense experiences of pain must be communicated to someone – to mother when we are small, to spouses, partners, or best friends later in life. Finally, if the pain persists or is intense enough, we may wish to communicate our experience of pain to a physician. One writer, reflecting on the politics of sickle-cell anemia, quotes a patient suffering intense pain from this lethal disease: “Before you can get past the agony, you have to convince a doctor that it’s real.”¹²¹

Pain is not just a physiological occurrence experienced subjectively. It is also a verbal and social occurrence. When we seek the assistance of a physician, we are seeking the help of an expert, which in turn places the patient as the under-empowered in a difficult power balance. Since the physician cannot objectively verify our pain in most cases, we must communicate our experience as best we can. If we are to be believed, we may be prescribed opioids.

It is at this point in our understanding of pain that we begin to return to the issue of opioids. The body’s first experience of opioids is of our body’s own reaction to pain. One of the methods that the brain uses to restore homeostasis after pain shocks the neuromatrix is to release

¹²⁰ Gillett, G. R. “The Neurophilosophy of Pain,” *Philosophy*, Vol. 66, No. 256, (April 1991): 191-206. Accessed online on April 1, 2022, at <https://jstor.org/stable/3751625>.

¹²¹ Wailoo, Keith. “Thinking through the Pain.” Chapter IV in *The Social Medicine Reader*, Volume 2, *Differences and Inequalities*:297. Accessed online on April 1, 2022, at www.jstor.org/stable/j.ctv11mxxm2.35.

endogenous, organic opioids. Understanding the endogenous opioid system (EOS) is essential to understanding opioid addiction.

One effect of the 1965 gate control theory was to open a gateway of research into the ways in which the brain and CNS respond to pain. Subsequent studies proved the existence of receptors which bind to opioid compounds that naturally occur in the body.¹²² Finally, in 1975, researchers¹²³ discovered “two naturally occurring endogenous morphine-like pentapeptides, leucine (leu-) enkephalin and methionine (met-) enkephalin.”¹²⁴ These discoveries would inform our understanding of opioid analgesia produced organically in our own bodies. Areas of the brain in which this analgesia is initiated are “rich in opioid peptides”¹²⁵ and “opioid receptors.”¹²⁶ These opioid systems, or endorphins, are found in high concentration in the spinal and medullary dorsal horns, where Melzack and Wall had posited the gate control. Subsequent research to date has identified over twenty types of endorphins, the best-known being beta-endorphin. When a runner says that she is experiencing an ‘endorphin high,’ she is referring to the analgesia provided by organic opioids.

One final note - How opioid receptors actually operate is still a subject of intense research. Some researchers have proposed that there are levels of sub-receptors, but this is still poorly understood. What we do know is that endogenous opioids “inhibit neurotransmitter release from dorsal root ganglion projections in the dorsal horn” to control pain.¹²⁷ One avenue of research,

¹²² Bonica, John J. et al. *The Management of Pain*. Second Edition, Vol. I, (Philadelphia: Lea and Febiger, 1990): 102.

¹²³ Fields, H.L. et al. “The activity of neurons in the rostral medulla of the rat during withdrawal from noxious heat.” *Neuroscience*, 3, (1983): 2545. As referenced by Bonica.

¹²⁴ Ibid.

¹²⁵ Peptides are amino acids linked in a chemical bond.

¹²⁶ Bonica, John J. et al. *The Management of Pain*, 102.

¹²⁷ Ibid.

unsuccessful so far, is to develop man-made opioids that have been stripped of addiction potential.

Key and Lock

For endogenous opioids to have effect they must fit like a unique key into a lock, which is the body's opioid receptors, the most well-known of these being the mu receptor.¹²⁸ In fact, there are three known opioid receptors – mu, delta, and kappa – each playing a different role.



For this reason, opioids can be classified into three categories by the effect they have on receptors.¹²⁹

- Agonists -induce maximum analgesic response (as in response to morphine)
- Antagonists – bind to a receptor but produce no response, while preventing an agonist to bind to that receptor (as in naloxone. Naloxone is widely used as an overdose medication because it negates the effects of the overdose.)
- Partial agonists – bind to a receptor but produce only a partial response, no matter the amount of drug administered (Buprenorphine. Because of this characteristic, buprenorphine is widely used in the treatment of opioid addiction.)

In recent years, the three receptors have been formally renamed MOP (mu), KOP (kappa), and DOP (delta), but the older references persist in the literature.¹³⁰

¹²⁸ Melzack, Ronald and Wall, Patrick D. *The Challenge of Pain*. (New York: Penguin Books, 1982/1996): 139.

¹²⁹ Williams, John. “Basic Opioid Pharmacology.” *Reviews in Pain*, Vol. 1, no. 2, (March 2008). Accessed online on April 9, 2022, at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4589929/pdf/10.1177_204946370800100202.pdf.

¹³⁰ Ibid.

These opioid binding sites were not discovered in mammals until 1978.¹³¹ The mu receptor (MOP) is perhaps best known because it is this receptor that causes opioids to have a pleasant effect. The marriage of endogenous opioids with opioid receptors affects three systems. The limbic system controls our emotions, creating relaxation and pleasure. The brainstem controls autonomous function, such as respiration. Thus, an overdose of man-made opioids causes respiratory depression, which can lead to death. Opioids acting on the spinal cord reduce feelings of pain.

Thus far we have considered the role of pain in addiction as well as contemporary research on the endogenous opioid system, which includes endogenous opioids and opioid receptors. The important thing to remember is that endogenous opioids, produced by our own bodies, are not harmful or addictive. The function of addiction enters the picture when exogenous or man-made opioids are introduced to the body, acting on the *very same receptors* as endogenous opioids. In the next chapter we will use this information to understand how opioid addiction operates.

¹³¹Bryen, Jordan A., Cvejic, Svetlana, and Devi, Lakshmi D. "Opioids and their complicated Receptor Complexes," *Neuropsychopharmacology*, 23, no. 54. (2000). 5-18. Accessed online on February 8, 2022, at [Result List: Opioids and their complicated Receptor Complexes: Milligan OneSearch \(oclc.org\)](#). Provided by Welshimer Library by courtesy of Interlibrary Loan.

Chapter Three

How Opioid Addiction Operates

*For it was you who formed my inward parts;
you knit me together in my mother's womb.
I praise you, for I am fearfully and wonderfully made.
Wonderful are your works;
that I know very well.*

Psalm 139: 13-14

Thus far we have considered the history of the opioid crisis and the role of pain management in that history. We have taken a close look at pain itself, to understand how the body responds to pain by releasing endogenous opioids into the system which bind with unique opioid receptors. The result of this key opening a lock is that of opioid analgesia. This endogenous opioid system is natural, and it eases our daily bumps and bruises. When we stub our toe or bang our hand with a hammer, our own bodies can spring into action to provide an analgesic effect. When we experience chronic pain or end-of-life pain, man-made opioids are used to decrease our suffering. But if we misuse those exogenous or man-made opioids serious problems ensue.

The Working Brain

- ✓ Is made up of 86 billion neurons
- ✓ Each neuron has a cell body, axon, and dendrites
- ✓ The axon extends out from the cell body and transmits messages to other neurons
- ✓ Dendrites receive messages
- ✓ Neurons communicate by neurotransmitters
- ✓ Neurons are arranged in clusters that perform specific functions

Typically, we speak of substance use disorder (SUD) to refer to substance related problem-use that can include alcohol, marijuana, cocaine etc. The term addiction is usually reserved to speak about the most severe side of SUD. In outdated but persisting views, addiction was simply

seen as moral failure, weakness, or a flaw in one's character. This led those of a certain view to assert that when it came to substances of abuse, one should "Just Say No." Those of a religious persuasion may have insisted that the person with SUD should just 'buck up,' 'get clean,' 'get back on the wagon,' or 'get Jesus.' For reasons we will examine below, for one living with a chronic opioid addiction, all of these comments are equally unhelpful. Yet, these views persist in the culture, despite the fact that modern science has greatly extended our awareness of what addiction means and how it works.

Chronic disorder

Due to this increased knowledge, we now understand that addiction is a chronic *disorder* of the *brain* which produces complex changes in brain structure (called *neuroadaptations*) and in the ability to function compared to a person who does not live with SUD. Addiction has common features that include recurrence, relapse, and recovery. Factors *other than* substance use that influence the development of addiction include:¹³²

- Early life experiences, also known as Adverse Childhood Events. This can include many factors in a family including, divorce, domestic violence, mental illness in the family, or incarceration of a family member.
- Genetic factors. The Office of the Surgeon General and other authorities state that genetic factors account for 40-70% of the risk for addiction.

¹³² I here am summarizing pages 2.21-2.24 in Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's report on Alcohol, Drugs, and Health*. Nov 2016. Available in PDF format from the website of the Substance Abuse and Mental Health Services Administration. Accessed online and downloaded on January 22, 2022, at https://store.samhsa.gov/product/Facing-Addiction-in-America-The-Surgeon-General-s-Report-on-Alcohol-Drugs-and-Health-Full-Report/SMA16-4991?referer=from_search_result.

- Co-occurring mental health disorders. The presence of a mental health disorder, such as depression, post-traumatic stress disorder (PTSD), schizophrenia and so on greatly increases the risk of also developing SUD. There is still debate as to what came first – addiction or mental illness. For our purposes it is sufficient to state that they are co-occurring.
- Differences based on sex. Research is continuing in this area, but overall, men are at higher risk for alcohol use disorder, while women move from initial use of a substance to SUD at a faster rate.

In other words, one who uses drugs and has any of the above-mentioned factors has a greater risk of developing addiction. If we are to treat addiction, then, I suggest, we must find ways to address each of these co-occurring factors.

In trying to understand addiction, many have found it helpful to compare it with other chronic health disorders, such as heart disease or diabetes. To offer a personal example to illustrate chronic disease, in my 50's I developed Type II Diabetes, despite the frequent warnings of my primary care physician that I was pre-diabetic. There were numerous factors that explain why I developed the disease. First, were behavioral reasons. I made poor life-long choices about my diet and continued to do so despite warnings. I liked wine and chocolate. I never turned down dessert if offered. Second, were genetic factors. My mother developed Type II Diabetes late in life, as did her mother. Third, were environmental and cultural factors. I was raised in a Southern household in a Southern culture, where carbs and desserts abound.

I now take my medications as prescribed, attend diabetes seminars to learn more about the disease, and make better diet choices. I test my glucose several times a week. Occasionally, I relapse, as when my friend makes apple pie and offers it with vanilla ice cream. I eat it and feel

bad about my choice immediately. I do not measure my glucose for several days after, in a feeble attempt at avoidance and denial.

Here is the difference between my chronic disease and that of addiction. I feel no shame from my friends, family, or church about diabetes. No one tells me to ‘straighten up.’ People who know I have a chronic disease are supportive. When I see my primary care provider, she does not say, “I told you so.” She just prescribes my medication and does blood tests frequently. I am largely able to manage my disease with her help. In both instances of chronic disease, diabetes and addiction, the diseases are treatable but not curable. In both cases, it takes a life-long commitment to learn to live with the disease and improve one’s care and choices.

Addiction moves through a predictable cycle of behavior that includes impulsivity, positive reinforcement, negative reinforcement, and compulsivity.¹³³ As an act of *impulsivity*, a person may take a first drink or smoke a first cigarette because it may be accepted in a family, or because of peer pressure. There is not much forethought in the choice, no recognition of possible consequences. If the experience brings pleasure, then the behavior is *positively reinforced*.

Positive reinforcement acts by rewarding that first experience. If we enjoyed the experience, then we are more likely to try a second experience.¹³⁴ As we increase our experiences with some substances, we are likely also to increase our *tolerance* to the substance. To get that next great experience that we had at first, we find that we must increase the amount of the substance we are using. We no longer want two glasses of wine - we want more and more. We are never satisfied,

¹³³ Office of the Surgeon General, *Facing Addiction in America*, 2.7.

¹³⁴ I have noticed with novice smokers that they do not on first use enjoy the nicotine. If they are to become addicted, they must learn how to enjoy the nicotine by numerous uses. We will look at this social aspect of addiction later.

however, because we can never replicate that first experience.¹³⁵ Eventually seeking that good experience leads to negative feelings, or *negative reinforcement*.

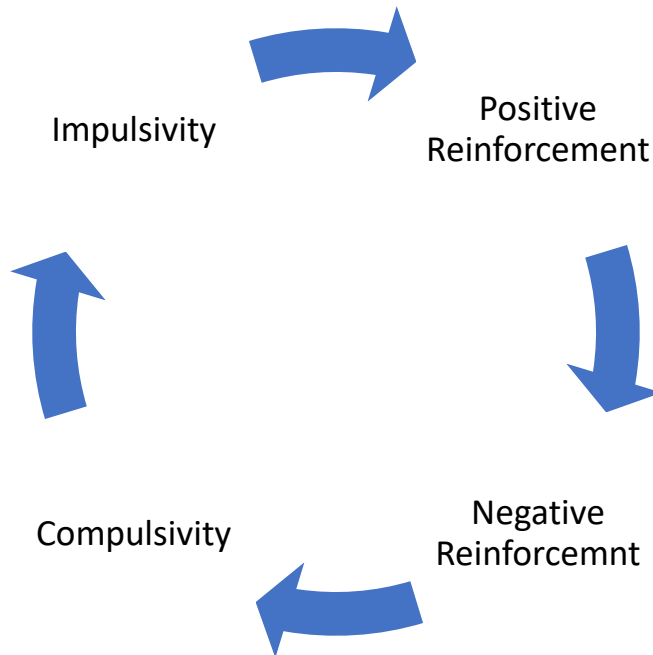
Our increasing dependence on substances increases our negative emotions about our dilemma. We begin to feel stress, depression, and anxiety. So, we seek immediate but temporary relief from our negative emotions. The negative emotions now reinforce our habit. We feel bad, so we seek to feel better through substance abuse, the result of which is feeling bad again. In the use of opioids, *withdrawal* is another negatively reinforcing phenomenon. Symptoms of opioid withdrawal can include increased temperature and flu-like response, cramps, diarrhea, sweating, insomnia, nausea, and vomiting.¹³⁶ Those who have gone through opioid withdrawal describe it as like the worst flu anyone has imagined, times ten. In severe cases, withdrawal can be life-threatening.¹³⁷ Generally, a person who is dependent on opioids will do anything to avoid the recurrence of withdrawal symptoms, so she seeks the next dose.

Compulsivity is a pattern of ingrained behaviors that lead us to continue the cycle of addiction. A pattern of compulsive substance-seeking develops, a pattern of seeking the next dose, the next drink, the next cigarette.

¹³⁵ A graphic example from the world of smoking heroin, known as “chasing the dragon.” The user chases, but never catches that which they seek – that pleasurable first experience.

¹³⁶ *The American Society of Addiction Medicine Handbook of Addiction Medicine*. Edited by Rastegar, Darius A. and Fingerhood, Michael I. (Oxford: Oxford University Press, 2020): 115.

¹³⁷ Withdrawal can be life-threatening because of resulting dehydration from loss of bodily fluids.



Opioids and Dopamine

Opioid addiction is powerful because exogenous opioids (man-made, such as morphine or oxycontin) bind to *the exact same receptors* (mu, kappa, and delta) as endogenous opioids (endorphins, enkephalins, and dynorphin naturally produced by our body). One other feature of opioid addiction that we need to consider is the interaction between opioids and dopamine. Having reviewed this neurofunction we will be able at the end of this chapter to examine a current definition of addiction.

Both opioid peptides and dopamine are neurotransmitters, chemical messengers, that carry information to receptors (see graphic below). The process of communicating between neurons is called *neurotransmission*. Neurotransmitters can either *stimulate or inhibit* neurons. According to the National Institute on Drug Abuse (NIDA):

Some drugs mimic neurotransmitters. Heroin and prescription opioids, for example, chemically resemble the brain's natural opioids sufficiently to engage and stimulate their

specialized receptor. Since heroin stimulates many more receptors more strongly than the natural opioids, the result is a massive amplification of opioid receptor activity.¹³⁸

We have already seen that opioid analgesia is produced by the marriage of an endogenous opioid and an appropriate opioid receptor (μ). Dopamine plays a role in our ability to feel pleasure and euphoria (and consequently a ‘high’). Dopamine is also responsible for the brain’s responses to such essential human functions as learning, motivation, mood, attention, pain processing, and the brain’s reward system, which will be crucial to our understanding of problems associated with addiction.

But dopamine also interacts with opioids. When the body releases endogenous opioids they act as neuromodulators to modulate other neurotransmitters, to include dopamine.¹³⁹ Most importantly for us, dopamine has a profound impact on the brain’s reward system.¹⁴⁰ By modulating GABA¹⁴¹ transmitters, neuroadaptations determine the effectiveness of reward predictors.¹⁴² By this adaptation the reward system responds to reward-aversion and approach-avoidance behaviors.¹⁴³ In animal studies, subjects un-learned regular conditioned responses that included drinking water and consuming food. Animals with depleted dopamine levels failed to search for food or bite available food.¹⁴⁴ Opioids in laboratory animals initially elevated dopamine levels with euphoric effect.¹⁴⁵

¹³⁸ National Institute on Drug Abuse (NIDA). “Impacts of Drugs on Neurotransmission,” (March 9, 2017). Accessed online on April 11, 2022, at <https://archives.drugabuse.gov/news-events/nida-notes/2017/03/impacts-drugs-neurotransmission>.

¹³⁹ Froehlich, Janice C. “Opioid Peptides,” *Alcohol, Health, and Research World*, Vol. 21, no. 2, (1997):132. Accessed online on April 11, 2022, at <https://pubs.niaaa.nih.gov/publications/arh21-2/132.pdf>.

¹⁴⁰ Wise, Roy A. and Robbel Mykel A. “Dopamine and Addiction,” *Annual Review of Psychology*, 71 (2020): 80. Accessed online on April 11, 2022, at <https://www.annualreviews.org/doi/pdf/10.1146/annurev-psych-010418-103337>.

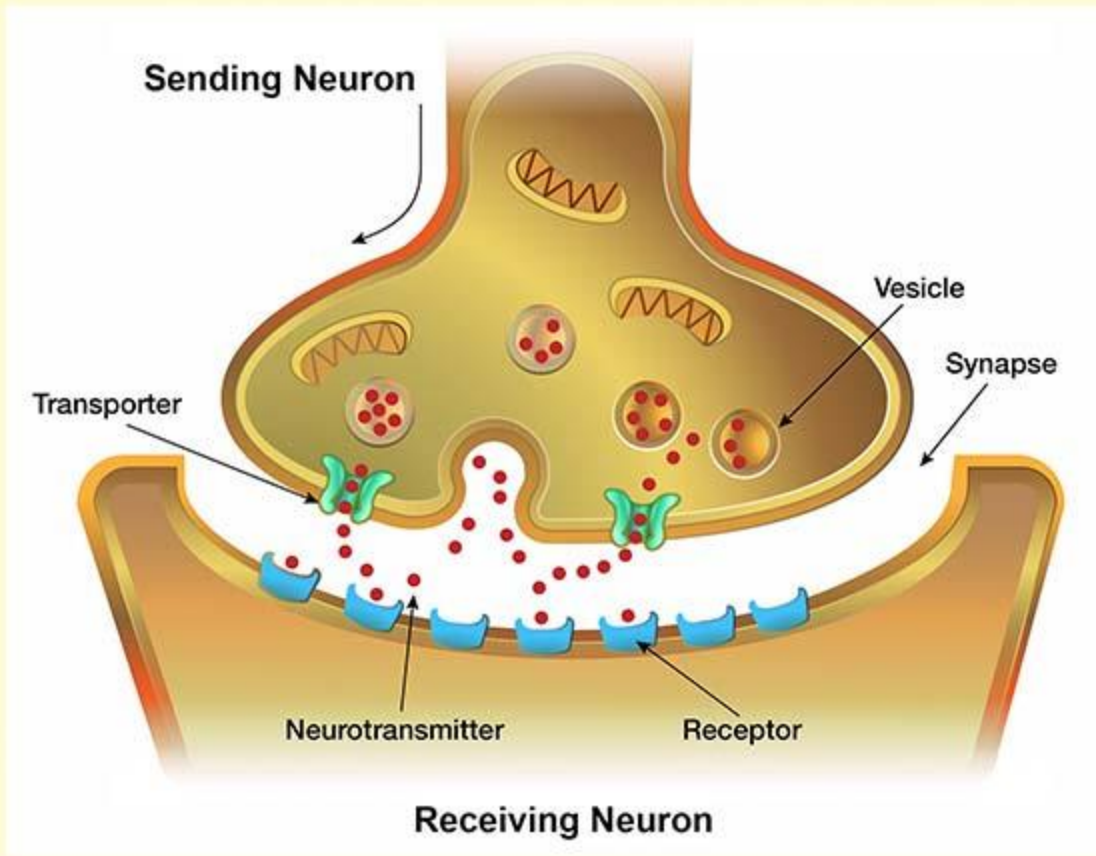
¹⁴¹ Gamma aminobutyric acid

¹⁴² Wise, Roy A. and Robbel Mykel A. “Dopamine and Addiction,” 80.

¹⁴³ Wise, Roy A. and Robbel Mykel A., 81.

¹⁴⁴ Ibid.

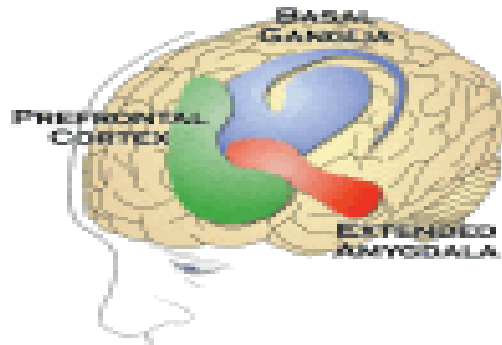
¹⁴⁵ Wise and Robbel, 90.



Graphic from the National Institute of Drug Abuse (NIDA) at <https://archives.drugabuse.gov/news-events/nida-notes/2017/03/impacts-drugs-neurotransmission>

In the beginning of drug abuse, the drug leaves the brain. However, if prolonged and repeated abuse occurs, changes take place in neuron structure and function. This inevitably leads to long-lasting abnormalities in neurotransmitters. This in turn leads to a common feature in drug abuse, tolerance, in which it takes higher and higher dosing of a drug to reach a similar effect as at last use. Fluctuation in dopamine levels leads to drug dependence. The brain no longer responds to natural rewards; instead, fluctuation in dopamine levels impairs normal reward function.¹⁴⁶

¹⁴⁶ National Institute on Drug Abuse (NIDA). "Impacts of Drugs on Neurotransmission." (March 9, 2017). Accessed online on April 11, 2022, at <https://archives.drugabuse.gov/news-events/nida-notes/2017/03/impacts-drugs-neurotransmission>.



Graphic from *Facing Addiction in America*, the Surgeon General's Report. 2.5.

As illustrated in the graphic above, drug addiction affects three distinct areas of the brain: the prefrontal cortex, basal ganglia, and the extended amygdala. We will look at each of these to understand how addiction affects these areas of the brain.

The Prefrontal Cortex

Loosely, *the prefrontal cortex (PFC)* orchestrates thoughts and actions, in conjunction with internal goals, such as the will to live. The PFC may be the seat of what we commonly and loosely refer to as 'personality.' The connections which the PFC has with other brain areas is too elegant to consider in this format. We do know that the PFC itself is divided into three regions, each with its own function control: the lateral PFC, the medial PFC, and the orbitofrontal cortex.

The lateral PFC controls language, attention, working memory, self-awareness, and reality monitoring. The lateral PFC also modulates the ability to maintain information in working memory and to change behavior in response to task demands. The lateral PFC represents past

events, goals, and planning. The ability to conceive of and utilize finances is also involved in this area.¹⁴⁷

The medial PFC modulates body arousal and spatial memory. It may also be involved in pain perception and emotional processing associated with pain. The medial PFC also controls reward and goal-related activities.¹⁴⁸

The orbitofrontal cortex (OFC) controls very important functions of human development. The OFC assigns significance to functions and to mnemonics. It is associated with the function of reward expectation. The OFC may also be associated with social and emotional behavior. The OFC seems to control our sense of aversion, and helps us distinguish, for instance, either aversion to a taste or the pleasure derived from a taste. Further, the OFC probably is associated with our ability to learn by experience and to respond to stimuli from the environment, known as somatic markers. Interestingly for psychology, “individuals who fail to develop context-appropriate somatic markers, either through a “sociopathic temperament” or through injury to the ventromedial frontal cortex will have inappropriate stimulus-bound behavior typical of sociopathy.”¹⁴⁹

Taken together in its component functions, the PFC manages what we term as executive function, although, as we have seen, it is inappropriate to say that this is the only function of the PFC. By executive function we mean those functions that allow us to start and carry out goal direction, to sustain attention, to modulate short-term memory to complete tasks, to control

¹⁴⁷ Siddiqui, Shazia Vegar, Chatteries, Ushri, Kumar, Devvarta, Siddiqui, Aleem, and Goyal, Nishani. “Neuropsychology of the Prefrontal Cortex,” *Indian Journal of Psychiatry*, Vol. 50, no. 3 (July-September 2008): 204. Accessed online on April 12, 2022, at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738354/>.

¹⁴⁸ Ibid.

¹⁴⁹ Siddiqui, Shazia Vegar, Chatteries, Ushri, Kumar, Devvarta, Siddiqui, Aleem, and Goyal, Nishani, “Neuropsychology of the Prefrontal Cortex,” 205.

interference, sequence tasks, plan or change plans as necessary, and problem-solve, among many other functions. Specifically, the PFC controls these functions:¹⁵⁰

- Memory - meaning the retrieval of information
- Intelligence - which includes verbal expression, the ability to process abstract information, the ability to formulate plans and pursue goals.
- Language - the ability to express speech spontaneously, to narrate, and to maintain fluency.

To give one example to illustrate the abilities of the PFC, let us consider a successful Doctor of Philosophy student. To achieve the *goal* of the degree, to maintain and retrieve information from *memory*, to *express* one's ideas in an appropriate academic register, to conduct thorough *research*, to *abstract* complex information, and to *write* a dissertation in a comprehensive format all illustrate a person with advanced functions of the PFC.

The Basal Ganglia

The basal ganglia (BG) is involved in numerous functions. The BG consists primarily of two subsystems, the nucleus accumbens and the dorsal striatum. One of the functions the BG manages is that of cognitive and motor control. Research has shown that Parkinson's Disease, for instance, is caused by cognitive and motor dysfunction due to a marked reduction in dopamine projections to the striatum.¹⁵¹

¹⁵⁰ Ibid.

¹⁵¹ Nagano-Saito, Atsuko, Martinu, Kristina, and Mochi, Oury. "Function of Basal Ganglia in bridging Cognitive and Motor Modules to perform an Action," *Frontiers in Neuroscience*, Vol. 8, Art. 187. (July 2014). Accessed online on April 12, 2022, at <https://www.frontiersin.org/articles/10.3389/fnins.2014.00187/full>.

Another function of the BG is pertinent to the study of addiction. One of the primary functions of the BG is to select actions based upon a system of risk/aversion or reward/pleasure.¹⁵² One example of this system of rewards may be observed at the survival level in birds. If a bird spots a source of food, the BG calculates the reward of the food versus the risk of landing on the ground to receive the reward.

The BG is also heavily involved in patterns of drug-taking. Since drug-taking increases pleasure, the reward of this pleasure will influence future decisions to take drugs. “Activation of the opioid system by these substances stimulates the nucleus accumbens directly or indirectly through the dopamine system.”¹⁵³ Another feature that is peculiar to addiction is the association of feelings with ‘people, places, and things’ (PPT). Dopamine projections influence a person’s mood, and over time with repeated drug use the person begins to associate the pleasurable reward with PPT. Being in the presence of people, places, and things associated with reward can *trigger* urges and become powerful cues to use again. In other words, if the last time I used I did so with a friend, the presence of that friend *alone* can *trigger* my desire for substance-seeking and taking.¹⁵⁴ This phenomenon of PPT triggering urges is known as incentive salience and is an important consideration for our work.

¹⁵² Mikhael, John G. and Bogacz, Rafal. “Learning Reward Uncertainty in the Basal Ganglia,” *PLOS Computational Biology*, Vol. 12, No. 9 (September 2, 2016). Accessed online on April 13, 2022, at <https://journals.plos.org/ploscompbiol/article?id=10.1371/journal.pcbi.1005062>.

¹⁵³ Office of the Surgeon General. *Facing Addiction in America: The Surgeon General’s report on Alcohol, Drugs, and Health*, (Nov 2016.): 2-9. Available in PDF format from the website of the Substance Abuse and Mental Health Services Administration. Accessed online and downloaded on January 22, 2022, at https://store.samhsa.gov/product/Facing-Addiction-in-America-The-Surgeon-General-s-Report-on-Alcohol-Drugs-and-Health-Full-Report/SMA16-4991?referer=from_search_result.

¹⁵⁴ Office of the Surgeon General. *Facing Addiction in America: The Surgeon General’s report on Alcohol, Drugs, and Health*: 2-10.

This phenomenon of incentive salience reminds us of the experiments conducted by the Russian psychologist, Ivan Petrovich Pavlov (1849-1936) to research salivation in dogs. Pavlov measured the amount of saliva produced by dogs, hypothesizing that the dogs would produce saliva when food was presented to them. What he found, in fact, is that dogs began to salivate when they *heard* the footsteps of a lab assistant approaching with the food. The footsteps triggered salivation because the dogs had associated the lab assistant with food. Further studies created the theory of classical conditioning, of which Pavlov is considered the father.

The basal ganglia is then associated with the release of dopamine in response to opioid signaling which in turn creates euphoria and feelings of pleasure. The BG is largely responsible for our brain reward system. These features of reward, incentive salience, and condition will be important when we consider treatment options for opioid addiction in Chapter Five.

The Extended Amygdala

The *extended amygdala* is the third center of brain function that affects our understanding of addiction. This center controls an amazing number of functions; we will only concentrate on those related to addiction. One function is that of maintaining our wakefulness and healthy sleep. Because disturbed sleep due to stress and insomnia can have negative effects on brain circuitry, the extended amygdala is highly tuned to detect and act on emotional and environmental stimuli.¹⁵⁵

¹⁵⁵ Giardino, William J. and Pomrenze, Matthew B. "Extended Amygdala Neuropeptide Circuitry of Emotional Arousal: Waking up on the Wrong Side of the Bed Nuclei of Stria Terminalis," *Frontiers in Behavioral Neuroscience*, Vol. 15, Article 613025 (February 2021). Accessed online on April 14, 2022, at <https://www.frontiersin.org/articles/10.3389/fnbeh.2021.613025/full>.

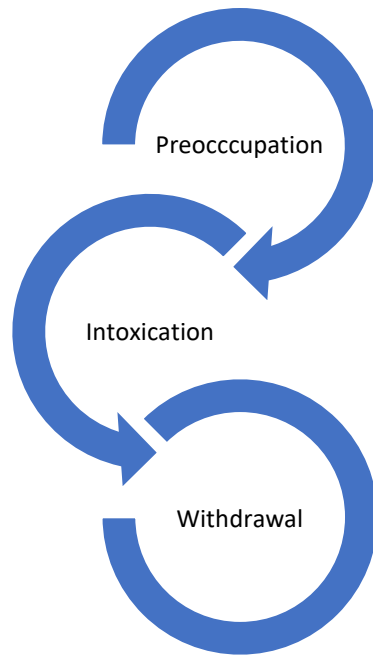
In chronic drug addiction, the extended amygdala plays an outsized role in manifesting some of the behaviors that are familiar to those who work with this population. We will examine the disruption of neural circuitry and the consequences of drug use on the extended amygdala.

One consequence of drug addiction is that when the drug is not available the drug user experiences negative emotions, such as irritability, dysphoria, or anxiety.¹⁵⁶ Deprivation of the drug causes stress, which is the body's response to any alteration in the brain's homeostasis.¹⁵⁷ Drug addiction also manifests the commonly seen phenomena of impulsivity and compulsivity. *Impulsivity* is the unplanned reaction to stimuli, despite the likely negative effects of the reaction (i.e., overdose, arrest, etc.). *Compulsivity* is the response of continued focus on drug use despite adverse effects. This cycle of impulsive use, deprivation of the drug (abstinence/withdrawal), and compulsive seeking for the drug results in a three-stage process of drug addiction.¹⁵⁸ These stages are *preoccupation/anticipation*, *binge/intoxication*, and *withdrawal/negative affect*. This is also a cycle between positive reinforcement (obtaining the drug) and negative reinforcement (withdrawal/forced abstinence). These cycles activate stress systems in the brain, which produce

¹⁵⁶ Koob, George F. "Brain stress systems in the amygdala and addiction," *Brain Research*, 1293, (2009): 61–75. National Institutes of Health, Author Manuscript accessed online on April 14, 2022, at Koob, George F. "Brain stress systems in the amygdala and addiction." *Brain Research*, 1293, (2009): 61–75. National Institutes of Health, Author Manuscript accessed online on April 14, 2022, at <https://doi.org/10.1016/j.brainres.2009.03.038>
<https://doi.org/10.1016/j.brainres.2009.03.038>

¹⁵⁷ *Ibid.*

¹⁵⁸ Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's report on Alcohol, Drugs, and Health*: This process is outlined in pages 2.12-2.18. Also noted in ¹⁵⁸ Koob, George F. "Brain stress systems in the amygdala and addiction." *Brain Research*, 1293, (2009): 61–75. National Institutes of Health, Author Manuscript accessed online on April 14, 2022, at <https://doi.org/10.1016/j.brainres.2009.03.038>



Three Stages of Drug Addiction

the negative reinforcement, manifested in a negative emotional state, which in turn drives compulsive drug-seeking behavior.¹⁵⁹ Withdrawal also produces a response of place aversion, or negative associations of place in which the drug is not to be found.¹⁶⁰ The specific pathways for these responses are still actively researched, but at the center of this process is the extended amygdala.

One other commonly seen result of drug addiction is related to relapse/re-addiction. Research has demonstrated that drug addiction “worsens over time, is subject to significant environmental

¹⁵⁹ For a most recent study confirming the role of corticosteroids in the brain stress system enforcing addiction see: Carmack, Stephanie A. et al. “Corticosteroid sensitization drives opioid addiction.” *Molecular Psychiatry* (March 16, 2022). Accessed online on April 11, 2022, at <https://doi.org/10.1038/s41380-022-01501-1>. Provided by Welshimer Library by courtesy of Interlibrary Loan.

¹⁶⁰ Church, for instance.

influences, and leaves a residual neural trace that allows rapid ‘re-addiction’ even *months and years* after detoxification and abstinence.”¹⁶¹ Because of these factors of brain stress and the activation of brain stress systems, drug addiction is now best described as a “dynamic break” with the brain’s homeostasis, the result of which is a state of allostasis, or the entire-body changes to the brain’s systems that regulate our emotional state.¹⁶²

One of the most maddening aspects of working with this population is precisely this cycle of relapse/re-addiction. Even after significant efforts by the person living with addiction and all those recovery systems developed to assist, this cycle of relapse and re-addiction can be observed months, even years after the person’s ‘recovery’ date. These neurochemical, psychological, and physiological changes caused by drug addiction are all the brain’s response to increased brain stress. The extended amygdala is implicated in all these responses. These responses include “decreased function of reward circuits, loss of executive control, facilitation of stimulus-response associations, and notably recruitment of the brain stress systems...”¹⁶³ All of these characteristics are familiar to one who lives with addiction and to those who work with the population.

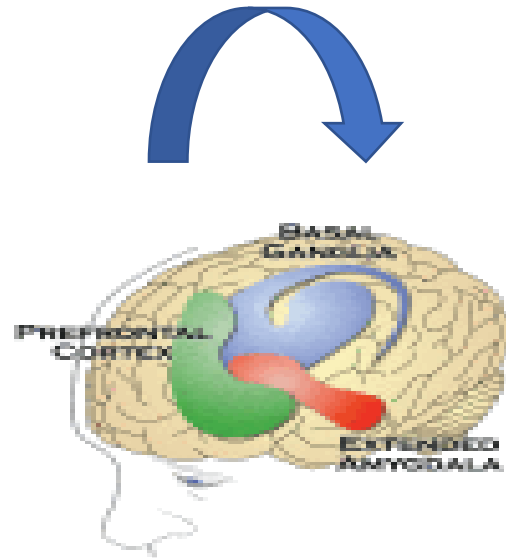
This has been a necessarily brief survey of the three brain functions most affected by addiction. All the interactions of these brain centers are exceedingly complex and beyond my ability to discuss in depth. We can, however, summarize that which is most important to those who work with this population, which we will attempt to do in the graphic below.

¹⁶¹ Koob, George F. “Brain stress systems in the amygdala and addiction,” 8.

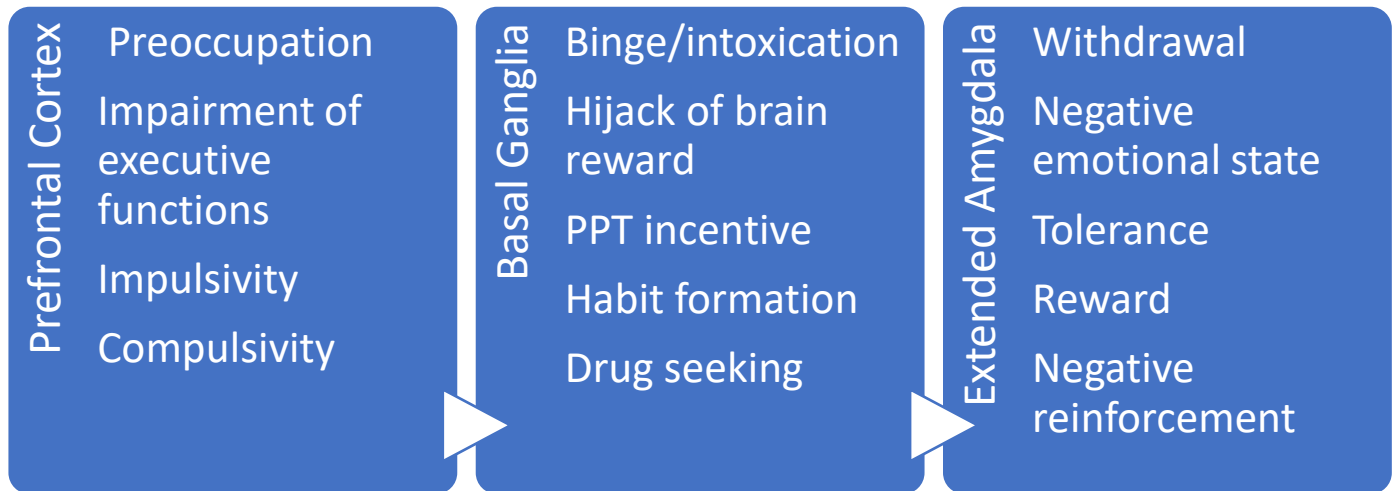
¹⁶² Ibid

¹⁶³ Koob, George F. “Brain stress systems in the amygdala and addiction,” 9.

Drugs are introduced to the brain, affecting these three brain centers



The effect of drugs manifested in these patterns of dysregulation are:



With these survey observations in mind and some awareness of how drugs affect the brain, we may now finally consider a definition of addiction, known as the NIDA Model (National Institute on Drug Addiction) or more loosely, the Standard Account.

Defining characteristics of addiction

Addiction is defined as 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. Those changes may last a long time after a person has stopped taking drugs.¹⁶⁴

In this section we will consider each of the characteristics of addiction outlined in the definition above: chronic relapse, compulsivity, adverse consequences, brain disorder, and functional changes. We will keep in mind that the resulting stress of deprivation of the drug causes a stress response to increased demands on the body. In other words, stress is the body's response to any alteration in the body's homeostatic processes.

1. *Chronic relapse* – We have seen that one of the consequences of opioid addiction is the hijacking of the reward system. One of the features of relapse is that relapse/re-addiction may occur at any point, days, weeks, months, or years after a person has obtained a state of recovery and abstinence. Relapse is frequently triggered by stress events or exposure to persons, places, and things that were previously associated with use. The state of relapse can exhibit denial about use, isolation, defensiveness, loss of behavioral control, and the creation of crises to justify relapse.¹⁶⁵
2. *Compulsivity* – The temporary relief that drug use provides becomes a stimulus for drug-seeking behavior. The drug user becomes preoccupied and anxious about obtaining the next dose. The person pursues positive reinforcement (pleasure) and avoids negative reinforcement (withdrawal).

¹⁶⁴ National Institute on Drug Abuse (NIDA). *Drugs, Brains, and Behavior: The Science of Addiction*, (August 3, 2021) 4. Accessed online on April 10, 2022, from <https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/>. (My italics).

¹⁶⁵ *The American Society of Addiction Medicine Handbook of Addiction Medicine*. Edited by Rastegar, Darius A. and Fingerhood, Michael I, (Oxford: Oxford University Press, 2020): 74.

3. *Adverse consequences* – As we have seen, drugs hijack the brain’s natural reward system and the drug user becomes focused (compulsive) about using, even though adverse consequences can be expected. Some of these include breakup of relationships and family, imprisonment, health implications, homelessness, financial risk and loss, overdose, and death, to name but a few.
4. *Brain disorder* – The effect of chronic drug use, particularly over an extended period, is that neuroadaptations occur in brain systems. We have seen that these changes occur in and affect three central regions of the brain. Healing the brain from these changes occurs over an extended period, as did the addiction to drugs. These neuroadaptations involve *functional changes* to the brain system.

Concluding remarks

Addiction is an equal-opportunity disorder that can affect humans regardless of age, race, gender, or socio-economic environment. People begin using drugs for a variety of reasons. Some, as we saw in Chapter Two, begin opioid use under the supervision of an attending physician. Many others, though, begin drug use to relieve boredom, to feel better, or to compete better (in the case of amphetamines). Some, particularly adolescents, succumb to peer pressure, or adults may be responding to social environment.

To be clear, the *first instance of illicit use and abuse* is entirely voluntary. If we need to blame the patient, then it is at this point that we could do so. For those who feel the need, we could call this a moral failure or poor decision. But rarely in our culture do we blame a person for an instance of poor decision-making and banish them for life. I, for instance, will live with Type II Diabetes for life, and I am aware that it may be a factor in my death. But I am not shunned,

banned, or exiled for the fact of a chronic disease. People do not swear at me and load stigma upon me.

The same is not so of the person who, for a host of reasons, initiates and continues to abuse opioids. In my opinion, the closest thing our society has to a caste of untouchables is that of the chronically addicted user of opioids. In our society, we can cast them away to an island that closely resembles hell, with no prospect of compassion, let alone forgiveness or rebirth.

I find the blame-seeking and lack of compassion at least unhelpful, at times appalling. While society at large may be capable of this lack of compassion, a believer expects more from the church. A vast army of the addicted walks our streets. They are our cousins, siblings, our aunts, and uncles. They are those we live next to, those we encounter on the road, those who wait our tables and serve our food. But, for most, the most haunting part of their lives, their addiction, remains hidden from view.

If I could impress but one thing upon the reader, it is this. The mechanism of addiction involves a complex series of brain functions that make sobriety a far-off dream. After the first cycle of ‘voluntary’ use (possibly determined by factors of gender, race, socioeconomic group, and genetics), the reward function of the brain is hijacked, and in time the brain becomes fastened to addiction. Once addiction has seized people, they are no longer in total control of their own minds.¹⁶⁶ Their minds, their life goals, their desires, their loves, have all been abandoned in the service of the morphine molecule. For the religious-minded, that could appear to be satanic work. And one function of the church is to combat satan and ‘bind the strong man’ wherever he may be, for the love of Christ.

¹⁶⁶ As Dr. Freud suspected of humans in general.

In the next chapter we will look at the consequences of chronic opioid addiction and its impact on the brain and brain functioning, keeping in mind what we have learned about the impact of addiction on brain systems. How do we heal the brain that has been hijacked by opioids?

Chapter Four

Long Term Effects of Chronic Opioid Use

“You don’t decide to be an addict. One morning you wake up sick, and you’re an addict.”

Junky

William S. Burroughs

Having seen so far how opioid addiction spread in the US and how addiction works in the brain, we need now to consider the long terms effects of *chronic* opioid use. I emphasize that we are considering the chronic user, not those who use and follow medical instructions or those who use occasionally recreationally. This task is essential to our project because it will help us to understand what our population is capable of and not yet capable of cognitively. This will help understand our population better and help us adapt our pastoral expectations of human performance.

While our concern is with opioid addiction, researchers have found it challenging to isolate the effects of opioids for one solid reason. Almost no opioid user consumes opioids only.¹⁶⁷ Cannabis intoxication is a steady state among our population. Methamphetamine use is frequent because opioid addicted persons use methamphetamine to mask withdrawal symptoms. Researchers have proved, for instance, that methamphetamine use has a more serious impact on the brain than opioids do.¹⁶⁸ Thus, we will attempt to understand the status of cognitive

¹⁶⁷ Ersche, Karen D., Clark, Luke, London, Mervyn, Robbins, Trevor W., and Sahakian, Barbara J. “Profile of Executive and Memory Function Associated with Amphetamine and Opiate Dependence,” *Neuropsychopharmacology*, Vol. 1 (2006): 1036-1047. Accessed online on February 15, 2022, at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1867318/pdf/nihms-295.pdf>.

¹⁶⁸ Ersche, Karen D. et al. “Profile of Executive and Memory Function Associated with Amphetamine and Opiate Dependence,” 1036.

functioning among opioid users, while realizing that the addicted brain may be affected by multiple substances.

A 2006 research study at the University of Helsinki compared a group of fifteen opioid users to non-users of the same age group, gender, and intelligence.¹⁶⁹ The study selected fifteen volunteer young adults who were chronic users of opioids, primarily heroin. After a period of medically supervised detoxification, participants were selected at random over a period of five to fifteen days of abstinence. At the beginning of the research phase, each participant underwent a psychiatric evaluation. Interestingly, each of the fifteen was found to have a personality disorder as a primary diagnosis. Thirteen were also diagnosed with anti-social disorder. The remaining two were diagnosed with anti-social disorder as a secondary diagnosis. Each had begun opioid use as a teen, consequently their high school classwork suffered. None of the fifteen completed secondary education.

One research question was whether chronic opioid use left permanent impairment of cognitive functioning (the lesion theory) or whether cognitive function improved with time. The study concluded that with increasing time of abstinence most cognitive function deficits did improve to a normal state compared to the control group. Initially, in all cases there was a general cognitive decline with opioid use. These functions include a deficit in attention, memory, and executive function. The study also noted a significant difference between level of cognitive decline in early and late abstinence.

¹⁶⁹ Pekka, Rapeli et al. "Cognitive Function during Early Abstinence from Opioid Dependence: a Comparison to Age, Gender, and Verbal Intelligence matched Controls," *BMC Psychiatry*, Vol. 6, No. 9 (2006). Accessed online on February 15, 2022, at <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/1471-244X-6-9>.

In early abstinence, opioid addicted persons experience considerable stress to brain function. Concentration was poor and fatigue normal. Studies identified a “cascade of neural dysregulation” caused by down-regulation of mu opioid receptors, elevation of GABA and dynorphin, and increased levels of noradrenaline.¹⁷⁰ When retested after fourteen days, there was marked improvement in brain function. This indicates that brain function does recover rapidly with increased time of abstinence. Persons with antisocial disorder showed continuing deficits in attention and executive function that those without the disorder did not experience.

The study also found that at the beginning of research addicted persons performed significantly worse than control in fluid intelligence (the ability to adapt and problem solve), complex working memory, and executive function.¹⁷¹ After nine months of abstinence the participants demonstrated normal functioning. The sort of deficits in functioning that one would expect while an addicted person is intoxicated and particularly during early abstinence due to ‘neural cascading’ creating brain stress, did in fact improve over time of abstinence.

The 2006 study by Ersche et al also identified significant cognitive impairments in the addicted population.¹⁷² These impairments included pronounced problems with executive function, including decision-making and planning, response inhibition (impulsivity), and working memory. This study did not note significant differences in impairment regarding age,

¹⁷⁰ Pekka, Rapeli et al. “Cognitive Function during Early Abstinence from Opioid Dependence: a Comparison to Age, Gender, and Verbal Intelligence matched Controls,” 2.

¹⁷¹ Pekkla, 5.

¹⁷² Ersche, Karen D., Clark, Luke, London, Mervyn, Robbins, Trevor W., and Sahakian, Barbara J. “Profile of Executive and Memory Function Associated with Amphetamine and Opiate Dependence,” *Neuropsychopharmacology*, Vol. 1 (2006): 1036-1047. Accessed online on February 15, 2022, at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1867318/pdf/nihms-295.pdf>.

gender, or IQ. This study further identified that users of amphetamines exhibited more pronounced deficits than did opioid users.¹⁷³

A French study in 2013 investigated whether opioid-dependent persons have a reduced ability of specific autobiographical memory recall. Researchers have theorized that various verbal maneuvers can be used as an avoidance mechanism to thwart anxiety.¹⁷⁴ One such mechanism includes the use of overgeneralized autobiographical recall to avoid more specific memories. The study confirmed that opioid-dependent subjects suffered an impoverishment of autobiographical memories.¹⁷⁵ This overgeneralization is a brain strategy to avoid disturbing thoughts, memories, or events.

While methadone maintenance treatment (MMT) has been shown to reduce mortality and comorbidity, it is possible that MMT, which involves substitution treatment via an opioid agonist, may have similar negative effects on cognition as is observed in opioid users, but to a lesser degree. A study at Meiringen, Switzerland and Munich, studied the effect of methadone on cognition. The study notes that as of the time of this longitudinal study (2010) this remained a barely researched area. Previous studies had shown impairments in methadone patients in executive function, decision-making, and attention.¹⁷⁶ The study tentatively demonstrated that

¹⁷³ Ersche, Karen D. et al. "Profile of Executive and Memory Function Associated with Amphetamine and Opiate Dependence," 1044.

¹⁷⁴ Gandolphe, Marie-Charlotte, Nandrino, Jean-Louis, Hancart, Sabine, and Vosgien, Veronique. "Reduced Autobiographical Memory Specificity as an Emotional Avoidance Strategy in Opioid-Dependent Patients," *Canadian Journal of Behavioural Science*, Vol. 45, No. 4 (2013): 305-312. Accessed online on February 15, 2022, at [Reduced autobiographical memory specificity as an emotional avoidance strat...: Milligan OneSearch \(oclc.org\)](#)

¹⁷⁵ Gandolphe, Marie-Charlotte. "Reduced Autobiographical Memory Specificity as an Emotional Avoidance Strategy in Opioid-Dependent Patients," 306.

¹⁷⁶ Soyka, Michael, Zinngg, Christina, Koller, Gabrille, and Hennig-Fast, Kristina. "Cognitive Function in short- and long-term Substitution Treatment: Are there Differences?" *The World Journal of Biological Psychiatry*, Vol. 11, No. 2 (2010): 400-408. Accessed online on February 15, 2022, at [Cognitive function in short- and long-term substitution treatment: are ther...: Milligan OneSearch \(oclc.org\)](#).

such impairments do exist in methadone patients.¹⁷⁷ This would be concerning, as these impairments could be expected to impact the patient’s ability to self-advocate and to benefit fully from psychotherapeutic counseling.

Following on the work of Soyka et al, a 2021 study examined the impairments of opioid-dependent patients regarding a Theory of Mind study (TOM). This is a study of mental states that allow one to make inferences regarding other people’s thoughts and feelings, ideas, expectations, and intentions.¹⁷⁸ This study was also conducted with patients in opioid maintenance treatment (methadone or buprenorphine). The study confirmed the results of other studies that maintenance patients suffer impairments in social cognition, to include the ability to experience empathy and to read facial expressions. The study contributed new thinking in understanding the role of adverse childhood events (ACE) and similar impairments in social cognition. This study with 150 patients in MMT found that 29% were diagnosed with Post Traumatic Stress Disorder (PTSD), frequently the result of ACE.¹⁷⁹ The study points out the need for more research regarding ACE and opioid dependent patients. The implication of this study is that Trauma Informed Care should be at the center of all interactions with this population.

One profound consequence of chronic opioid use is an impairment in episodic foresight, according to a 2015 Australian study. Episodic foresight is the ability to “mentally travel forward in time...the ability to project oneself forward in time,” which are capacities critical to survival,

¹⁷⁷ Soyka, Michael et al. “Cognitive Function in short- and long-term Substitution Treatment: Are there Differences?” 406.

¹⁷⁸ Eidenmueller, Katharina et al. “Exploring Influences on Theory of Mind Impairment in Opioid Dependent Patients,” *Frontiers in Psychiatry*, 12: 721690. Accessed online on February 15, 2022, at [Frontiers | Exploring Influences on Theory of Mind Impairment in Opioid Dependent Patients | Psychiatry \(frontiersin.org\)](https://www.frontiersin.org/articles/10.3389/fpsyt.2021.721690/full).

¹⁷⁹ Ibid.

planning, and pondering the future.¹⁸⁰ Episodic foresight also influences one's ability to live independently and an impairment in this capacity would explain the poor outcomes our population has in social and financial affairs.¹⁸¹ This study found that an impairment in episodic foresight could be one consequence of chronic opioid use.

Taken together all these findings demonstrate the profound consequences of 'chronic' opioid use. Not every addicted person, of course, will demonstrate each of the consequences we have looked at here, but an awareness of these potential outcomes is important to our work with this population. To work effectively, we must carry an awareness of possible exposure to trauma and its effects, and not be alarmed at an individual's inability to express empathy, make decisions, plan, and provide a consistent narration. In addition, our population may experience difficulties imagining the future, which has theological implications for one's ability to hope. Having looked at these negative outcomes, we will now consider what medical treatment looks like for this population.

¹⁸⁰ Mercuri, Kimberly et al. "Episodic foresight deficits in long-term opiate users," *Psychopharmacology*, Vol. 232. (2015): 1337-1345. Accessed online on February 16, 2022, at [Episodic foresight deficits in long-term opiate users | SpringerLink](#)

Chapter Five

Medical Treatment for Opioid Addiction

“The management of drug addiction is not a police or penological problem. On the contrary, it is a medical problem purely and exclusively. The drug addict is sick, with a pathology as definite as that of any other toxic disorder.”¹⁸²

Charles Terry, 1915

We have considered the insidious process by which one becomes addicted to opioids. In Chapter Four we looked at the consequences of chronic opioid use. In this chapter we will look at attempts to medically treat the person who is addicted to opioids. I believe the goal is to *heal* the *whole* person, which is to be distinguished from treating a person. I will address this distinction fully in Chapter Thirteen when I offer my own understanding of a pastoral theology of addiction, but first, because words are important, we want to consider the terminology we will use.

I have made a conscious decision to select the term ‘healing’ over other terms for three reasons. First, ‘healing’ is a gerund, a verbal form which indicates action conducted in a continuing process. This idea of continuing action is descriptive of the process we wish to employ. Second, ‘healing’ includes all spheres of human existence: financial, relational, physiological, spiritual, and psychological. When we speak of healing the whole person, we must take all these fields of existence into consideration. Third, according to the New Testament account, the action that Jesus undertook was to heal. This was not only physical healing. In

¹⁸² Terry, Charles. *American Medicine, Vol. X, No. 11 (1915): 799-801. Quoted from Charles Terry, The Opium Problem, 877.*

Jesus' society, those who were blind, or lame had greater problems than just the physical affliction. Their very existence was at the margins of life and death. They would have been compelled to beg for alms to survive. Some would be shunned, since it was assumed that physical affliction was punishment for sin (Matt. 9.2). So, Jesus' healing restored the whole person, physically, economically, socially, religiously, and emotionally.

The term used in the NIDA model, though, is almost exclusively 'treatment.' When we use this term, our minds invariably imagine a medical setting. When we go to a medical office with a complaint, our physician will hear us, evaluate us, and then open a treatment plan in which she will outline the treatment to be undertaken to address our problem. The plan could be simple, as in the treatment of a broken bone, or complex, as in treatment for cancer. Since the word treatment is associated with this medical model, I will only use the word when describing medical attention given to opioid addiction. The goal, I believe, is not only treatment but healing in all the spheres of human activity. To understand how the medical treatment of opioid addiction developed we must first consider its history.

The Cure

On December 17, 1914, President Woodrow Wilson signed a public law, *The Harrison Narcotics Tax Act*.¹⁸³ The law, sponsored by Representative Francis Harrison, was intended to control the manufacture, sale, and prescription of "opium products" and cocaine products by taxing them under the authority of the Internal Revenue Service. The law was intended to respond to growing opium addiction in the years after the Civil War and after several military

¹⁸³ Harrison Narcotics Tax Act, 1914. Public Acts of the Sixty-third Congress. (December 17, 1914). Woodrow Wilson, President. Full text of the Act accessed online on April 23, 2022, at <https://www.druglibrary.org/schaffer/history/e1910/harrisonact.htm>.

expeditions overseas. In addition, by the early 1900s, about a third of all those addicted to opioids were women, who had been liberally prescribed morphine for “female problems.” A 1914 study in the State of Tennessee found that 66.9 percent of opiate users were women.¹⁸⁴

As lawmakers acknowledged, the purpose of the Act was not to open a new revenue stream into the federal coffers; rather, it was to tax and control the manufacture, importation, use, and prescription of narcotics. The Act had the effect of regulating the physician’s prescription pad for the first time. All physicians and hospitals that prescribed narcotics were to register and pay a tax to prescribe. For the first time, the government had moved to take the sale of opioids from the hands of “saloon keepers and street peddlers” and into the hands of the presumably more responsible medical community.¹⁸⁵

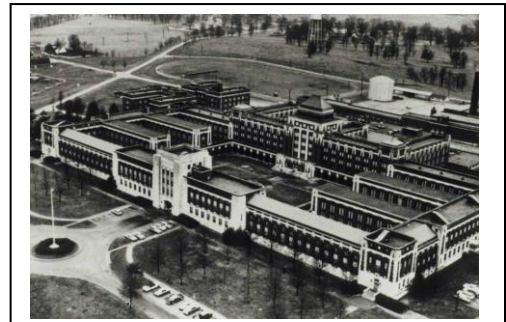
The Act provided for severe criminal punishment. Not only was possession or use of narcotics illegal, but it was also a federal crime, punishable in a federal penitentiary, such as Ft. Leavenworth. At this point the only “cure” for opioid addiction was federal imprisonment. The result of this approach was predictable. By the 1920s, one-third of all federal inmates were serving time for drug offenses.¹⁸⁶ But this, the federal government’s first ‘War on Drugs,’ was unsustainable. By the 1930s a new option was pressed into service.

¹⁸⁴ DeGranpre, Richard. *The Cult of Pharmacology: How America became the World’s Most Troubled Drug Culture*. (Durham, NC: Duke University Press, 2006): 126. Accessed online as eBook via Welshimer Library on May 9, 2022 at <https://www-jstor-org.milligan.idm.oclc.org/stable/j.ctv1131497>.

¹⁸⁵ Courtwright, David, T. “Preventing and Treating Narcotic Addiction – A Century of Federal Drug Control,” *New England Journal of Medicine*, Vol. 373 (November 26, 2015): 2095-2097. Accessed online on April 23, 2022, at <https://www.nejm.org/doi/full/10.1056/NEJMp1508818>. DOI: 10:1056/NEJMp1508818

¹⁸⁶ Campbell, Nancy D., Olsen, JP, and Walden, Luke. *The Narcotic Farm: The Rise and Fall of American’s First Prison for Drug Addicts*. (New York: Harry N. Abrams, 2019): 12.

In the 1930s two federal agencies, the Federal Bureau of Prisons and the Public Health System, began to collaborate on a new approach to the scourge of opioid addiction. In 1935 the two agencies opened the United States Narcotics Farm in Lexington, Kentucky on a sprawling one-thousand-acre estate. Soon the combination of federal prison and hospital for the treatment of addiction would be simply known as the



The Narcotic Farm, Lexington, KY
Image from *Kentucky Historic Institutions* at
[U.S. Narcotic Farm – Kentucky Historic Institutions](#)

Narcotics Farm, or to locals, Narco. The idea for the facility was revolutionary for the time. Here, the federal government, rather than just imprisoning addicted persons, would offer *The Cure*. Soon, inmates serving time for drug addiction were released to Narco. After a few years, a second Farm was opened in Ft. Worth, Texas. A second agency was opened simultaneously at Lexington, the Addiction Research Center (ARC).

The ARC was to the field of addiction medicine what the Manhattan Project was to the field of nuclear physics. Young physicians and clinical researchers with promise were handpicked from the Public Health Service to work at the laboratory in Lexington. Like the Manhattan Project, the best and brightest were removed, one could say almost cloistered, off the beaten track where they could focus on the scientific work at hand. Much of what we know about addiction was developed by these brilliant and dedicated researchers in Lexington.¹⁸⁷ In fact, it

¹⁸⁷ Campbell, Nancy D. “‘A New Deal for the Drug Addict:’ The Addiction Research Center, Lexington, Kentucky,” *Journal of the History of the Behavioral Sciences*, Vol. 42, No. 2. (Spring 2006): 135. Accessed online on April 22, 2022, at <https://eds-s-ebscohost-com.milligan.idm.oclc.org/eds/pdfviewer/pdfviewer?vid=1&sid=d218ca34-a9c8-4159-931d-71e1c2c080e8%40redis>. DOI 10.1002/jhbs/20167/. Dr. Campbell is an assistant professor at the Polytechnic Institute of Troy, NY. She has written extensively about the ARC and the Narcotics Farm.

was at the ARC that researchers connected the classical theory of conditioning with the idea of a relapse ‘trigger.’ The research was conducted to some degree on animal subjects, but the real reward was in direct access to experimentation on inmates.¹⁸⁸ At the time, this was not considered a conflict, as the inmates volunteered and consented to the research. Over time, of course, the ARC had to come to terms with the fact that no one who is incarcerated can ever give what we would today consider informed consent. Later, considering the fallout with the Public Health Service over problematic experimentation on black men at Tuskegee, the ARC was moved to Baltimore in 1976, where it became a component of the National Institute on Drug Abuse.¹⁸⁹

In the early twentieth century narcotics addiction was seen not just as a biological phenomenon but as a moral failure. The cure at Lexington, therefore, would have two prongs of attack. Physicians were drawn from the Public Health Service to administer the first, biological part of the cure. Inmates from Leavenworth were given a full medical examination and intake assessment. They were administered ‘shot therapy’ for approximately eight days. The drug injected was a synthetic form of morphine. The physician would determine the level of the first dose, then each day the dose level would be tapered, until the last injection was of pure saline. This, it was thought, would eliminate the physical craving for opioids. After the ‘patient’ had tapered to zero, the patient was released to the next phase. Patients were released into

“The cure at Lexington is not designed to keep the addicts comfortable. It starts at one-quarter of a grain of M three times a day and lasts eight days...For a man with a heavy habit, this is a very rough schedule.”

William S. Burroughs

Junky

¹⁸⁸ Campbell, Nancy D. “‘A New Deal for the Drug Addict,’ 136.

¹⁸⁹ Ibid.

general population for eight days, where they received barbiturates to ease discomfort.¹⁹⁰ After this, the second avenue of attack began. This was ‘moral therapy.’ Now, supposedly free of the pull of opioids, the inmate was offered a program of religious services, vocational therapy, psychotherapy, group work, and labor in the fresh air of a rural setting. All of these, it was presumed, would return the addict to ‘normal’ society. After a period, there were two avenues to be admitted for the cure. The first, as we have seen, was through federal imprisonment, but soon the cure was opened to any addict who wished to undergo the cure voluntarily.

The Narcotics Farm offered several advantages over the previous handling of the population. While it was still a federal prison, it offered a more humane opportunity to address addiction under medical and correctional supervision. The brand-new facility itself was more like a temple to addiction medicine than a prison. It offered vaulted, cathedral-like ceilings, airy lighting, and sweeping views of the estate. Each prisoner who participated in research at the ARC had a private room, which was an improvement over a correctional cell. The Farm was also the first opportunity for medical officers of the Public Health Service to work exclusively with the problems of addiction medicine. They were thus the first pioneers in a foray into addiction. What they would learn would become invaluable knowledge.¹⁹¹

¹⁹⁰ The author, William S. Burroughs, was himself a voluntary enrollee at Narco, where he went to take “the cure” to avoid arrest in New York City. He describes the experience at Narco in Burroughs, William S. *Junky*. (New York: Penguin Books, 1953). (The book, which was perhaps intentionally salacious, was first published under his mother’s maiden name. First editions are under the name William Lee. Text box quote from page 67.)

¹⁹¹ Campbell, Nancy D., Olsen, JP, and Walden, Luke. *The Narcotic Farm: The Rise and Fall of American’s First Prison for Drug Addicts*, 15.

There was just one problem with this novel approach. *The Cure* did not work. After ten years of operation, the Narcotics Farm had a ninety percent relapse rate. One entry from case notes at the time reads as if it could have been written in any recovery center today.

At 19 he began to use heroin, and shortly thereafter was placed on probation for three years for forging a narcotic prescription. After one year he violated probation by returning to the use of narcotic drugs. He was committed to Lexington for four years, was granted parole after serving more than two years, and was returned after a few months as a violator. He had again relapsed, and he was again committed to Lexington. Three months after his conditional release in the summer of 1957, he was again using drugs and a few weeks later was returned to custody as a violator.¹⁹²

Eventually the government would learn that *The Cure* was not viable, but they did learn something of immense value. The insight and expertise that physicians from the Public Health Service had gained in exclusive practice with the population was invaluable.

Before moving on I want to reflect on the great and lasting influence that both the Harrison Narcotics Act and the Narcotics Farm have had on the field of addiction research and treatment. These are some of the lessons learned.

- Despite what appeared to be best efforts at rehabilitating the whole person and attempting to transform addicted persons into the image of polite society in the early twentieth century, the experiment failed. Theoretically, it was reasonable to assume that the approach should have worked, but we were beginning to learn that something very complex was going on in the addicted brain.
- The idea of moral failure, although it persists probably in most of our society today, and certainly in the church, was misguided. As we were beginning to learn that something

¹⁹² Campbell, Nancy D., Olsen, JP, and Walden, Luke. *The Narcotic Farm*, 16.

very complex was going on in the addicted brain, we realized that not everything could be attributed to moral lapse.

- For the first time, the idea of controllable prescriptions in a medical setting was codified.
- The idea of ‘maintenance therapy,’ by which the addicted person is not tapered off from opioids but maintained on a minimal dose of synthetic morphine was criminalized until methadone maintenance became a standard approach in the 1960s. Unfortunately, so effective was the stigma put in place against maintenance therapy that it persists virulently to this day, despite clear clinical evidence, as we shall see below, that the therapy is effective. We will discuss maintenance therapy at some length beginning on page 109.
- We greatly benefitted from human research conducted at the ARC. Much of what researchers learned about addiction in Lexington is still valid today.
- The Narcotics Farm and the ARC had the effect of producing a trained expert cadre in the nascent field of addiction medicine.
- At least one part of the impetus for the Harrison Act was racial. Newspapers of the time frequently railed against the dangers to white women that “Negro” addicts presented. There was also pressure against Chinese immigrants and ‘their opium dens.’¹⁹³

Another Try

In 1922, a British researcher wrote of the American experience of providing extended law enforcement powers in attempts to reign in drug abuse:

¹⁹³ Special Report, “How did we get here?” *The Economist*, (August 14, 2018). Accessed online on April 23, 2022, via subscription at <https://www.economist.com/special-report/2018/08/14/how-did-we-get-here>.

It appears that not only has the Harrison law failed to diminish the number of drug takers - some contend, indeed, that it has increased their number - but, far from bettering the lot of the opiate addict, it has actually worsened it; for without curtailing the supply of the drug it has sent the price up tenfold, and this has had the effect of impoverishing the poorer class of addicts and reducing them to a condition of such abject misery as to render them incapable of gaining an honest livelihood.¹⁹⁴

The federal government continued to seek a better approach. They did this by increasing punishment for addiction. Between 1920 and 1950, state and federal agencies increased penalties to terms including ninety-nine-year maximum sentences as well as imposed minimum sentences, usually beginning at five years. In the 1950s, federal regulation attempted to dissuade dealers by offering life imprisonment or the death penalty for distributors.¹⁹⁵ The first offender sentenced to life imprisonment under these laws was a twenty-one-year-old epileptic man from Mexico, who had an I.Q. of fifty-nine, and who had just been released from a state mental institution.¹⁹⁶

In 1966, President Lyndon B. Johnson signed the Narcotic Addict Rehabilitation Act (NARA). This constituted another governmental attempt to regulate the problem of narcotics addiction. To some degree, NARA humanized the problem. Essentially the approach was what we today would term diversion treatment. Instead of imprisonment, the addicted person was offered a treatment approach, that if successful, would erase the criminal record of narcotics use. Persons with a record of violent crime were not allowed into the program, but NARA made provisions for other groups, including youth. The program worked by first verifying that a

¹⁹⁴ As quoted in Brecher, Edward M. "Drug Laws and Drug Law Enforcement: A Review and Evaluation Based on 111 Years of Experience," *Drugs and Society*, Vol. 1, Issue: 1, (Fall 1986): 7. Accessed online on April 14, 2022, at <https://www.ojp.gov/ncjrs/virtual-library/abstracts/drug-laws-and-drug-law-enforcement-review-and-evaluation-based-111>.

¹⁹⁵ Brecher, Edward M. "Drug Laws and Drug Law Enforcement: A Review and Evaluation Based on 111 Years of Experience," *Drugs and Society*, Vol. 1, Issue: 1. (Fall 1986): 7. Accessed online on April 14, 2022, at <https://www.ojp.gov/ncjrs/virtual-library/abstracts/drug-laws-and-drug-law-enforcement-review-and-evaluation-based-111>.

¹⁹⁶ Brecher, Edward M. "Drug Laws and Drug Law Enforcement: A Review and Evaluation Based on 111 Years of Experience," 8.

prospect was an addict and likely to benefit from rehabilitation. If accepted, NARA allowed for civil commitment into the care of the Surgeon General. The term of care was generally three years, but the addicted person could be considered for conditional release in less time if the case was deemed a success.¹⁹⁷

The effect of NARA was to decriminalize treatment for opioid addiction. Our vacillation as a nation, however, continued as we waiver between compassionate treatment and criminalization, ending up in a War on Drugs (which is in effect a war on drug users), a global initiative to combat drug use initiated by President Richard M. Nixon in 1971. The War on Drugs and the criminalization of drug activity is one reason that the United States has the largest penal system in the world, with an overrepresentation of ‘minority’ groups. “In 2015 there were 469,545 Americans imprisoned for drug-related offenses, and in 2010 there were 1,638,846 drug-related arrests, eighty-two percent of which were for simple possession.”¹⁹⁸

Contemporary models of treatment for opioid addiction

In terms of treating opioid addiction today, there are two different, competing models.¹⁹⁹ The first is a criminal model. Under this viewpoint, opioid addiction is criminal behavior by morally reprehensible social deviants. The answer to addiction then, is an abstinence-only approach. The

¹⁹⁷ Public Health Law 89-793 (November 8, 1966). H.R. 9167. The Narcotic Addict Rehabilitation Act of 1966. President Lyndon B. Johnson. Accessed online on April 23, 2022, at <https://www.govinfo.gov/content/pkg/STATUTE-80/pdf/STATUTE-80-Pg1438.pdf#page=13>.

¹⁹⁸ Wakeman, Sarah E. “Why it’s Inappropriate not to treat Incarcerated Patients with Opioid Agonist Therapy,” *AMA Journal of Ethics*, Vol. 19, No. 9. (September 2017): 923. Accessed online on April 26, 2022, at <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/stas1-1709.pdf>.

¹⁹⁹ Fischer, Benedikt. “Power and Politics: The turbulent History of Methadone Maintenance in Canada,” *Journal of Public Health Policy*, Vol. 21, No. 2. (2000): 187-210. Accessed online on April 27, 2022, at <https://www-jstor-org.milligan.idm.oclc.org/stable/3343343>.

second is the medical model, which sees addiction as disease and advocates for maintenance treatment not punishment. Because our population experiences both models, we will examine both in some detail.

I. *Abstinence only*

We noted above the institutional resistance to any approach that did not have its end goal as complete abstinence from opioids. This goal is substantially driven by the interests of federal and state bureaucracies, law enforcement, and religious conservatives. In this model, abstinence is imposed forcibly on the addicted, usually by incarceration. Most jail systems do not allow for the medical treatment of withdrawal, beyond perhaps unhelpfully offering Tylenol. The addicted person undergoes approximately two weeks of grueling withdrawal symptoms, generally with no or with minimal medical care. Law enforcement officials, as I have witnessed in my own experiences, seem to pride themselves on running a ‘treatment program’ of their own. They see their role as ‘cleaning up’ the addicted person and separating them from access to opioids. This goal is in accordance with an overarching motivation to conduct a war on drugs (and those addicted to them.) Law enforcement is in the business of removing criminal elements from the community, walling them off from the community, and punishing them for their illegal actions. This model, then, is “institutionally dominated by the interests of law enforcement.”²⁰⁰

The abstinence-only model, colloquially known as ‘cold turkey,’ is an inadvisable and dangerous approach to chronic opioid addiction. This model “typically involves intolerance of any use of drugs, often with little patient choice, and takes a confrontational, even punitive

²⁰⁰ Fischer, Benedikt. “Power and Politics: The turbulent History of Methadone Maintenance in Canada.”: 204.

approach to ongoing drug use.”²⁰¹ In fact, jails and prisons frequently *countermand* the treatment of persons under a physician’s care and ban prescribed maintenance medications for opioid withdrawal. It would be difficult to imagine a jail removing a diabetic from prescribed insulin or metformin, simply because the person was incarcerated.

Involuntary withdrawal while incarcerated (abstinence only) occurs daily across our nation. In fairness, some who are addicted see their compulsory withdrawal while incarcerated as a positive event. One qualitative research study found a small number of such cases out of a sample research population of ninety-two participants.²⁰² Generally, recovery without medical care or medication is *possible* (but not recommended) “for a small number of stable patients with high motivation. The small number of patients who are able to recover without help from medication report relying on personal motivation, past treatment experiences

²⁰¹ Selby, Peter and Kahan, Meldon. *Methadone Maintenance: A Physician’s Guide to Treatment, 2nd Edition*. (Toronto: Centre for Addiction and Mental Health, 2011): 7. Accessed as eBook via Welshimer Library at <https://eds-p-ebshost-com.milligan.idm.oclc.org/eds/detail?sid=b8c67695-9df3-4c83-9f32-5b5810af29ee@redis&vid=0&format=EB&rid=1#db=nlebk&AN=522289>.

²⁰² Mitchell, Shannon G. et al. “Incarceration and Opioid Withdrawal: The Experiences of Methadone Patients and Out-of-Treatment Heroin Users,” *Journal of Psychoactive Drugs*, Vol. 41, no. 2. (June 2009): 146. Accessed online on April 26, 2022, at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2838492/pdf/nihms164083.pdf>.

religion/spirituality, and support from family and close friends.”²⁰³

This subset of the population, however, does not represent the great majority of cases. We should also note that up to ninety percent of persons who undergo opioid detoxification will relapse within the first one to two months after release from incarceration unless they are treated with opioid maintenance medications.²⁰⁴

While we honor and appreciate the efforts of law enforcement in its mission ‘to protect and serve’ the community, law enforcement is not best situated to offer treatment for opioid addiction. This approach is based on ideology and not scientific best practices. While criminal policymaking is beyond the scope of this project, I defend my statement for the following reasons.

1. *Fatal outcome*

There are no reliable reports of the number of persons who die annually while undergoing opioid withdrawal. Nevertheless, death is a possible outcome if medical care is not rendered. Death can and does occur for the simplest and most treatable reasons. Symptoms of withdrawal include severe vomiting and diarrhea. The simplest treatment for this is an IV of fluids, but jail staff are typically not prepared for such measures. Frequently, one nurse may serve an entire jail population. If the person is not treated with fluids, vomiting

Steve Earle



Born in 1955 in Texas, the Legendary Americana/Roots and Grammy Award winning singer/songwriter grew up in Houston but left home at age 13, at which time he began using heroin. He hitchhiked to Nashville at 14 and became a star in the 1980s, but his drug and alcohol problem plagued him. In the 90s he was arrested several times and sentenced to a year in prison for heroin possession. He served 60 days and then went into rehabilitation. He credits the experience for saving his life. He now lives in Greenwich Village and in 2022 released his 22nd album.

www.steveearle.com

²⁰³ “Medically Supervised Withdrawal followed by complete Abstinence.” *Providers Clinical Support System*. Accessed online on April 25, 2022, at <https://pcssnow.org/resource/medically-supervised-withdrawal-followed-by-complete-abstinence/>

²⁰⁴ Ibid.

and diarrhea lead to dehydration, elevated sodium levels and eventual cardiac arrest.²⁰⁵ One investigative report found records of twenty wrongful death lawsuits filed against jails nationwide, between 2014-2016, although the actual number of deaths is underreported.²⁰⁶ In one case in Detroit, a person undergoing severe opioid withdrawal suffered sixteen days of chronic diarrhea, vomiting, and seizures before finally expiring.²⁰⁷ I emphasize that all deaths from opioid withdrawal are completely preventable. In short, “withdrawal needs to be recognized within the correctional system, and elsewhere, as potentially life-threatening and managed accordingly.”²⁰⁸

2. Bioethics

Withholding medical care or providing sub-par medical care to those withdrawing from opioids obviously raises ethical, if not legal, concerns. *The American Medical Association Journal of Ethics* makes this statement: “That the current opioid crisis is due to a medical condition rather than a moral failing or criminal behavior is an important distinction when shaping a response; People with an illness must be treated not punished.”²⁰⁹ One 2004 study found that there were 440,000 people with opioid use disorder incarcerated annually, raising the

²⁰⁵ Darke S; Larney S; Farrell M. “Yes, People can die from Opiate Withdrawal,” Editorial, Society for the Study of Addiction, *Addiction*, ISSN: 1360-0443, 2017 Feb; Vol. 112 (2), pp. 199-200; Publisher: Wiley-Blackwell. Accessed online on April 15, 2022, at [Result List: yes, people can die from opiate withdrawal: Milligan OneSearch \(oclc.org\)](#).

²⁰⁶ Lurie, Julia. “Go to Jail. Die from Withdrawal. Welcome to the Criminal Justice System,” *Mother Jones* (February 5, 2017). Accessed online on April 15, 2022, at <https://www.motherjones.com/politics/2017/02/opioid-withdrawal-jail-deaths/>.

²⁰⁷ Ibid.

²⁰⁸ Darke S; Larney S; Farrell M. “Yes, People can die from Opiate Withdrawal,” 200.

²⁰⁹ Wakeman, Sarah E. “Why it’s Inappropriate not to treat Incarcerated Patients with Opioid Agonist Therapy,” *AMA Journal of Ethics*, Vol. 19, No. 9. (September 2017): 922. Accessed online on April 26, 2022, at <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/stas1-1709.pdf>.

issue of the treatment of withdrawal to an acute level.²¹⁰ Some jails now provide medication assisted treatment to those undergoing withdrawal, but the majority of jails do not. The vast Rikers Island jail complex in New York City has provided such care since the 1970s, but most cities and counties do not have similar resources. In 1976, the Supreme Court ruled in *Estell v Gamble* that deliberate indifference to a prisoner’s serious illness is cruel and unusual punishment as defined in the Eighth Amendment.²¹¹ To date, this issue of the appropriate treatment of those with opioid use disorder in jails and prisons remains a large area for improvement and reform.

3. *Health outcomes*

The failure of jails to address opioid use disorder appropriately has serious public health outcomes. Addicted persons are at highest risk for overdose death within the first month from release from jails. Even if they underwent detoxification while incarcerated, if the addicted person returns to the same People, Places, and Things, she may use opioids again. If she does, she will likely resume at the level that was familiar to her before incarceration. This is a great danger since her tolerance after incarceration is significantly decreased, leading to a greatly increased risk of overdose and death. In fact, the “risk of death from overdose for those within two weeks of release from prison is 129 times higher than that of community residents.”²¹² Further, those released from prison, who may have maintained an opioid addiction even while incarcerated, are at greater risk of infection from HIV and hepatitis, due to the probable sharing of needles in prison.

²¹⁰ Ibid.

²¹¹ Wakeman, Sarah E. “Why it’s Inappropriate not to treat Incarcerated Patients with Opioid Agonist Therapy,” 925.

²¹² Wakeman, 923.

4. *Racial*

Dr. Nora Volkow is currently Director of the National Institute on Drug Abuse (NIDA) and an esteemed leader in the research of addiction, particularly by brain imagery. She raises the concern of racial disparities in the treatment of addiction, especially among an incarcerated population.

The COVID-19 pandemic has highlighted the large racial health disparities in the United States. Black Americans have experienced worse outcomes during the pandemic, continue to die to a greater rate than white Americans, and also suffered disproportionately from a wide range of other acute and chronic illnesses. These disparities are particularly stark in the field of substance use and substance use disorders, where entrenched punitive approaches have exacerbated stigma and made it hard to implement appropriate medical care. Abundant data showed that black people and other communities of color have been disproportionately harmed by decades of addressing drug use as a crime rather than as a matter of public health.²¹³

²¹³ Volkow, Nora. "Addiction Should be treated, not punished," *Neuropsychopharmacology*, Vol. 46. (2021): 2048-2050. Accessed online on April 15, 2022, at the NIDA website <https://pubmed.ncbi.nlm.nih.gov/34404909/>.

She further notes that drug laws are inequitably enforced and ineffectively punished. Persons of color with opioid use disorder also have inequitable access to treatment.²¹⁴

Last, I wish to address the proposed abstinence-only treatment facility to be opened at Roan Mountain. This treatment is planned to last two years, so that the addicted person may work on recovery skills. If this plan sounds familiar, it should. This is really the old Lexington “Cure” model in new shoes. We hope that some may indeed benefit from this environment, but the statistics remain the same as they were in the 1930s in Lexington. Such an approach will still need to address the 90% relapse rate after release. We should note that: “Residential treatment programs have very high reported relapse rates, and patients who attend an abstinence-based program have a higher risk of fatal overdose than waiting-list controls do because of loss of tolerance.”²¹⁵

We close this section by recognizing that abstinence-only treatment is widely endorsed, against all scientific and medical evidence to the contrary. The approach is inadvisable and dangerous if not managed appropriately. This situation is exacerbated by a byzantine federal



Dr. Nora Volkow

Director, NIDA

Dr. Volkow has served as Director of NIDA since 2003. NIDA is the world’s largest funder of research on drug use and addiction. A research psychiatrist, she has pioneered the use of brain imagery to prove that addiction is a disease of the brain. The great-granddaughter of the Russian Revolutionary, Leon Trotsky, she was born in Mexico City and educated at the National University of Mexico. She completed her psychiatric residency at New York University.

²¹⁴ Ibid.

²¹⁵ Srivastava, Anita, Kahan, Meldon, and Nader, Maya. “Primary Care Management of Opioid Use Disorders,” *Canada Family Physician*, Vol. 63. No. 3. (March 2017): 203. Accessed online on April 25, 2022, at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5349718/>.

drug policy that has wavered between waging a war on drug users and inflicting punishment by imprisonment, to a more scientifically based medical approach. Before the situation can improve, our society will need to come to terms with the reality of addiction and develop a scientifically-based public health policy to address the seemingly overwhelming need.

II. Medication Assisted Treatment (MAT)

To begin this section about medications used to treat addiction, please refer to the chart below.

Medication Assisted Treatment (MAT)

| <i>Medication</i> | <i>Type</i> | <i>Usage and Frequency</i> |
|--|-----------------|---|
| Methadone (methadose, dolophine) | Opioid agonist | Daily, usually liquid dosage |
| Buprenorphine (with naloxone) (various formulations including suboxone, probuphine, bunavail, sublocade) | Partial agonist | Daily, sublingual film or tablet |
| Naltrexone (under brand names Vivitrol and ReVia) | Antagonist | Injectable, once monthly (but see discussion below) |
| Naloxone/Narcan | Antagonist | Used to rapidly reverse the effects of opioid overdose. Now is generally found in nasal spray form. Anyone can undergo brief training and be issued a Narcan kit. |

Medication Assisted Treatment (MAT) is defined as the use of any of the medications above *together with* wrap-around services to include counseling, behavioral health, and social service support to provide a whole-person approach to the treatment of opioid use disorder. In 2018,

approximately 2 million Americans had an opioid use disorder.²¹⁶ MAT has been shown to improve patient survival, increase retention in treatment, decrease illicit opioid use, and improve birth outcomes for pregnant patients.²¹⁷ Indeed, today “the safety, effectiveness, and value of properly applied MMT (methadone maintenance therapy) is no more controversial than is the assertion that the earth is round.”²¹⁸

In 1959, in Vancouver, British Columbia, the local health department authorized an experiment in which methadone was administered to those addicted to opioids to manage withdrawal pain. Dr. Robert Halliday executed the program, but over time began to administer methadone for ‘prolonged withdrawal’ – which we would recognize today as methadone maintenance therapy (MMT).²¹⁹ In 1964 Dole and Nyswander, working in New York City, began their own practice of methadone maintenance.²²⁰ By the end of the 1960s, methadone maintenance was already well established both in Canada and the United States. The Substance Abuse and Mental Health Services Administration (SAMSHA) regulates Opioid Treatment Programs (OTP) facilities where MAT is offered. From a modest start in the 1960s the number of OTPs rose from 1,100 in 2003 to more than 1,500 in 2016.

²¹⁶ “Medication-Assisted Treatment (MAT).” (Washington: DC: Substance Abuse and Mental Health Services Administration (SAMSHA), 2021. Accessed online on April 15, 2022, at <https://www.samhsa.gov/medication-assisted-treatment>.

²¹⁷ Ibid.

²¹⁸ Payte, J. Thomas. “A Brief History of Methadone in the Treatment of Opioid Dependence: A Personal Perspective,” *Journal of Psychoactive Drugs*, Vol. 23, No. 2 (1991): 106. Accessed online on April 15, 2022, via Google Scholar at <https://www.tandfonline.com/doi/abs/10.1080/02791072.1991.10472226>.

²¹⁹ Fischer, Benedikt. “Power and Politics: The turbulent History of Methadone Maintenance in Canada,” *Journal of Public Health Policy*, Vol. 21, No. 2. (2000): 190. Accessed online on April 27, 2022, at <https://www-jstor-org.milligan.idm.oclc.org/stable/3343343>.

²²⁰ Fischer, Benedikt. “Power and Politics: The turbulent History of Methadone Maintenance in Canada,” 191.

How does Medication Assisted Treatment Work?

Methadone Maintenance Treatment (MMT) – We will begin by considering the use of methadone to treat opioid use disorder. Methadone is the gold standard for treatment. Since the 1950s methadone has been one of the most researched and best-understood medicines on the market. Federal regulations state that methadone may not be prescribed by a primary care physician but must be administered in a special clinic setting devoted to recovery. When used properly, it is safe and effective. For an OTP, methadone offers a significant advantage. In the beginning stages of treatment, the patient is required to attend daily to receive a dose of methadone. This means that the clinic has daily access to the patient to assess progress and compliance, but daily dosage also provides counselors, nurses, and social service workers daily opportunities to interact with and become acquainted with the patient.

Initiating MMT – Usually a patient hears about MMT by word-of-mouth. Typically, by the time patients seek help at a clinic, they have a chronic, years-long addiction problem and resulting problems financially and emotionally. The most important motivator for treatment is the constant severe sickness the patient has experienced and the daily, constant grind to find enough of a next dose of anything to ward off withdrawal symptoms.

As a new patient in a clinic, the patient meets with the addictionologist, usually for more than one hour. The physician takes a history of addiction and does a physical examination. Part of the rationale for the choice of methadone is patient preference. Some know that only this approach will assist them. If the physician accepts the patient for methadone treatment, the physician initiates methadone dosage, based on the patient's level of opioid use and history of addiction. At

treatment levels, the patient is not ‘getting high,’ as is commonly argued by opponents of MMT. Generally, the physician follows a start-low and go-slow approach, beginning the patient on enough methadone to avoid withdrawal symptoms (generally ranging from 20 to 60mg daily). The patient returns daily to receive the assigned dose orally. If the patient makes sufficient efforts toward recovery, she may begin to receive ‘take home’ doses. This is a reward for progress and this reward alleviates the demand of daily attendance. After the patient is accepted into care she is assigned to a counselor and a case manager, who may be able to help with financial assistance. The physician continues to monitor the patient’s tolerance to methadone and may increase or decrease dosage as needed. We should bear in mind that MAT is medication *assisted* treatment. In other words, methadone is an essential component of treatment, but counselors and case management, and, in fact the entire clinic team, are also important components of MMT.

For those who wish to know more about methadone or other medications, SAMSHA publishes a free series of books, known as TIPS (treatment improvement protocols.) These manuals are intended for providers, caregivers, and family. They are thorough but readable. These free resources, and other resources geared for youth, are available at the SAMSHA

James Taylor



Legendary singer-songwriter James Taylor grew up in an accomplished family (his father was dean of the School of Medicine at UNC and his mother was an opera singer), but a family that suffered with addiction and persistent mental health problems. As a teen in the early 60s he began experimenting with an array of drugs, including heroin. He would go in and out of treatment facilities for his addiction, eventually ending up in England in 1968, where he tried methadone maintenance for the first time. Several relapses later, he entered methadone treatment in NYC in the 1970s. He states that his greatest addiction was to methadone. Finally, in 1983, he decided to end methadone treatment and has been sober since. He states that the reason for his success was a deep desire to be better and a rigorous exercise regime. Although he has decades of sobriety, he still identifies as an opiate addict. He is one of the best-selling musicians of all time.

www.jamestaylor.com

website <https://www.samhsa.gov/kap/resources>.²²¹ Here, we will simply summarize TIP 63, *Medications for Opioid Use Disorder*.

Generally, MMT is seen as a 2-year process. Along the way, some patients may decide to “taper off” and attempt to make another try at sobriety without medication. We should note that the methadone program is rigorous, and therefore quite hard for some patients. They must find transportation to the clinic every day for medication, meet counselors and case managers for assistance, and provide urine drug tests. This process requires accountability and responsibility, which may be difficult for some patients. If unassisted financially, the cost of the medication is approximately \$500 a month. This is incredibly reasonable compared to other medications, but if financial assistance is not available the cost of medication can be prohibitive.

In the 1960s researchers working with methadone discovered that it has a unique profile which makes it especially suitable for the treatment of opioid use disorder. Methadone is a long-acting opioid agonist that reduces opioid craving and withdrawal. Being a full opioid agonist, methadone works with the mu receptors to replace illicit opioids, to decrease the patient’s tolerance to opioids, to reduce or eliminate cravings, and to ward off withdrawal. Methadone remains in the system for 24-48 hours, depending on the person, and so is in a unique position to achieve the desired effects.

The benefits of MMT include higher rates of treatment retention compared to other approaches, lower rates of illicit opioid use (supplementing methadone with other opioids),

²²¹ Treatment Improvement Protocol (TIP) 63. *Medications for Opioid Use Disorder: for Healthcare and Addiction Professionals, Policymakers, Patients, and Families*. (Washington: DC: Substance Abuse and Mental Health Services Administration), 2021.

reduced mortality, reduced risk of overdose death, decreased criminal behavior, and decreased likelihood of HIV infection and transmission.²²² Research has proven that the longer the stay in MMT the better the treatment outcomes will be. This, in part is true because the patient is gradually removed from the triggers of Persons, Places, and Things. It is also the result of intense therapeutic work with staff. Please refer to the table below for a comparison of the benefits of methadone treatment compared to no treatment.

Isn't Methadone or other medications just replacing one drug with another?

| Illicit use without treatment | Medication Assisted Treatment |
|---|---|
| Criminal purchase and use of street narcotics | Medically prescribed medication removes use from the street and replaces opioids with a clinically monitored and individually prescribed dose while under the care of a professional physician. |
| Daily severe withdrawal syndrome | Daily dose of methadone is individually prescribed to ward off withdrawal. |
| Criminal behavior to pursue street drugs | Daily dose of methadone wards off withdrawal syndrome, allowing the patient to think about activities other than pursuing drugs |
| Negative health outcomes including overdose, disease transmission, and overdose death | Reduced risk of overdose, disease transmission, and death, since the dose is medically prescribed and monitored |
| All activities focused on finding the next illicit dose to ward off withdrawal syndrome, with no thought for other activities | Daily interaction includes intense work with a therapist to help a patient understand her addiction, family, relationships, and to set life goals |
| Financial collapse. All money obtained is designated for illicit drug use | Case managers work intensely with patients to improve their financial life and to set life goals, such as education or employment |
| Usually, unemployment or underemployment | Case managers work with clients to set vocational goals |

²²² Treatment Improvement Protocol (TIP) 63. *Medications for Opioid Use Disorder: for Healthcare and Addiction Professionals, Policymakers, Patients, and Families*, summarizing pages 3-17.

Buprenorphine Treatment

Some patients may be better suited for treatment with buprenorphine, as determined by the patient in conjunction with a physician. The benefits, if the medication is appropriately used, are roughly the same as those mentioned for methadone. One reason that a patient may prefer buprenorphine is that the medication can be dosed every other day, for instance on Mondays, Wednesdays, and Fridays. The obvious advantage is that this treatment relieves travel and time burdens. It also is appropriate, for instance, for those whose weekends are spent in community service or incarceration. Buprenorphine is a better choice for those who are gainfully employed by making the treatment schedule less onerous. Buprenorphine patients should receive the same counseling and case management services. One other advantage over methadone is that buprenorphine may be prescribed by a specially licensed and waived physician. Interested physicians may apply for a waiver to prescribe buprenorphine by qualifying for a DATA 2000 physician waiver through SAMSHA.²²³ This means that treatment may be provided in an office setting, thus offering more treatment options.²²⁴

Buprenorphine is a partial agonist, meaning that both an agonist and an antagonist, naloxone, are formulated together. If a patient attempts to break or crush buprenorphine for illicit use, the naloxone present will block the agonist effects, making this formulation abuse-deterrent (but not abuse-proof).²²⁵ TIP 63 notes that long-term use of buprenorphine up to eight years leads to longer periods of abstinence from illicit use and increased clinical stability. In both cases of methadone and buprenorphine, relapses may be a part of the recovery process.

²²³ www.samsha.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver.

²²⁴ Some have recently recommended dispensing with the waiver process and allowing all willing physicians to prescribe buprenorphine.

²²⁵ TIP 63, 3-54.

One disadvantage to both methadone and buprenorphine is the possibility of diversion for illicit use. Clinics, physicians, and medications are placed under rigid controls by the federal government. Many measures have been taken to prevent diversion, yet it persists. We should note, however, that diversion of these medications is not a first choice for addicted persons. They are popular on the street because they can help addicted persons not in treatment avoid withdrawal syndrome.

Naltrexone

One final treatment option exists. Naltrexone was developed in the 1960s as an opioid antagonist, meaning that it completely blocks the euphoric effects of opioids. In lay terms, naltrexone ‘sits’ on the opioid receptors, preventing opioid interaction.²²⁶ Because treatment with naltrexone does not involve the use of opioid agonists, it has become something of a golden child option among those who oppose treatment with methadone or buprenorphine. One of the great advantages of naltrexone is that it is dosed monthly, usually through intramuscular injection. Naltrexone, however, has low rates of acceptance in treatment for a number of reasons. First, only those patients who are already abstinent (ranging from 7-14 days) are eligible for the medication. If the patient presents for naltrexone and has any level of opioids in her system, the antagonist will interact with the agonists in the patient’s system to induce adverse outcomes. Patients, therefore, who are prescribed opioids for pain management or those still opioid dependent would not be candidates. One other disadvantage to naltrexone is the cost. In 2018 the price for one dose was more than \$1000. Currently heavy marketing strategies reminiscent of

²²⁶ TIP 63, 3-37.

Oxycontin practices are used to promote Naltrexone. State and federal grant programs may be available to assist with the cost. Naltrexone is also used for the treatment of alcoholism.

Summary

In summary, the purpose of this chapter has been to discuss treatment options available to those who are addicted to opioids. Great varieties in treatment options are available, based on the patient's history and severity of use. My goal has been to impress upon the reader the seriousness of MAT and the dedication that is required both of patients and treatment staff. This daily war against opioid addiction goes on mostly unnoticed by, or in some cases even opposed by,²²⁷ the general public. Opioid addiction is a serious, chronic, life-threatening biological problem and it should be treated as such by the attention of addiction specialists.

²²⁷ For local coverage of opposition to a new methadone clinic in Gray, TN see https://www.johnsoncitypress.com/do-2-drugs-make-a-right-gray-residents-say-no-to-proposed-methadone-clinics/article_de405579-8e60-5480-abfb-7044d12892bb.html.

Part Two

Other Perspectives

“To understand holy water, we must of course examine priests and parishioners, not water; and to understand abused and addictive drugs, we must examine doctors and addicts, politicians, and populations, not drugs.”

Thomas Szasz

Ceremonial Chemistry

Chapter Six

Perspective

They started at once, and went about among the Lotus-eaters, who did them no hurt, but gave them to eat of the lotus, which was so delicious that those who ate of it left off caring about home and did not even want to go back.

Homer

The Odyssey, Book IX

Humankind has used psychoactive substances since time immemorial. We use them to relieve the boredom of daily drudgery, to enervate our work, to invoke spirits of imagination, and to engage in mystical experiences. To do so we took advantage of native plants: tobacco, coffee beans, coca, opium, cannabis, peyote, and mushrooms. In time, we learned to engineer our drugs, producing coffee and tea, beer, wine, and mead. We learned the art of distillery, producing brandy, whiskey, and fine Scotch. We learned to eat our drugs, chew them, smoke them, drink them, and in the nineteenth century, inject them. Chinese and Indian society recognized opium smoking as a legitimate pastime. Some of our greatest writers in English – Samuel Taylor Coleridge, Elizabeth Barrett-Browning, Charles Dickens, and Edgar Allan Poe, to name a few - used opium recreationally, and believed in its powers to stimulate imagination and artistry. Jazz, blues, and rock aficionados would be hard-pressed to imagine the music scene without the influence of drugs.

Generally (except for alcohol), we used drugs non-problematically until the late nineteenth century, when scientists entered the laboratory and began to create synthetic drugs. We created the process of making powder cocaine, of modifying opium to generate a variety of products from laudanum and morphine to heroin, oxycontin and fentanyl. The Big Tobacco industry

invented the most efficient method imaginable to deliver nicotine in the form of cigarettes. Our love of new psychoactive substances knows no bounds.

As we continue to think about the problem of addiction and build toward a responsive pastoral theology, we should consider perspectives other than the Standard Account of opioid addiction. In this chapter we will consider addiction from the perspective of pharmacologicalism. In the chapters that follow we will continue to develop our perspective with the goal of creating a nuanced model of a pastoral theology of addiction.

Pharmacologicalism

In Part One I have provided a standard, medicalized account of the Crisis of Opioid Addiction in America. The account I have followed is essentially that of addiction as explained by the NIDA paradigm, in which addiction is a brain disease (verified by brain imagery), that is a “chronic, relapsing brain disease with a social context, a genetic...component and significant comorbidity with other mental and physical disorders.”²²⁸ Persons who are addicted engage in addictive behavior despite obvious adverse consequences. The NIDA paradigm is the predominant account, and that which receives millions in federal research and treatment funding.

There is one problem with the account, in that it provides an exceptionally thin description of the human experience of addiction. In this account, (to be simplistic) opioids appear in mass in our society, some people become addicted, and some of those people enter medical treatment for opioid addiction. While I believe the account is correct from a purely biological perspective, it

²²⁸ Courtwright, David T. “The NIDA brain disease paradigm: History, resistance, and spinoffs,” *BioSocieties, The London School of Economics and Political Science*, Vol. 5, No. 1. (2010): 137-147. Accessed online on May 10, 2022, via the author’s website at <https://davidcourtwright.domains.unf.edu/>.

lacks any attempt to understand the phenomenon with any historical, political, economic, philosophical, or religious acumen. I open Part Two and begin to build a pastoral theology by accessing other perspectives that would help us construct a thicker description of the crisis of opioid addiction in America.

First, to be absolutely clear, possessing an academically nuanced perspective on addiction does not heal our population. It can, though, help us to understand the problems better. In the words of one prominent historian of addiction, David Courtwright:²²⁹ “Things are the way they are because they got that way, as any evolutionary biologist will attest. Understanding the present state of things requires understanding past events.”²³⁰

Dr. Courtwright outlines principal challenges to the NIDA paradigm that lie along two axes of opposition. First, is the protest from other disciplines that the NIDA model is a form of biological reductionism that ignores everything that cannot be detected by science.²³¹ Science is in the business of observation, of detecting what can be seen. There is a fear, however, that the model reduces all human behavior to a sort of bioessentialism – preferably to that which can be detected by Positron Emission Tomography (PET). This medicalization of the problem of addiction has suited the medical community, which wants to view addicts as (fee-paying) patients. But other perspectives exist, such as that of law enforcement, which is interested in the

²²⁹ Dr. Courtwright is Presidential Professor Emeritus at the University of North Florida. He has written broadly on addiction and public policy.

²³⁰ Courtwright, David, T. “Addiction and the Science of History,” *Addiction*, Vol. 107, Issue 3. (2012): 486. Accessed online on February 18, 2022, at <https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1360-0443.2011.03723.x>.

²³¹ Courtwright, David, T. “Addiction and the Science of History,” *Addiction*, Vol. 107, Issue 3. (2012): 489. Accessed online on February 18, 2022, at <https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1360-0443.2011.03723.x>.

criminal effects of addiction; politicians, who have cycled between punishing and helping addicts; and social scientists, who see addiction as a social construct.²³²

The problem with the topic of addiction, as I found in my own academic career, is twofold. First, there is little academic interest outside medicine in the fascinating field of addiction. Second, academic disciplines do not talk to one another about their interests. Neuroscientists are interested in neuroscience and social scientists are interested in the human conditions that produce addiction. There is a healthy mistrust between disciplines. But what would happen if neuroscientists listened to pharmacologists who both listened to sociologists and theologians?

The second axis of opposition is more profound. If the NIDA model explains addiction so well, then why are therapeutic outcomes so poor? Currently the most effective treatment for opioid addiction is through maintenance therapy with methadone or buprenorphine, but the results of such treatment are subpar, characterized by high relapse rates and mediocre ‘success’ rates. In addition, maintenance therapy is controversial, as some protest its inability to ‘get people clean’ while others decry the diversion of methadone and buprenorphine on the street. To put it another way, if we know so well what causes addiction, why do we not yet have effective treatment options, such as we have with metformin for diabetes, or a multitude of medications to treat hypertension or heart disease? The holy grail of addiction medicine would be to develop a medication that eliminates craving and relapse. So, why has such a medication not been developed if our knowledge under the NIDA paradigm is so effective?

The problem is perhaps best illustrated from another field of addiction – that of tobacco dependence. According to the brain disease model, tobacco contains an addictive component,

²³² Courtwright, David T. “The NIDA brain disease paradigm: History, resistance, and spinoffs,” 140.

nicotine. “Big Tobacco,” the worldwide tobacco industry, modified and manipulated its cigarettes to add more nicotine to the tobacco product used, thus ‘addicting’ millions of people worldwide.²³³ According to the NIDA model, treatment should be relatively easy. Replacement or maintenance therapy (in the same way that methadone replaces other opioids) is provided in the form of nicotine patches or gum. Over time, the theory goes, the user tapers away from nicotine and becomes nicotine free. The problem? In one study, only twenty-six percent of those who attempted to quit through replacement therapy obtained abstinence.²³⁴ Not only that, but ninety percent of those who do quit nicotine do so without any pharmacological support, such as nicotine patches.²³⁵ So, maybe there are more factors to addiction than just the ‘addictiveness’ of a particular drug.

Perhaps the most vociferous critic of the medical model is independent scholar Richard DeGranpre. He holds a doctorate in psychopharmacology and was a Fellow of the National Institute on Drug Abuse. He has since become a critic of the “NIDA model.” He has authored five books that are essentially social histories of pharmaceutical products, accompanied by summaries of dozens of research tests in the field of addiction. His central thesis is that American society has coopted the religious or mystical category of ‘good and evil’ and applied that category to medications/drugs.²³⁶ In doing so, science replaces religion as the arbiter of good and evil. When we refer to ‘medications,’ we are classifying them as ‘good.’ We could, for

²³³ DeGranpre, Richard. *The Cult of Pharmacology: How America became the World’s Most Troubled Drug Culture*. (Durham, NC: Duke University Press, 2006): 68. Accessed online as eBook via Welshimer Library on May 9, 2022, at <https://www-jstor-org.milligan.idm.oclc.org/stable/j.ctv1131497>.

²³⁴ DeGranpre, Richard. *The Cult of Pharmacology: How America became the World’s Most Troubled Drug Culture*, 85.

²³⁵ DeGranpre, Richard, 93.

²³⁶ DeGranpre, Richard, 27.

example, agree that heart and blood pressure medications are ‘good’ drugs. Heroin, we could all probably agree, is a ‘bad’ drug. There are, therefore ‘angel’ drugs and ‘demon’ drugs.

To illustrate the point, DeGranpre provides one example from recent history. In the 1980s, the United States became more and more aware of the ‘scourge’ of cocaine.²³⁷ The answer to the problem, the government suggested, was to go to Colombia and tell that government to stop producing cocaine and exporting it to the States. Firm words were followed by millions of dollars to support a war on cocaine. Soon, Colombia was full of US personnel from the military, the CIA, and the Drug Enforcement Agency. This war on cocaine in Colombia has raged since the 1980s.²³⁸

In 1948, the pharmaceutical company, CIBA, patented a new drug, methylphenidate, which would later be marketed as the latest wonder drug, Ritalin. The drug was a combination of stimulants, which in laboratory rats seemed to increase attention and focus. In the 1980s, when the cocaine war was charting out under full steam in Colombia, Ritalin was introduced to the US market for the treatment of adults and children with attention deficit disorder. Millions of adults and children were and are prescribed Ritalin.

Ritalin also has a great potential for diversion for illicit use as a ‘party drug.’ This is so because pharmacologically Ritalin is *indistinguishable* from cocaine.²³⁹ The main difference is in the route of administration, as Ritalin, the angel medication, is a tablet, while cocaine, the demon drug, is a powder that can be snorted or injected. If, however, we take Ritalin and crush it, we can snort or inject it too. Thus the ‘angel’ medication Ritalin is in a liminal state with the

²³⁷ This story is developed in Chapter One of *The Cult of Pharmacology*.

²³⁸ Since his election as President of Colombia in 2022, the former guerilla leader, Gustavo Petro, has promised to end the war on drugs and to legalize cocaine and cannabis.

²³⁹ DeGranpre, 11.

‘demon’ drug cocaine. Use Ritalin as other-than-prescribed and suddenly the angel is a demon. In this way, DeGranpre illustrates our irrationality in our conversation about drugs.

The NIDA model classifies drugs as either good or evil, medicinal or recreational. The Drug Enforcement Agency goes further in developing a ‘schedule’ to classify all drugs by use, licit and illicit.²⁴⁰ DeGranpre refers to this model of thinking about drugs as ‘pharmacologicalism.’ “Technically speaking, pharmacologicalism, like racism, is an ideological system rooted in a set of assumptions that, although false and exaggerated, govern a whole range of perceptions, understandings, and actions. A key supposition of pharmacologicalism is that pharmacological potentialities contained within the drug’s chemical structure determine drug outcomes in the body, the brain, and behavior.”²⁴¹

The imagery of pharmacologicalism draws on mystical categories familiar to religion, such as that of demon possession. My statement in my autoethnography that I had worked with the image of opioid addicted persons as ‘slaves’ similarly draws on metaphysical and mystical categories to discuss a topic that is hard to understand and describe. Acknowledging my own magical thinking about opioid addiction has been one of the learnings I have gained from my research.

Why do *some* (not all) who use drugs appear to be unable to change and continue in harmful habits, knowing that the habits are harmful? How do I explain, for instance, a hospice patient of mine dying a slow death with emphysema from a lifetime of cigarette smoking, who continued to

²⁴⁰For more information about drug scheduling, see [Drug Scheduling \(dea.gov\)](https://www.dea.gov).

²⁴¹ DeGranpre, 27.

smoke when he was receiving oxygen? That *looks like* a type of slavery, but is slavery a useful metaphor, or does it simply amplify some of the assumptions of pharmacologicalism?

The fact is that drugs by themselves are neither good nor bad. That fact flies in the face of my lifelong indoctrination through hysterical propaganda about demon drug and weed, cases of LSD insanity, PCP fueled violence, and brains on drugs frying like eggs. Drugs by *themselves* are completely and totally neutral. Problems only arise when drugs, usually synthetic drugs, make the acquaintance of human beings, who bring to the experience all that it means to be human: loves and hates, economics, social relations, social conditioning, and meaning making. Perhaps, as Szasz observed in the opening quote of the chapter, we should be studying human behavior and personality, not drugs themselves.



When we use a drug, any drug, we make meaning. If I have cancer, I can put great hope in a drug to cure me, to restore me to health and an abundant life. If I have diabetes, I pray that metformin can help overcome decades of poor dietary choices. If I use alcohol, tobacco, caffeine, marijuana, or other drugs, what meaning do I make?

To illustrate the point of meaning-making, permit a thought experiment. What if I had never tasted alcohol in my whole life but had heard from acquaintances that a great time could be had by all, if only they would imbibe. Curious, alone, and bored one night, I head off to the liquor store to buy a bottle of whiskey (quite legally), determined to avail myself of this wonder drug. Home alone, I open the bottle and sniff the pungent, woody odor. I pour a drink and taste it. And....

And what? Many people never try a drug of any kind. Some try it and do not see what all the fuss is about. Some try it and like it, even using it enough to become dependent on it. A percentage of those who continue to use drugs will develop a chronic addiction. In my imaginary story of drinking alone, I assume that this solitary experience would be completely different from my real experience of first drinking as a teenager with a group of rowdy 82nd Airborne paratroopers on a deserted drop zone at Ft. Bragg. I learned from them how one was supposed to act when intoxicated, how to ‘have fun.’ This is so because, for most, drinking, at least initially, is a social act, even a rite of passage. We make meaning about what it means to drink in part by the influence of those with whom we drink.

Sociological approaches

One of the most influential thinkers on the topic of addiction was Alfred E. Lindesmith. While working in the 1930s as a researcher in the School of Sociology at the University of Chicago, he developed an interest in the social history of addiction. He conducted qualitative research by interviewing fifty opioid addicts, some for a short period of time, some for more than a year. One of his interests was the effect of first use of morphine. He relates the result of one interview that points toward a social learning process in drug use.

The learning processes involved in the first trials of the drug are illustrated by incidents related to me by addicts. For example, a man who experimented with opiates in the presence of two addicts reported that he felt nothing except nausea, which occurred about half an hour after the injection. It took a number of repetitions and some instruction from his more sophisticated associates before this person learned to notice the euphoric effects.²⁴²

²⁴² Lindesmith, Alfred E. *Addiction and Opiates*. (Chicago: Aldine Publishing, 1947/1968): 84-85. Dr. Lindesmith was later Professor of Sociology at Indiana University.

What Lindesmith learned is that social relations affect drug use, and that there is even a learning process that the novice user undergoes at the hands of more experienced users. The novice, as the incident points out, had to learn how the drug feels, and this took several attempts.

Lindesmith insists that we broaden our understanding of addiction from the purely biological to the behavioral.

Some students of addiction from the Biological Sciences insist that addiction ought to be defined in biological or biochemical terms and sometimes equate it with physical dependence. Such a definition is clearly unacceptable for one who studies the behavior of the addict since it would require that infants born of addicted mothers be called addicts while drug users locked up in jail could not be. As has been shown in this chapter, physical dependence may exist without addiction and addiction without physical dependence. If one is interested solely in the bodily effects of opiates it is certainly legitimate and necessary to study the phenomena of physical dependence and tolerance, but if one is concerned with the social psychology of addiction, that is, with behavior, the definition of addiction must be in behavioral terms.²⁴³

As I look back on my understanding of addiction, I see that there were always clues pointing to the fact that addiction is much more nuanced than I had believed, but I filed them away because they did not meet the grand narrative our society tells us about addiction. By way of illustration, I offer Rene's story.

When I was teaching at the Defense Language Institute, I had a brilliant young female Russian student, Rene. She had already proved herself as a military linguist and had served a previous enlistment as an Arabic linguist. She was an intelligent Non-Commissioned Officer who appeared dedicated to her career. I did note that she did not mingle well with others, but I attributed that to the fact that she was older than the other students and that she was a single mother.

²⁴³ Lindesmith, Alfred E., 66.

I was working in my office one morning when she entered and asked to speak. Soon her entire demeanor had fallen, and she wept bitterly. She wanted to tell me that she was an alcoholic, frequently drinking alone after her child had gone to sleep, bitter about her divorce, and concerned about her child and her career. She did not know what to do. I told her that our department chair, Sergei, had worked through a similar problem and that he had over twenty years of sobriety. I asked if she would be comfortable speaking with him because I knew that he would handle this discreetly. She agreed, and I arranged for her to talk with Sergey. Soon she was attending Alcoholics Anonymous regularly. After several months, Sergei told me that she was doing fine and was working hard.

I was surprised when one morning she appeared again in my office. Again, she was crestfallen and weeping. When I asked her what she was feeling, she replied through tears and running mascara, “I feel like I’ve lost *my best friend!*” She meant that she had lost her best friend, alcohol. This was one of the most important indications I could have been given about addiction, but for years I missed the meaning, pushing this incident back in my mind. For Rene, alcohol had taken on *meaning*. It was not just a substance of abuse. Divorced and alone except for a small child in the home, alcohol was the best friend with whom Rene watched a movie on Friday night. It was the best friend who tried to cheer her up about her life prospects. It was the friend who blunted all the trauma, disappointment, and sorrow. Alcohol was more reliable than an ex-husband and it always kept its promises. Alcohol had meaning.

To understand this meaning-making better I turn to one of DeGranpre’s most profound insights, a phenomenon called the placebo text, which he defines in this way: “Placebo text refers to any unwritten cultural script that, like a religious text, informs a group’s beliefs and expectations about a given drug, animating the “drug effects” once the substance is taken. If by

placebo effect one means an outcome produced not by a drug but *by beliefs and expectations about a drug*, then a placebo text becomes the cultural teachings, however subtle, that inform these beliefs and expectations” (my italics).²⁴⁴ In other words, drugs can and do create a drug effect, but that effect is moderated by a cultural script. The Army, as I had learned as a teen, could be a sub-culture where alcohol excess is commonplace. But Rene not only drank until it became a problem; she had somewhere a cultural script that informed her that alcohol could be a companion, comforter, and friend.

One of the problems with our thinking about addiction is that our language to describe it is impoverished. We think people are either sober or drunk, ‘clean’ or ‘dirty.’ DeGranpre writes that many opiate users “become trapped within the prevailing pharmacologicalism of addiction – a placebo text, in essence, that promotes drug dependence...”²⁴⁵ Opioid addiction is the example par excellence of pharmacological demon possession. Opioid addiction, in this construct, is a self-fulfilling prophecy, because we have magically invested so much power in the drug itself, giving it the power of good and evil. In this script an addicted person becomes enslaved, probably for life.

But that is not true. Canadian researcher Bruce K. Alexander suggested that drug use occurs along a continuum of seven levels, starting with abstinence, then experimental use, to circumstantial use, casual use, regular use, dependence, and finally, addiction.²⁴⁶ This is a far more constructive way of talking about addiction, because it is far more descriptive of the human

²⁴⁴ DeGranpre, 120.

²⁴⁵ Ibid.

²⁴⁶ Alexander, Bruce K. *Peaceful Measures: Canada's Way out of the 'War on Drugs*. (Toronto: University of Toronto Press, 1990). See, for instance, the discussion of ‘normal use’ beginning on page 304.

experience of drugs. We have been told, smoke cigarettes and you will be hooked. Smoke marijuana and you will be a lazy bum the rest of your life. Use heroin, and you will end up a narco zombie or overdosed. But the human experience just does not work that way.

Again, there have been clues along the way regarding drug use. Addiction science, for instance, has had a full array of fuzzy terminology to describe the problem. Experts have tried to distinguish between substance use disorder, dependence, and addiction. *The American Society of Addiction Medicine Handbook of Addiction Medicine* reminds us that ‘addiction’ “may be used when referring to the more severe end of the spectrum.”²⁴⁷ But, to discuss alcohol, for instance, the field has tried to distinguish between problem drinking, alcohol abuse, hazardous drinking, harmful drinking, binge drinking and heavy drinking.²⁴⁸ Some in the field prefer the term substance abuse, which intimates that the user has taken something good, like oxycontin, and sullied it with abuse. Furthermore, in a 452-page book, the *Handbook* gives only two paragraphs to something called ‘psychosocial factors.’²⁴⁹

The clues to the truth about drug use – clues that run counter to the predominant model – have been there all along. Perhaps when some of us think about drug use in America, our minds may go to heroin use by servicemen in Vietnam. In the 1970s, Lee Robins was tasked and funded to research opiate use in Vietnam and its outcomes. What she found was perplexing.

Although as many as 20 percent of the soldiers reported opiate addiction while in Vietnam, where opiates were smoked, snorted, and swallowed, and although many of them reported opiate use during their first year back in the United States, fewer than 1 percent of them showed any sign of opiate dependence after one year. Of those who reported a subjective sense of being addicted to opiates while in Vietnam, about 33 percent tried opiates after returning home, yet only one in five of them showed any sign

²⁴⁷ *The American Society of Addiction Medicine Handbook of Addiction Medicine*. Edited by Rastegar, Darius A. and Fingerhood, Michael I. (Oxford: Oxford University Press, 2020): 5.

²⁴⁸ *Ibid.*

²⁴⁹ *Ibid.*

of dependence a year later. Equally perplexing to those who viewed drug issues through the lens of pharmacologicalism was Robins' finding that those "addicts" who did not receive treatment after returning home fared as well as those who did, which suggested that addiction in Vietnam was neither an individual or pharmacological problem nor a disease, but purely a situational phenomenon.²⁵⁰

Robins' findings should have been the death knell for the disease model of addiction, but the disease model persists.

Another perplexing phenomenon about opiate addiction is in the instance of 'chipping.' Chipping in the drug culture is the occasional, generally non-problematic use of opiates, on the weekends, for instance, or when in the company of a particular friend. Rather than opiate use developing into full-blown addiction, as the disease model would predict, some users seem capable of using or not using at will.

I recall an instance from my own practice in New York City. I received a referral for assistance for a Vietnam veteran, David, who reported that he was homeless. I contacted David, and he suggested that we meet at the Manhattan VA Center on the East Side. When I arrived at the VA canteen, I found a clean, appropriately dressed, middle-aged, African American male. He was affable and readily forthcoming with information. Over the next year and a half, I worked with David and got to know more about him. He had suggested meeting at the VA, it turned out, because he worked there full-time as a back-office clerk. He had lost previous housing and was homeless. He worked a full forty-hour work week, but when his work was over, he would disappear into the back halls and hiding spots of the vast VA building to find a place to sleep. He rose the next morning, showered and dressed in an employee locker room, and went to work.

²⁵⁰ DeGranpre, 117.

After a couple of months, I was able to provide him with an apartment through the supportive housing program in New York.

The more I got acquainted with David, the more intrigued I was. David had been nineteen when he joined the Navy. He was trained for an exceptionally dangerous job as a ‘special boat operator,’ which in military parlance is the person who operates a high-speed, armed river boat to insert Special Forces operators up and down the river systems of Vietnam. David was young and scared, and soon, like many others, he began using heroin to ease his anxiety and to find some sense of calm in a turbulent war zone.

Unlike most of Robin’s veteran research subjects, David continued using heroin when he returned home to New York City. He described himself as a ‘chipper’ – an injection heroin user who does not use daily. David assured me he used two or three times a week, which I was later able to confirm, but I suppose at first, I did not believe him. By the time David and I became acquainted, he had been using heroin regularly for *fifty* years. He was not addicted but was a regular user. In all that time he had never been arrested for drug use, having only a few misdemeanor infractions on his record. He held down a forty-hour a week job and had decent social relations with others. He had been married once, and although divorced, he maintained some contact with two sons. If I knew now, what I knew then, I would have probed David about the meaning that heroin had for him – a meaning that had sustained him for fifty years.

The point of the story is this. David breaks the mold of the brain disease model. Theoretically, after fifty years of use, he should have developed a raging addiction, should have experienced overdose, should have developed serious health problems, and should have serious legal and social problems. He did not. When I secured housing for him through a city housing program,

my bosses balked at allowing him to move in, based on his drug use. To their great chagrin, I had learned to take his heroin use in stride.

Drug use can never be considered in its singularity but must be understood as suspended within a web of complex factors that include proximity to supply, social location, social conditioning, social relations, economics, genetics, racial makeup, historical considerations, and meaning making. As DeGranpre puts it: “The shortcomings of the disease model of addiction lie not in the general ideas on which it is premised, but rather on the sheer lack of evidence supporting it.”²⁵¹

Understanding this complex of conditions that creates addiction is vital, when we ask one probing question: Can Opioid Addiction be Cured? One day we may develop a biological or neurological cure for the craving caused by addiction. Current research has focused on three areas of promise, including brain stimulation, behavioral therapy (CBT), and therapeutic gene modulation.²⁵² Even if we create a biological cure, have we cured addiction? What of the socioeconomic, relational, and cultural influences that led one into opioid use in the first place? How do we ‘cure’ those? So, as we will see later in Part III, a more nuanced understanding of substance use, dependence, and addiction opens the door for a more informed model of pastoral theology.

²⁵¹ DeGranpre, 189.

²⁵² Liu, Jian-feng and Li, Jun-xu. “Drug Addiction: a curable mental disorder?” *Nature: Acta Pharmacologica Sinica*, (Spring 2018): 1823-1829. Accessed online on May 25, 2022, at <https://www.nature.com/articles/s41401-018-0180-x.pdf>.

Chapter 7

Opposing Forces

In Part Two of this work, we are looking outside the standard disease model of addiction to gain other perspectives. In the last chapter we looked at the issue of pharmacologicalism. In this chapter we will consider two primary critics of the disease model: Thomas Szasz and Stanton Peele.

Thomas Szasz (1920-2012)

There has been no more controversial figure in the field of psychiatry than Thomas S. Szasz, who in his groundbreaking 1961 book, *The Myth of Mental Illness*, shocked the psychiatric community by questioning the founding principles of the field. Medicine is based on observable facts, he noted. How then, he argued, can mental disorders be considered illness or disease if all evidence of such a disorder disappears at death? We can conduct an autopsy to prove that a person died of a gunshot wound, or heart disease, or cancer, but what evidence is there postmortem of mental disease? The fact is, Szasz claimed, that the nosology of psychiatric illnesses is based entirely on fallacious reasoning.

Modern advances in neuroscience and brain imagery can now prove that a person's brain has, for instance, been damaged and transformed by prolonged addiction, making some of Szasz's claims outdated. According to his obituaries, he had the peculiar ability of alienating practically every fellow psychiatrist in the United States, Canada, and Great Britain. He appears to have been obstinate and even insulting toward colleagues. He thought in rigid categories, and one either was correct in agreeing with him or decidedly incorrect if he did not. He refuted charges that he was anti-psychiatry by practicing and teaching psychiatry and psychoanalysis for

over fifty years. In writing he had a flair for the dramatic and inflammatory sentence. While his impact on the field of psychiatry has waned (his book had entered a third reprinting within three years), his thinking on addiction and drug use is still capable of shedding some light on the state of our current thinking about addiction.

Szasz' writings remind one more of the cultural criticism of Sigmund Freud in his later years, than that of a medical writer. It is precisely because of Szasz' criticism, I believe, that his works exert continued influence. I would argue that few have thought more deeply about the practice of psychiatry. In his 1985 book, *Ceremonial Chemistry*, Szasz turns his attention to the issue of drug use and society's treatment of those who use. The central thesis of the book is that, rather than focusing our attention on drugs, we should focus on the meaning behind drug use. He finds this meaning in ritual and ceremony. Szasz takes us on a historical tour to Ancient Greece and through the Old and New Testaments, to examine two words to clarify his position.

First, he reminds us of the root of the words pharmacist and pharmacology, which is φαρμακος.²⁵³ The term was used in Ancient Greece for the scapegoat, the person or persons who bore all sin or illness on behalf of the village and culture. In ceremony, the scapegoat was invested with the concerns of the society, then was ritually executed, or driven into the wilderness as a propitiation. The term traveled through time, taking the meaning of 'poison,' and then of 'medicine.' In reminding of the case of the scapegoat in ancient society, Szasz calls to mind the binding of Isaac and the sacrifice of Our Lord on the cross as prime examples.

²⁵³ Szasz, Thomas. *Ceremonial Chemistry: The ritual persecution of drugs, addicts, and pushers*. (Holmes Beach, Florida, 1985): 19ff.

Szasz refers to the sacrifice of the scapegoat as riddance rituals.²⁵⁴ Through these rituals and ceremonies, society rids itself of sin, illness, and filth. The φαρμακος was then a ‘remedy, a περιπσεμα, ‘an offscouring’, or a καθαρμαδα, ‘that which is wiped off.’²⁵⁵ From these ceremonial terms, it is not difficult to arrive at the terms scourged, scum, and filth. In dealing with our population, we will frequently hear them referred to as scum, filth, and castoffs.

Szasz sees in these rituals and ceremonies that we in modern society have come full circle. We have come from “cure-alls through human sacrifice to cure-alls through chemistry; and to the sacrifice of pharmacological φαρμακοι – through whose expulsion Man, the god of chemistry, seeks to purify his polluted earthly Garden.”²⁵⁶ Szasz believes that contrary to what modern science would assert, we have not abandoned our religious rituals and ceremonies; rather, we have transferred them to a modern, scientific context.²⁵⁷ Indeed, man “...cannot live without religion. The objects of his faith and his religious practices have thus been transformed and renamed...into the worship of science and the ‘general welfare’ in the West.”²⁵⁸

Concerning drugs, he finds that “most people cannot live without drugs any more than they can without religion.”²⁵⁹ From time immemorial humankind has sought the comfort of drugs. Drugs such as opium, alcohol, coca, and caffeine have served us well. They lift our spirits when we are tired and offer us a sense of well-being. They have helped us through long workdays in the field or factories and have helped us celebrate at work’s end. Modern science, despite its best efforts, has not eliminated drugs, but in fact, has, through medical prescription offered us ever

²⁵⁴ Szasz, Thomas. *Ceremonial Chemistry* 23.

²⁵⁵ Szasz, Thomas 25.

²⁵⁶ Szasz, 27.

²⁵⁷ 29.

²⁵⁸ 30.

²⁵⁹ 30.

new and improving mind-altering drugs in synthetic psychopharmacologicals.²⁶⁰ If, for instance, we think we suffer from something psychiatry has called attention deficit disorder, we fill a prescription for Ritalin. If we are depressed, any number of new antidepressants will do. If our sleep is disturbed, pharmaceuticals ease us into rest. Szasz makes his foundational assertion in these terms: “If it is true that the phenomena we now call drug addiction and drug abuse constitute certain kinds of ceremonial behaviors, then it follows that they can be understood only in terms appropriate to the analysis of the ceremonial.”²⁶¹

Szasz’ second linguistic turn is to focus our attention of the use of the word ‘addiction.’ As he and other writers have pointed out before the beginning of the twentieth century the term ‘addiction’ as we now understand it did not exist. Previously, addiction signified only our inclination to engage in a certain type of behavior.²⁶² One could be ‘addicted’ to bad habits, like playing poker, playing pool, or even reading. What happened in the early twentieth century to change this word to signify a disease model, first in the use of drugs, and then to our current disease model for other activities like gambling, sex, or video gaming?

By the beginning of the early twentieth century, the success of the disease model in medicine had provided significant advances for humankind. The problem that Szasz points out is that the disease model became a *metaphor* in the field of addiction. If smallpox could be averted by a vaccine, then could we not approach addiction with the same model to find treatments and cures? But to do so the medical community “progressively metaphorized disagreeable conduct and forbidden desire as a disease,”²⁶³ thus creating categories of mental ‘illness.’ Medicine would

²⁶⁰ 31.

²⁶¹ Ibid.

²⁶² 6.

²⁶³ 5.

insist that “disapproved behavior was not merely *like* a disease, but that it *was* a disease...”²⁶⁴
This medicalization of behavior was the first step in asserting that ‘addiction’ was a disease.

By the mid-twentieth century, “...the noun *addict* ha(d) lost its denotative meaning in reference to persons engaged in certain habits, and has become transformed into a stigmatizing label possessing only pejorative meaning referring to certain *persons*.”²⁶⁵ This result of the medicalization of language is that the term addict/addicted no longer is descriptive, as it was in the nineteenth century of a person’s predilection to a certain habit; rather, ‘addict’ and ‘the addicted’ now become nouns to denote certain categories of people. Those categories of people, in turn, could be seen as exhibiting anti-social behavior (society clearly does not want me to use heroin) and thus, they are suffering from a disease, called addiction.

This was an entirely new usage of the term addiction. In Emil Kraepelin’s classic psychiatric textbook, published in 1883, there is no mention of a disease or disorder called addiction.²⁶⁶ In the United States, addiction was not recognized as mental illness until 1934, when it was first listed in the American Psychiatric Association’s *Standard Classified Nomenclature of Diseases*.²⁶⁷ Summing up his thinking about addiction, Szasz writes: “As I see it... drug abuse is a matter of conventionality; hence, it is a subject that belongs to anthropology and sociology, religion and law, ethics and criminology - but surely not to pharmacology.”²⁶⁸ In other words, there was no such thing as addiction until society created the convention.

²⁶⁴ Ibid.

²⁶⁵ 6-7.

²⁶⁶ 7.

²⁶⁷ Ibid.

²⁶⁸ 9.

We should mention one last important concept from Szasz. In all the reading reflected in the bibliography of this project, I have only once encountered a question that I would consider fundamental to the field. *Why do people begin to use drugs in the first place?* Szasz' ritual/ceremony theory provides a possible answer, or at least a hint. "The human need for social contact, for a communion with others of one's own kind, is second only to the organismic need for the satisfaction of the biological requirements for survival. In the satisfaction of this need for sociability, ceremony plays an indispensable part."²⁶⁹ What Szasz suggests is that communions, holy or unholy, are fundamental to being human. The need to commune with other humans is essential to our life together.

Szasz asserts that drugs of all types have always formed a central part of communion. Wine, for instance has for millennia been an essential element of social and religious communion. From the cult of Dionysus to the Christian church, wine was essential to worship, until, in 1893, some Christian congregations, influenced by the temperance movement, adopted the new product of teetotaling dentists Thomas and Charles Welsh - grape juice that did not ferment. Otherwise, wine has been the essential element of Holy Communion from the time of Christ. But alcohol in all forms has served as the vital part of social communion throughout the ages. Whether to celebrate a marriage or the end of the work week, gathering to consume alcohol has been a routine part of human life.

Szasz points out the ritual aspect of these gatherings. "The adherents to our majority religions thus congregate at cocktail parties and 'smokers'; and have elaborate ceremonies symbolizing the virtues of mixed drinks and wines, cigars and cigarettes, pipes and tobaccos, and so forth.

²⁶⁹ 39.

These are the holy communions of our age.”²⁷⁰ To phrase this in Freudian terms that Szasz might approve, we have a *drive* to communion, and we fulfill this drive in a variety of ways, to include drug use.

We could point out the ritual nature of heroin users as an example. Frequently users do not inject alone, but rather they gather with friends with like interest. The product is displayed and ‘cooked.’ A hypodermic needle is sterilized, and the heroin product is drawn into the syringe. Then the user ‘shoots up’ – injects the product. Indeed, in my own practice with heroin users, my clients frequently spoke about an ‘addiction to the needle’ itself – the needle and all that it signifies for them. Just the production of a hypodermic needle will trigger craving.

Szasz is a fascinating (and polemical) writer, but we should stop to review what we have learned from him and why it is important to an understanding of our population. Central to the book is the idea of ceremony and ritual. This applies to users and to those who would work with them or ‘help’ them. Beginning in the late 1800s, there has been a steady movement to control, manage, and criminalize certain drugs, but not others. Central to this movement is the ceremonial process of declaring some drugs good and some evil. Szasz asserts that the medical-scientific community has virtually replaced the religious community in its ability to make declarations of good and evil.

Let me now support my suggestion that we oppose illicit drugs not because they are the wrong chemicals but because they are the wrong ceremonials, by citing a quite extraordinary newspaper account of our efforts to control the ‘heroin epidemic.’ If read with an eye on the possible parallels between drugs and religions, between ritual drug use and ritual religious observance, it will be apparent that what we *call* ‘a war against drug abuse’ is actually a war to eliminate, everywhere if possible, the use of drugs of which we

²⁷⁰ Szasz, 41

disapprove, and at the same time to encourage everywhere the use of drugs of which we approve.²⁷¹

We can see this rather illogical process at play in our changing attitudes toward alcohol.

Before the Prohibition, alcohol was socially approved, and alcohol use was rampant. Suddenly, for moralistic reasons, it was illegal. This experiment in social control lasted from 1920 to 1933. Then alcohol was legal, as before. Now, alcohol use is socially approved again, as long as such use does not cross a boundary into severe intoxication. Beyond this boundary, particularly if one operates a motor vehicle under the influence, one can teeter into criminality.

I have attempted to draw out three major themes, which I now present. The first theme I wish to bring out is that since the late nineteenth century, we have witnessed a steady process of developing social conventions about drugs. While illogical, we assert that some drugs, some chemicals, are good while others are bad. This, however, is not based on ‘science’ but on social convention. Entirely illogical is the assertion that ‘licit’ opioids are good, while illicit ones are bad, based entirely on the purpose of use. All opioids metabolize into morphine equivalency. The body does not, therefore, ‘know’ that one drug is good and the other evil. Equally illogical is the social convention that tobacco and alcohol are socially acceptable, when both do immeasurable damage to the health of individuals and society. The subtitle of Szasz’ book points to the result of this process of ceremony and ritual, social convention, and criminalization: the ritual persecution of drugs, addicts, and pushers.

The second theme is that of our developing idea of ‘addiction.’ Szasz (and others) traces the development of the word and its reflection of our thinking. Before the twentieth century, we did not have an ‘addiction’ problem. Why is it, then, that suddenly in America in the twentieth

²⁷¹ Szasz, 46.

century, addiction became ‘public enemy number one’? The answer lies in the medicalization of the ‘problem,’ which determines addiction to be a ‘disease’ that can only be ‘treated’ by medical intervention. While Szasz was a practicing and teaching physician for over fifty years, he spares no criticism of his own profession and its intentions. Usually, though, anyone today who wishes to work with our population must do so by acquiescing to the medical model.

The third theme is that of our human desire and need for communion. In Szasz’ phrasing, some ceremonials of communion are holy and some unholy, again based on social convention. Users gather to ‘party,’ to come together in an ‘unholy’ act of communion. We could agree that this is a misguided attempt at communion, and we would likely suggest a more holy way. But we also could conclude that all humans share a deep drive to be together, to gather, to commune.

While Szasz has undergone severe criticism and rejection (and some of this is justifiable) he remains a rich resource for one who wishes to think about the medical community, psychiatry, and drug use. He calls into question the very foundations of psychiatry, but what he offers is a deep dive into those assumptions and conventions by which we agree to live. He also suggests that these conventions could be otherwise.

Stanton Peele (1946-)

Stanton Peele is a psychologist, psychotherapist, and attorney who has written broadly on the theme of addiction. His 1985 book *The Meaning of Addiction* is a classic within addiction studies. In the decades since its publication, its ideas have been modified and updated, but it set the tone for conversation about addiction.

Peele establishes a platzdarm in the opening pages of the book.

The conventional concept of addiction this book confronts - the one accepted not only by the media and popular audiences, but by researchers whose work does little to support it - derives more from magic than from science. The core of this concept is that an entire set of feelings and behaviors is the unique result of one biological process. No other scientific formulation attributes a complex human phenomenon to the nature of a particular stimulus.²⁷²

This is a direct attack on the disease model, a model that says that use of a substance is a disease and can only be treated by the medical model. What Peele will suggest is that the causes and consequences of addiction are multifactorial and that to address addiction requires us to identify and address each of the influencing factors. What the disease model suggests is that one substance can create an entire constellation of feelings, beliefs, rituals, and behaviors – an approach that any reasoned observer would reject. To address the idea of addiction is to address the meaning of human will, because the disease model asserts that “only compulsive consumption of narcotics and alcohol...is believed to be the result of a spell that no effort of will can break.”²⁷³ To hold this view is to assert a sort of bioessentialism – that substances can control our human will.

Peele sets out his task clearly. “It is the burden of this book to show that exclusively biological concepts of addiction (or drug dependence) are ad hoc and superfluous, and that addictive behavior is no different from all other human feeling and action in being subject to social and cognitive influences.”²⁷⁴ What he suggests was (and for some still is) revolutionary. While addiction is a pathology, in human terms it is no different in meaning than other human activities, like falling in love or the phenomenon of gun violence, that involves an entire complex of circumstances, feelings, behaviors, laws, and assertions. I believe that one consequence of this

²⁷² Peele, Stanton. *The Meaning of Addiction: An Unconventional View*. (San Francisco: Jossey Bass Publishers, 1985): 1.

²⁷³ Ibid.

²⁷⁴ Peele, Stanton. *The Meaning of Addiction*, 2.

thought is that those who wish to address addiction must do so without the use of value-laden language. In order to address the phenomenon, we must drop our prejudicial thinking and observe the phenomenon as it actually presents. Peele presents the case in this way.

The evolution of the idea of narcotic - and particularly heroin - addiction was part of a larger process that medicalized what were previously regarded as moral, spiritual, or emotional problems. The idea central to the modern definition of addiction is that of the individual's inability to choose: that addictive behavior is outside the realm of ordinary consideration and evaluation.²⁷⁵

I would phrase the same idea in this way. Addiction has fallen under the hegemony of social, legal, and medical controls. One who is a priest may look at the phenomenon of addiction and see a dire spiritual crisis, but religion in modern America now plays a backbench role. Certainly, when it comes to funding, billions are available for those who assert the disease model. Those who hold another opinion of addiction are heretics. If science and medicine have become our new religion, then we could certainly assert that it is a state-funded, established religion.

American society has confronted addiction on a war model. We have instituted federal legislation to 'combat' drugs and addiction. Massive efforts are underway to 'treat' addiction. We have imprisoned millions of drug perpetrators. And what is the result of this combined action? "The fact that the United States has long been the most active propagandizer against recreational narcotic use - and drug use of all kinds - and yet has by far the largest heroin and other drug problems than any western nation indicates the limitations of this strategy."²⁷⁶ Any objective observer may well conclude that our strategy is a failure. Peele suggests that our failure is based on a misunderstanding of the meaning of addiction.

²⁷⁵ Peele, 5-6.

²⁷⁶ 9.

I want to offer one illustration of the misunderstanding of addiction, realizing that what I will say would be an irritant to the addiction treatment community. One well-known attempt to address addiction can be found in the Twelve Step program. Twelve Step groups have been an indispensable support to millions of people. But I would assert that Twelve Steps help those whom it helps. By internal claims, AA has a success rate for short-term recovery at approximately seventy percent, but this is misleading. According to a 2000 report in *Alcoholism Treatment Quarterly* that analyzed AA attendance from 1968 to 1996, “on average 81 percent of newcomers stopped attending meetings within the first month. After 90 days, only 10 percent remained. That figure was halved after a full year.”²⁷⁷ If we consider long-term recovery (more than two years) the recovery rate drops to 10%. In other words, the movement has helped millions, but it has also failed millions. This is so because the movement (founded by a physician) fully asserts the disease model of addiction but endues it with religious imagery. But as Peele notes, “(t)he disease theory of alcoholism - with its emphasis on lifelong abstinence, the need to confront people actively about their denial, and the treatable nature of alcoholism - has become firmly ensconced in American law and social services, at the same time success rates from typical abstinence programs seem to center in the five to 10% range.”²⁷⁸ In fact, as we have seen historically, abstinence-only programs have a ninety to ninety-five percent failure rate.

While the Twelve Step program has attempted to subdue overtly religious language, it in fact relies on religious ideas. Half of the twelve steps make direct appeals to the existence of God. The sixth step asks God to remove defects of character. To put it simply, many who are not

²⁷⁷ Flanagan, Jake. “The Surprising Failure of 12 Steps,” *The Atlantic* (March 25, 2014). Accessed online on September 16, 2022, at [The Surprising Failures of 12 Steps - The Atlantic](#).

²⁷⁸ Peele, Stanton., 45.

Christian believers are turned off by God talk. Recent years have seen the rise of drug courts, in which an alcoholic or user is mandated to a Twelve Step program. This is problematic, however, as numerous legal decisions have ruled that this practice is unconstitutional, in that it violates the First Amendment and the Establishment Clause of the US Constitution.

In fact, the Supreme Court of the State of Tennessee ruled in favor of a petitioner, Jimmy Arnold, who had appealed a parole decision in part because of its mandate to attend a Twelve Step program. Although his parole appeal was denied on other grounds, the court did uphold the petition that mandating attendance to such a group violated the petitioner's First Amendment rights, finding that:

The centerpiece of the program, as petitioner experiences it, is the twelve (12) steps of Alcoholic[s] Anonymous (AA) program/effort. The concept of a higher power is at the center of the twelve (12) steps. The twelve (12) steps explicitly deny that recovery from alcoholism is possible without reliance on a higher power. The emphasis on a higher power is also the central theme of the third edition of AA's basic text entitled "Alcoholics Anonymous" which is used as an all-purpose guide for anyone having difficulty in working the twelve (12) steps. Group prayer is common at the meetings attended by petitioner. The meetings open with the "Serenity Prayer," essentially non-denominational, and close with the "Lord's Prayer," a Christian prayer. The First Amendment to the United States constitution guarantees that "government may not coerce anyone to support or participate in religion or its exercise, or otherwise act in a way which' establishes a [state] religion or religious faith or tends to do so."²⁷⁹ (my note - see *Everson v. Board of Education*).

I am thankful that Twelve Steps helps those whom it helps. I know that the number of those who owe their lives to the approach numbers in the millions internationally. We should at the same time say why some fail in the program, or never even turn to it for help. I offer a few reasons, based on my own conversations with persons with a substance problem. Some will not

²⁷⁹ The Supreme Court of the State of Tennessee. Walkup, John Knox, Attorney General and Reporter. *Jimmy Arnold, Petitioner v. Tennessee Board of Parole*. (Nashville: November 10, 1997). Accessed online on September 16, 2022, at [Arnold v. Tennessee Bd. of Paroles, 956 SW 2d 478 - Tenn: Supreme Court 1997 - Google Scholar](#).

air personal problems in a group setting, or for a variety of factors do not feel comfortable in a group. Some reject the blatantly parareligious nature of the program (higher power). Others will not take the step of admitting that they have no control over their substance of choice. Some have such chronic behavioral problems that they are clearly not a 'fit.' Most reject the abstinence-only approach and reject the idea that they must be abstinent for life, even if that is only approached 'one day at a time.'

In short, while the Twelve Steps program is broadly endorsed by society, it is not science. My observations align with Peele as he considers the therapeutic approach.

The dominant disease and exposure models of addiction have been widely marketed with the promise of reducing drug and alcohol abuse. The models propose that the behavior we are concerned to rectify cannot be stopped without external therapeutic intervention and that controlled use of some substances is never possible....They attribute virtually all the motivation in addictive behavior to factors over which the individual has no control once the initial contact is made with a substance. These views of addiction, as I have shown, do not fit the facts. The model of addiction I put forward in this book calls into question all the treatment programs and public policies that rely on such models of addiction for their support.²⁸⁰

I concur. I do so not just intellectually, but experientially – based on decades of work with those who are addicted. I have worked within the therapeutic model as a manager and counselor. I have worked in prisons and jails as a chaplain. I see evidence of a great failure in our nation in its approach to addiction. It fails, as I have attempted to prove, because the disease model is too thin a description of a complex problem that involves genetics, culture, patterns of behavior, and the availability of drugs. It fails because we have relied on a penal approach to addiction. The failure is one of meaning. The phenomenon of addiction points to a deeper meaning behind the problem.

²⁸⁰ Peele, Stanton. *The Meaning of Addiction: An Unconventional View*, 133.

I do not believe the disease and therapeutic model is the sole approach to addiction. But the disease and therapeutic model controls a huge part of our society and creates vast material wealth for those on the right side of the model. So, what could possibly be done? I turn again to Peele:

Preparing people better to achieve joy and competence offers us our only substantial chance at affecting the incidence of addiction. It is certainly not a modest goal: Some might call it utopian or quixotic. Yet to the extent that our addiction theories avoid this realization - whether these theories come from pharmacologists, from clinicians and self-help groups who see themselves as combating a disease, from sociologists, from psychologists - we will only obfuscate and exacerbate the addictive tendencies of our society.²⁸¹

His response (and mine) is possibly quixotic, although looking back over my career I certainly see the work of the programs I helped manage as Sisyphean. What I see in Peele's text is great hope, but that hope comes at great cost. Preparing people better to achieve joy and competence requires a society-wide response to addiction that would involve education as well as prevention and treatment. The concern is not just the biological phenomena of addiction, but a host of socioeconomic issues. A new look at addiction would require us to examine our past and the burden of racism. It would require the therapeutic community to work hand in hand, modestly, with authorities in other fields, including religious leaders, legislators, therapists, and sociologists to address the vast network of problems that cause the problem of addiction to be so severe. In the end, I would humbly suggest that preparing people to better achieve joy is a religious quest.

²⁸¹ Peele, Stanton, 157.

Chapter Eight

Control

Previously I wrote that humankind has used psychoactive substances, largely non-problematically, until the final years of the nineteenth century. By non-problematically, I mean that governments generally did not interfere in this field of human activity, did not criminalize drug use, and that drug use did not lead to the sorts of addiction problems and overdose deaths that we now experience on a global scale. Before turning to the American experience, we should remark on four points about opium and its derivatives globally.

One element that impacted opium use greatly was the attempt in the 1800s to control the opium trade (and its resulting profits) on a global scale, which led to the Opium Wars (1839-1842) and (1856-1860). Great Britain warred against China in the first war, while French and British forces waged war in the second. China, which was receiving massive shipments of opium from India via unscrupulous British traders, moved to rescue its people from the flood of opium and ban opium imports, which action would have hurt the pocketbooks of European traders. After the conclusion of the second war, England and France had reached their objectives, which were to open ports to European trade (including the cessation of Hong Kong to British rule) and to force the legalization of opium importation in China.

Second, I want to be clear that opium and its products are not 'evil.' In fact, throughout the ages, opium has seemed a God-given relief from a host of ills, from which there was no other available relief. In earlier times opium was used as a cough-suppressant, a treatment for menstrual pain, a general pain reliever, and as a solution to diarrhea. We are fortunate in our time

to have a knowledge of bacteria and how to fight harmful bacteria. In earlier times when gastrointestinal problems were commonplace, the effects of opium seemed miraculous. Throughout time, opium has been a boon to humankind. We should, then, attempt to understand how its beneficial effects turned deadly.

Third, we note at the outset the modern technological advances made in pharmaceuticals, beginning in the late 1800s. These advances in technology gave us hypodermic needles, and ever improving and ever more powerful opioids. The first known use of the *hypodermatic* method of injecting drugs in liquid form under the skin is attributed to Dr. Alexander Wood of Edinburgh in 1843. Tragically, the first known victim of this method was Wood's wife, the "first individual to succumb to this method of administration, dying a victim of her husband's ingenuity."²⁸²

Isolating the alkaloid compounds in opium led to the development of morphine. As many authors have noted, the development of new pharmaceuticals, as evidenced by the plethora of drug advertisements in our society, can be compared to an arms race. The pressure of the market and its pecuniary rewards have led to better and stronger opioids: opium to morphine, heroin, methadone, oxycontin, fentanyl, and carfentanyl. As we noted earlier, all of these drugs, with the exception of heroin, have a continuing valid medical use. They relieve pain, including the acute pain of cancer and surgery.

Fourth, as horrible and deadly as our current opioid crisis is, it is only one in a series of addiction problems that our nation has faced. For instance, while early surveillance of the opium

²⁸² Terry, Charles E. and Pellen, Mildred. *The Opium Problem*. (Montclair, NJ: 1928). Publication No. 115 in the Patterson, Smith Reprint Series in Criminology, Law Enforcement, and Social Problems, Reprinted in 1970: 67. Provided by Welshimer Library by courtesy of Interlibrary Loan.

problem generated a wide range of estimates depending on varying methods of calculation, most specialists estimate that by 1900 America had between 200,000 and one million known opioid users.²⁸³ That number is quite small compared to the population at that time, and certainly compared to our problem today, but the presence of any opioid addiction frightened America at large. America resolved to fight back. Understanding why opium use and addiction dismayed America so profoundly reveals societal, religious, racial, and moral attitudes that affect society to this day. In particular, they still affect the population with whom we work.

Much of our modern-day thinking about addiction, and about those who are addicted, was heavily influenced by Victorian-era religious and morality sentiments that eventually evolved in the late nineteenth and early twentieth centuries into Temperance Societies. I do not wish to address these societies and their history, except to note their lasting impact. Our population is still held to account by religious mores that are largely informed by Victorian notions of morality, so it is important to consider where our thinking originates and how it has evolved in our society. One authoritative resource for the evolution of our thinking is *The American Disease: Origins of Narcotic Control*, by David F. Musto.²⁸⁴ Musto (1936-2010) was a physician/researcher who became interested in the roots of American drug policy. He served as adviser on drug policy to the Carter Administration. We will consider his work to understand the issue of control.

²⁸³ Terry, Charles E. and Pellen, Mildred. *The Opium Problem*, 37. The first chapter of the work is dedicated to the extent of the opium problem in America and various methods for calculating an estimate.

²⁸⁴ Musto, David, F. *The American Disease: Origins of Narcotic Control (Expanded Edition)*. (Oxford: Oxford University Press, 1973/1987).

In the remainder of this chapter, I want to turn to some of the reasons why the phenomenon of problematic opioid use arose in America and reach an understanding of the ways, right or wrong, that America responded to control the issue. Understanding these reasons will help us to understand the web of complex factors that constitute drug use today.

The Rt. Rev. Charles Brent and the International Opium Commission

I suggest that one driving factor that shaped American society's response to the reality of opioid use and addiction is *fear*. As we will see in this chapter, fear reigns supreme. Some of that fear was solidly grounded. The existence of addiction, for instance, and how to deal with addiction is a natural source of fear, particularly when it was a new phenomenon in American society. Other sources of fear, however, were quite irrational, as we will discover here. The causes of this irrational fear, as we will discuss, reveal the darker heart of our American society.

As Musto writes:

This fear had certain elements which have been powerful enough to permit the most profoundly punitive methods to be employed in the fight against addicts and suppliers. For at least 70 years purveyors of these drugs for non-medical uses have been branded 'worse than murderers,' in that destroying the personality is worse than simply killing the body. What is most human is what is destroyed in the drug habitues, the opponents of narcotics argued.²⁸⁵

To put the point in religious terms, what America seems to fear is the loss of one's soul, personality, free will, and sense of morality. Indeed, I would assert that addiction challenges many of our preconceptions of what is 'most human' in our human nature. Do opioid addicted persons lose their free will, or even their very soul due to their addiction?

²⁸⁵ Musto, David, F. *The American Disease: Origins of Narcotic Control*, 5.

The first effort made to address this fear was to seek to take control of opioids and addiction. I want to highlight the way in which this control was exerted, because to a great degree that control was guided by Christian moral sensibilities. Those sensibilities have had a lasting impact on the way we think of addiction now.

One of the more reasonable leaders in this effort was the Right Reverend Charles Brent (1862-1929), who was the Episcopal Bishop of Western New York from 1918 to his death. In the course of my research, I have encountered a number of simply remarkable people, who have had an outsized influence on their time. Bishop Brent is one of these persons. He was born in Canada, where his father served as Anglican rector of the town parish. When he later removed to New York and then Massachusetts, he assumed dual Canadian-US citizenship. Brent was a zealous Anglo-Catholic, heavily influenced by the monastic movement of the Cowley Fathers, with its American foundation in Boston at the Society of St. John the Evangelist.²⁸⁶ As a curate and priest, he served in Boston under Bishop Philipp Brooks. Under Brooks his understanding of the social gospel expanded, and Brent served as priest to the St. Augustine's Negro Mission in Boston. On his first ocean voyage to England to visit the Cowley monastic foundation, Brent heard an impassioned sermon from an Indian Quaker, who warned of the dangers of opium.²⁸⁷ This was Brent's first introduction to the problem that would shape much of his ministry.

²⁸⁶ Nichols, James Hastings. Review of the Book, *Bishop Brent, Crusader for Christian Unity*, by Alexander Zabriskie, *The Journal of Religion*, Vol. 29, No. 1 (Chicago: University of Chicago Press, 1949): 68-68. Accessed on June 8, 2022, at www.jstor.org/stable/1197608.

²⁸⁷ Zabriskie, Alexander C. *Bishop Brent: Crusader for Christian Unity*. (Philadelphia: The Westminster Press, 1948). I have relied on Zabriskie for biographical information about Bishop Brent. The Rev. Dr. Alexander C. Zabriskie was Professor of Church History at the Episcopal Church's flagship seminary, Virginia Theological Seminary. Zabriskie served as Dean of the seminary from 1940-1950.

On October 11, 1901, Brent was elected the Episcopal Church's first Missionary Bishop to the Philippines. Brent and the newly appointed civil Governor of the Philippines and future twenty-seventh president of the United States, William Howard Taft, voyaged together from America to the Philippines and struck up a life-long friendship.²⁸⁸ Brent's vigorous mission made him aware of the problem of opium trafficking and its consequences. While serving in the Philippines, Bishop Brent attracted several influential people to the Anglican tradition. He confirmed three generals into the Anglican Communion: Gen. Wood, Gen. Brush, and Gen. John J. "Blackjack" Pershing. When World War I broke out, Pershing took charge of the American Expeditionary Forces in Europe. There, Pershing called on Brent to organize the Army's Chaplain Corps. Subsequently, Brent was appointed Chaplain General to American forces during the First World War. He was also one of the first voices to proclaim the idea of the 'social gospel' in the opening years of the twentieth century. After a long and eventful missionary experience, Brent was elected Episcopal Bishop of Western New York on October 6, 1917.

Brent, because of his experiences of opium addiction among the peoples of the Philippines, became an early leader in the movement for control of narcotics. As a social reformer, Brent was "charitable, but unwilling to compromise" his thinking regarding narcotics.²⁸⁹ Brent was a powerful voice in part because of his upper-echelon connections in the military, with President Theodore Roosevelt, and with Taft. Taft organized an Opium Commission, to examine the international trade of opium and how other nations addressed that trade. Bishop Brent was appointed to chair that commission, which set out in August 1903 to travel the Far East in search

²⁸⁸ Taft is another remarkable figure. He proved himself ably as an administrator and judge, before being appointed civil governor of the Philippines. In 1904 he was recalled to Washington to serve in Theodore Roosevelt's cabinet as Secretary of War. Taft was elected 27th President and served in that post from 1909-1913. He is deemed by history a mediocre presidential figure, but his real impact was as 10th Chief Justice of the Supreme Court, a post in which he served from 1921-1930. He is the only person in US history to serve as both President and Chief Justice.

²⁸⁹ Musto, David, F. *The American Disease: Origins of Narcotic Control*, 11.

of answers to the opium problem.²⁹⁰ Brent approached this fact-finding mission with “the spirit of a crusader.”²⁹¹ Like others of his time, Brent primarily saw opium as a problem because it was ‘personality destroying.’ Brent approached the problem not just as one of personal failure, but of the failure of society toward the individual. In 1903, Brent wrote a memorandum to Washington, outlying the central issue as he saw it. “The consumption of opium is not merely a personal weakness; it is a social vice, a crime.”²⁹²

We should note here the bishop’s language, which reveals his thinking – and that of his time. Opium use is a personal failure, a societal failure, and a crime. The widespread use of opium in Asia is a scourge, an evil, and a curse. These, of course are value judgments based in a morality that was not shared among the peoples of Asia, who had used opium for centuries. This American ‘crusader’ insistence would also lead, in our own time, to our demand that cocaine be controlled in coca-producing countries, and that the opium poppy be controlled in Afghanistan. The logic of this insistence was that other nations were poisoning America, not that America has a drug problem. As we will see below, it was the American insistence on remedies to evil opium and America’s demand for legislation that would drive an understanding of addiction that was based largely on American moralism and imperialism, as well as fear of the other and fear of the unknown.²⁹³

On June 15, 1904, the commission submitted its findings to the governor. Their recommendations were for the Philippine government to establish a monopoly over opium, limit

²⁹⁰ Musto, David, F., 27.

²⁹¹ Zabriskie, Alexander C. *Bishop Brent: Crusader for Christian Unity*, 97.

²⁹² Zabriskie, 97.

²⁹³ Our focus is on opium and opioids, but we should note that the early years also saw movements against demon weed and cocaine – and the war on alcohol expressed during Prohibition. All of these actions together demonstrate the general societal reaction to the existence of drugs.

sales only to males over the age of twenty-one, and after three years to ban opium entirely. In 1906, Brent wrote directly to President Roosevelt, stating that an international agreement on the problem of opium trade was the only solution to the problem. Three years later, Roosevelt and Taft called for the establishment of an International Opium Commission in Shanghai in 1909. A second conference on opium was scheduled for the Hague in December 1911. Taft, who was by then President, appointed Bishop Brent to head the American delegation. When the nations had gathered in conference, the national delegations elected Brent as head of the International Commission.

The results of these conferences were lackluster. Only twelve nations were willing to participate in the ‘international’ conference.²⁹⁴ Those who did attend did so largely at the insistence of the American government which wished to confront this ‘evil.’ The work of the conference was extended to two other conferences, the last of which was in 1924.²⁹⁵ Bishop Brent, discouraged by India’s de facto approval of the opium trade and by Britain’s addiction to opium profits, addressed a plenary session with these words.

To us it seems as though we are at the parting of the ways. The question is: shall we try to make a compact with an evil, or shall we declare a war of extermination upon it in terms that admit of no compromise? There is an increasing caution among physicians in their use of habit-forming drugs. An alliance with the enemy would be as an alliance between a lamb and a tiger or a cobra and its victim. Were our gallery in this room composed of addicts of every country forcibly separated from their drug, I do not hesitate to say that the character of the document we would sign would be far more drastic than anything contained in the American suggestions. I repeat we cannot compromise with a curse.²⁹⁶

The International Commission closed with a few nations signing agreements, but the commission never achieved its stated goals of international agreement on the opium trade.

²⁹⁴ Musto, 50.

²⁹⁵ Zabriskie, 108.

²⁹⁶ Zabriskie, 109.

Part of the reason for the disappointing results was the fact that other cultures simply had a different understanding of the nature of opium. In 1893 a Royal Commission on Opium was formed to study the effects of opium use in the British Empire, primarily hearing testimony regarding opium use in India. The commission found that opium use in India was no more problematic than alcohol use in England. An English physician serving in the Punjab, Henry Martyn Clark, reported that: “The fact that a man takes moderate doses of opium does not of necessity imply that he forms the opium habit... There is no such thing as a murderous opium mania, or a man under its influence assaulting people.”²⁹⁷

By the time of the Royal Commission, opium had been used in some parts of America for almost a century, largely introduced by Chinese immigrants. How our understanding changed from the “non-murderous” use of opium to the ‘plague’ of opiate addiction and overdose death currently happening in the United States is the story of the soul of America and its views on drug use.

Federal Legislation

The Harrison Act. Before the late nineteenth century, drugs in America were unregulated. This was the era of ‘patent medicine’ – which was comprised of all types of concoctions, but opium and cocaine were primary ingredients. Examples of patent medicine include Coca-



Cola, Bayer’s Heroin, and numerous cough syrup formulations whose main ingredient was morphine. The closing years of the nineteenth century saw numerous instances of state

²⁹⁷ As quoted in DeGranpre, 129.

legislation introduced to stem the patent medicine trade. Since some states allowed patent medicines freely while other states did not, the federal government made several legislative attempts to intervene so that standards were set at the national level.

The Harrison Act was in conformance with the same Victorian principles that guided the Prohibition, which was established by the ratification of the Volstead Act in 1919. The Volstead Act made illegal the manufacture, transport, and sale of alcoholic beverages. The Prohibition lasted from 1920 until 1933, when Prohibition was revoked. As Musto phrases it:

Prohibitionists believed that their reform could be made to work perhaps not perfectly but well enough to rid the nations of such glaring evils as the saloon. The movement was supported by the characteristic progressive assumption that government could change or neutralize the habits of large groups by well written legislation and honest enforcement.²⁹⁸

The Victorian era presupposed the primacy of its own brand of morality. In Victorian England medical professionals asserted that the ‘lower classes’ had a worse problem with opium than the middle or upper classes. Opium in the lower classes produced degeneracy, while in the upper classes one could only observe certain behavioral changes.²⁹⁹

The impetus behind all these efforts was that of control – a theme that recurs to this day. The Harrison Act, which we discussed briefly earlier, was the first major federal legislation that strove to exert national control over drugs, those who could legally prescribe them, and those who use them. I want here to focus, not on the legalities of the Act, but on the social methods of control that led to the passage of the Harrison Act.

The most profound change induced by the Harrison Act was to invest great power, authority, and responsibility in the hands of the medical community – a consequence which remains to this

²⁹⁸ Musto, 66.

²⁹⁹ 70.

day. Before the Act, access to drugs was something of a free-for-all. The Act federalized the physician's prescription pad and made access to drugs a medical issue, under medical control. Any drug not under medical control was henceforth illegal.

The Act at first had unseen consequences for physicians. So tight were the federal controls that a number of physicians were imprisoned for improper prescribing. Among this number were some who prescribed opioids to addicts to ease their pain. Physicians asserted that they had this right, as these addicts were under their medical care. The federal government should not come between the patient and physician. At first the federal government did not share this view. The Act outlawed any instance of maintenance therapy, providing severe penalties to any physician who crossed this line. This action had the consequence of looking at maintenance therapy through Prohibition eyeglasses. Although this prohibition was overturned in the 1960s as methadone clinics spread nationwide, the result was that to this day there exists a profound stigma against maintenance therapy – a stigma that deeply affects our population.

The Act eventually had the effect of greatly enriching physicians. Since under the Act all drug prescriptions and sales passed through medical hands, the business of prescribing became a lucrative activity. These opening years of the twentieth century also saw the consolidation of various medical associations, which sought to fight for physicians' rights, to improve the quality of the profession, and to provide ongoing medical education.³⁰⁰ One leader in this movement was Lester Volk, who stated his intention that the medical profession should be modeled on the labor union movement.³⁰¹ He stated his passion eloquently.

Membership in our leagues will mean to the physician what membership in his organization means to the working man. And when we have once realized that we are not

³⁰⁰ Musto, 107ff.

³⁰¹ Musto, 110.

far removed from the level of the working man in our daily acts and duties, then we will lose the false sense of high position we so dearly love to assume towards the laity, but which we fail to maintain among ourselves. Think organization, speak organization, and shout organization until by repetition it becomes a by-word.³⁰²

The various state and national medical leagues and associations, eventually consolidated under the wings of the American Medical Association, which formed in 1847. With the organization of this labor union for physicians came the ever-increasing influence of physicians on legislation to further their interests at the local, state, and national levels. Some suggested that the medical profession simply “wanted a monopoly on all narcotic sales to the public and wanted a fee for every citizen's head cold.”³⁰³

Medical control was boldly asserted by Dr. Thomas Davison Crothers, who was the head of Walnut Lodge Hospital in Hartford. In his book *Morphinism and Narcomanias from Other Drugs* (1902), Crothers stated that “the first prerequisite to treatment was ‘control of the patient’ for his will must be subservient to the physician’s.”³⁰⁴ Fear also drove pharmaceutical control. Society felt that we should fear the addict, because if the addict was not corrected, one day we would find that the addict was a ‘Wobbly’ (member of the International Workers of the World), or even a Bolshevik.³⁰⁵

One other remarkable figure that I have discovered in my research is Charles E. Terry (1878-1945). Terry was a physician trained at the University of Maryland Medical College. He later moved to Jacksonville, Florida, where he became a physician under the Public Health Service and served as chief public health officer for the City of Jacksonville. Terry was a zealous public health officer, who moved quickly to gain control of the city’s health issues. This included

³⁰² Ibid. As quoted by Musto

³⁰³ Musto, 58.

³⁰⁴ 78.

³⁰⁵ 83.

enforcement of sanitation codes, lobbying for drainage and sewage improvements, mandating examinations for school age children, eradicating rats, and ensuring smallpox vaccinations.³⁰⁶

Terry saw drug addiction as one of the primary public health challenges, and took firm steps to address the issue.

In the first decade of the twentieth century, Terry took decisive measures to address the addiction problem in Jacksonville. His first step was in accord with the spirit of the times. At his encouragement, the City Council of Jacksonville passed an ordinance regulating the sale of drugs, requiring a written prescription and record of such, and insisting that each prescription bear the name and address of the patient.³⁰⁷ The second step, however, was at least five decades ahead of his time. At Terry's insistence, the public health service clinic provided habitual opium users free care and prescriptions for drugs to relieve their suffering. This practice with time evolved into maintenance therapy as we currently understand it.

Terry estimated the number of addicts in Jacksonville as about one percent of the population.³⁰⁸ His clinic registered and treated 646 users. Terry also registered the names of physicians who had been prescribing drugs for them. In 1912, he established the first maintenance drug program in the United States. While some of his patients were transient, he stated that he closely worked with 213 habitues and conducted extensive case histories of each of

³⁰⁶ Fee, Elizabeth. "Charles E. Terry (1878-1945): Early Campaigner against Drug Addiction," *American Journal of Public Health*, Vol. 101, No. 3 (March 2011). Accessed online on June 15, 2022, at <https://eds-p-ebSCOhost-com.milligan.idm.oclc.org/eds/pdfviewer/pdfviewer?vid=3&sid=e3b8a32f-b3e7-4a5f-a7fe-22bda9aac751%40redis>.

³⁰⁷ Terry, Charles E. "Drug Addictions, a Public Health Problem." Excerpted and reprinted in *American Journal of Public Health*, Vol. 4, No. 1 (1914): 28-47. From a paper read before the Section of Public Health Officials, American Public Health Association, Colorado Springs, CO, September 1913. Accessed online on June 15, 2022, at <https://eds-p-ebSCOhost-com.milligan.idm.oclc.org/eds/pdfviewer/pdfviewer?vid=4&sid=e3b8a32f-b3e7-4a5f-a7fe-22bda9aac751%40redis>.

³⁰⁸ *Ibid.*

these. While he was wary of the users and was aware of their “mendacity,” his real scorn was reserved for fellow physicians. In the case histories he searched for the etiology of drug addiction and reported these results:

- Addiction as the result of treatment personally administered by a physician – 54.8%.
- Through the influence of other users – 21.6%
- Through “dissipation and evil companions” – 21.2%
- Due to chronic or incurable disease – 2.4%

In other words, “the largest class of all, 54.8% owed their unfortunate condition to the offices of the medical man.”³⁰⁹

After the passage of the Harrison Act in 1914, Terry ceased his maintenance program, in accordance with federal law, but expressed grave reservations about the cessation of this type of care. “Experience has conclusively shown the futility of looking to the medical profession for the solution of the narcotic evil, and until legislators both state and national, come to realize this fact and take cognizance of it in anti-narcotic enactments, a continuance of the abuses of the past may be expected.”³¹⁰ Dr. Terry’s healthy suspicion and skepticism of fellow practitioners and their control over a vulnerable population would be echoed over and over by fellow physicians, sociologists, and philosophers in the decades to come.

³⁰⁹ Ibid.

³¹⁰ ³¹⁰ Fee, Elizabeth. “Charles E. Terry (1878-1945): Early Campaigner against Drug Addiction.”

Drug Wars

We turn now to one recent interpretation of the effects of the Harrison Act. Redford and Powell report an analysis of the federal acts of the early twentieth century through an economic lens to examine federal intervention in the drug marketplace.³¹¹ Each intervention at the state level created the need for federal intervention, which in turn created unintended confusion in the market. In their study of the period, they focus “on how interventions into smoking-opium markets failed to produce the intended result...increased smuggling, and incentivized American citizens’ involvement in opium importation.”³¹² The felt-need to intervene was the result of the growing societal opinion that opium use was ‘evil.’ America attempted to legitimate its legislation by referring to the work of the International Opium Commission, which was created to examine and regulate the opium trade.

Initially, American intervention in the opium marketplace was based on society’s negative feelings about Chinese immigrants, who introduced opium smoking in the United States, not on the potency of opium itself.³¹³ In fact, in the opening years of the twentieth century, opium and morphine addiction were primarily seen as a phenomenon of the upper class.³¹⁴ Society’s growing hysteria about opium addiction (and the Chinese) led to the passing of the Pure Food and Drug Act of 1906, which prohibited misbranding of products and required labeling of ingredients.³¹⁵ In the opening years of the twentieth century, Representative Francis Harrison led

³¹¹ Redford, Audrey and Powell, Benjamin. “Dynamics of Intervention in the War on Drugs: The Buildup to the Harrison Act of 1914,” *Independent Review*, Vol. 20, Issue 4. (March 1, 2016): 509-530. Accessed online on May 26, 2022, at <https://eds-s-ebscohost-com.milligan.idm.oclc.org/eds/pdfviewer/pdfviewer?vid=2&sid=786629ea-c882-488f-9280-ba19aea5bbeb%40redis>.

³¹² Redford and Powell. “Dynamics of Intervention in the War on Drugs: The Buildup to the Harrison Act of 1914,” 511.

³¹³ Redford and Powell, 512.

³¹⁴ 518.

³¹⁵ 520.

efforts to introduce federal legislation to control patent medicine use. In 1909, he introduced the Opium Exclusion Act, which banned importation of opium and was aimed primarily at Chinese immigrants.³¹⁶ The Exclusion Act banned opium importation, so those who were addicted turned to other opiates, primarily heroin and morphine. This is a pattern that would persist to the modern day, whereby the federal government introduces legislation, or even declares a ‘drug war,’ which has the effect of increasing costs for users and stimulating the use of ‘harder’ drugs.

In December 1914 Congress passed the Harrison Act, which we considered earlier. The Act outlawed all medicines that were not under the control of physicians. This saddled physicians with great responsibility and the threat of imprisonment for impropriety, but it also had the effect of granting physicians control over a significant sphere of behavior in society, that of drug use. The Act had the additional effect of greatly empowering the American Medical Association. To use DeGranpre’s metaphor, from here on all drugs under the control of physicians were good, while all drugs not under their control were evil.

Redford and Powell contribute to an understanding of the background of the Harrison Act. One major pressure on Congress to act came from religious and moral societies, a theme that will be repeated throughout the history of drug legislation. “At the behest of Protestant missionaries, temperance groups, and religious groups, something needed to be done to resolve the ‘obvious damage’ that this ‘sinful, depraved, and immoral behavior’ caused among the ‘inferior races’ as well as the ‘foreign drug habits [believed] to be a moral threat to native-born Americans.”³¹⁷ In short, the Harrison Act was the first volley in America’s War on Drugs.

³¹⁶ 521.

³¹⁷ Redford and Powell, 525, quoting from McNamara, Joseph D. “The Hidden Costs of America’s War on Drugs. *Journal of Private Enterprise*, Vol. 26, No. 2 (2011): 97-115.

While this work is not a study on American drug policy, we note its effects on our population. While the Harrison Act can be commended for controlling the patent medicine trade, it created a dire set of circumstances for opiate users. By outlawing some drugs, other drugs, such as heroin and now fentanyl, become more essential to users. What the Act and subsequent legislation has not done is eliminate the importation and misuse of opioids or opioid addiction. Instead, our legislation has driven illicit drug use underground, where trade is primarily controlled by vast and dangerous drug cartels. Our federal legislation has filled our prisons with drug users. At the end of 2020, more than 5.5 million Americans were under the supervision of adult corrections.³¹⁸ The United States has the highest rate of incarceration in the world, with approximately one in every forty-seven Americans under adult correctional supervision. NIDA research indicates that 65 percent of inmates have a substance use disorder and that another twenty-five percent were under the influence of drugs at the time of arrest.³¹⁹

In 1971, in the ultimate act of legal controls, President Richard Nixon launched an all-out war on drugs when he declared: “Public enemy number one in the United States is drug abuse. In order to fight and defeat this enemy, it is necessary to wage a new, all-out offensive.”³²⁰ Whether or not this war on drugs has been effective is beyond the scope of my ability to answer, but we should point out significant features of War-on-Drugs language. First, the Harrison Act simplified our thinking about drugs, so that all drugs fall into two categories, legal (medicinal) and illegal (anything else). The language about drugs has also been highly charged with religious

³¹⁸ *Bureau of Justice Statistics*. Accessed online on May 30, 2022, at [Home | Bureau of Justice Statistics \(ojp.gov\)](https://www.bjs.ojp.gov/).

³¹⁹ NIDA. “Criminal Justice Drug Facts.” (June 1, 2020). Accessed online on May 30, 2002 at <https://nida.nih.gov/publications/drugfacts/criminal-justice>.

³²⁰ The University of California at Berkeley. “Did Drugs win the War on Drugs?” *Drugs and Incarceration*. Online resource accessed on May 30, 2022, at [Drugs & Incarceration \(berkeley.edu\)](https://www.berkeley.edu/).

and moralistic language, which sees drugs as good or evil. This language makes it simple to *wage war* on evil drugs (and thereby *promote* medicinal drugs). While the goal is a war on drugs, those who use drugs are significant *collateral damage*. Second, we should point out the obvious warlike imagery that President Nixon and others have employed. Drug ‘abuse’ is a *public enemy* that must be *terminated*. In order to do so we must launch an *all-out offensive*. Remembering the timeframe in which Nixon made the statement, we recall that this was the era of a losing American war effort in Vietnam.

One could assert that the War on Drugs has been no more effective than our war in Southeast Asia. What a War on Drugs has done beyond the shadow of a doubt is to increase the level of violence associated with drug use, criminalize a large segment of our population, and fill our prisons and jails. This state of affairs has of course affected our population, and many bear the physical and emotional scars of incarceration.

One theme that we are developing in Part Two is that our thinking about drugs as a society is irrational and that our thinking is greatly influenced by factors other than biology and science. To demonstrate one instance of this irrationality, I offer the following example. In 1996 I sat in the Carter County Criminal Court, waiting for one in a series of hearings for my father. His case was always called last, so I sat through many cases, but one caught my attention and stayed with me.

As I sat, a young man, mid-twenties, was led into the courtroom to appear before the judge. The judge knew the man, as the young man had appeared before the judge twice before for charges of marijuana possession. After the judge listened to the details of the current case, he declared a sentence with this introductory thought. “Well, son, you’ve smoked your way into prison.” The man was sentenced to six years. Twenty-six years hence, marijuana use is legal or

decriminalized to a misdemeanor in forty-one states and the District of Colombia. Marijuana, evidently, lives in a liminal state between angel and demon.

In this chapter we have considered ways, primarily legal and religious, by which American society moved to control addiction and addicts. I have attempted to demonstrate that our thinking has been founded on a number of irrational concepts, fear being among them. Another instance of this irrationality toward drug use and addiction is that of the influence of thinking based upon racism in its purest form. In the next chapter we will examine the racist roots of American drug policy.

Chapter Nine

Racism

“The little boy who sticks a needle in his arm and seeks an out in other worldly dreams, who seeks an out in eyes that droop and ears that close to Harlem screams, cannot know, of course, (and has no way to understand) a sunrise that he cannot see beginning in some other land.”³²¹

Junior Addict

Langston Hughes

I have only later in my life come to a full appreciation of the fact that the White House, an international symbol of American democracy, was built by the hands of slaves. Slaves quarried the stones for the structure and carted them to the building site. Slaves served as masons to assemble the structure. Our nation, willingly and not, has struggled mightily with the fact that the horrible sin of slavery was a foundation stone in our democracy.

Racism is the lovechild of fear and dreadful history. That fear and dread, expressed in racist form, influenced the composition of the US Constitution, in which “the framers carefully constructed a document that preserved and protected slavery without ever using the word.”³²² The slave trade enriched the Brown family of Rhode Island, who used part of their wealth to establish one of our most prestigious universities. Likewise, Georgetown University has been compelled to address its complicated history with slavery. Looking at my own religious tradition, Virginia Theological Seminary, the flagship seminary of the Episcopal Church, was built by the

³²¹ Hughes, Langston. *The Collected Poems*. Edited by Arnold Rampersad. (New York: Vintage Classics, 1994): 539.

³²² Hannah-Jones, Nikole. *The 1619 Project: A New Origin Story*. (New York: One World Publishing, 2021): 19.

hands of slaves.³²³ My own seminary at the University of the South was started by two men, an Episcopal bishop and Confederate general and a renowned slave trader.

Fear, racism, and the legacy of slavery have influenced government policies, most especially for our purposes, drug policy. It is my intent in this chapter simply to refer to the instance of racism, not to document or catalogue its incidents. My hope is that this chapter can simply open the door for discussion.

It is painful to read some of the rationale behind the drive to control narcotics in America. Possibly the first group affected included Chinese immigrants, as David Musto relates:

At first the Chinese represented only one more group brought in to help build railroads, but, particularly after economic depression made them a labor surplus and a threat to American citizens, many forms of antagonism arose to drive them out or at least to isolate them. Along with this prejudice came a fear of opium smoking as one of the ways in which the Chinese were supposed to undermine American Society.³²⁴

The Chinese were seen as an infectious force that could carry the disease of opium smoking to the rest of America. In 1902, a member to an ad hoc committee of the American Pharmaceutical Society commented: “If the Chinaman cannot get along without his ‘dope,’ we can get along without him.”³²⁵

Cocaine, particularly that used by blacks in the South. was especially feared in American society.

If cocaine was a spur to violence against whites in the South, as was generally believed by whites, then reaction against its users made sense. The fear of the cocaineized black coincided with the peak of lynchings, legal segregation, and voting laws all designed to remove political and social power from him. Fear of cocaine might have contributed to

³²³ In 2019, the seminary announced a reparations fund of \$17 million.

³²⁴ Musto, David. *The American Disease*, 6.

³²⁵ Musto, David, 17.

the dread that the black would rise above ‘his place’, as well as reflecting the extent to which cocaine may have released defiance and retribution.³²⁶

Indeed, the fear of the African American male on a cocaine high was so great that local sheriffs in the South subscribed to the belief that their .32 caliber pistols could not stop a ‘crazed’ African American male on cocaine. Police forces, therefore, increased their firepower to the .38 caliber service revolver.³²⁷ This act reflects the beginning of the militarization of our police forces that continues to the present day.

This fear and dread of the other was enshrined in national drug policy, by shifting legal blame to the user, but not to the supplier. The American Pharmaceutical Society noted with alarm that between 1898-1902, although the US population had only grown by ten percent, import of cocaine rose forty percent, opium by 500 percent, and morphine by 600 percent.³²⁸ The committee reached the not-so-surprising conclusion that the fault was not with overprescribing physicians or eager pharmacists; rather, the fault lay with the morally incompetent and criminal user. Federal legislation, therefore, presented the most obvious solution to the narcotics problem in America.

The fact is that much of our national drug policy was formed on the grounds of outrageous racism and fear of others. Of particular concern was that the ‘disease’ of addiction would be spread to white women.³²⁹ The national resolve was not to treat the addicted, nor to pursue physicians who overprescribed drugs in the first place; rather, the focus was on interdiction and incarceration. Simply put, in the field of interdiction, the United States resolved to tell other

³²⁶ Musto, 7.

³²⁷ Ibid.

³²⁸ Musto, 16.

³²⁹ 17, 43, 44.

nations not to produce coca and opium (which they had done from time immemorial) so that naïve Americans should not become addicted.³³⁰

We wish we could state that the racism behind drug policy was left to pre-WWII American society. But the policies over the last century have filled our prisons, primarily with people of color charged with drug offenses. We have become a carceral state. According to latest Bureau of Prison figures, while African Americans constitute 14.9% of the US population (2021), they make up 38.4 percent of the US prison population.³³¹ Louisiana and Mississippi, with historically high African American populations, have the highest incarceration rates *in the world*, if each US state is treated as a country and compared to other countries.³³²

Racism continued to drive American opinions on drug use, particularly in the 1980s. The fear rose with the rise of AIDS, which was sometimes transmitted by intravenous drug use. The decade also saw the rise of the myth of the ‘crack ho’ and the ‘welfare mother.’ Both were targeted toward African American females, who were seen as immoral, sexually promiscuous, and exploitative of the welfare state. The crack cocaine which fueled an epidemic of the decade was seen as use of a lower-class drug of the urban African American, while its elite cousin, white powder cocaine, was a drug of the upper classes. Unfortunately, this sort of obvious racism persists to this day, as can be seen in the June 2022 testimony to the Congressional Hearings on the January 6 insurrection.

³³⁰ 7.

³³¹ Bureau of Prisons. *Inmate Race*. Accessed online on September 16, 2022, at [BOP Statistics: Inmate Race](#).

³³² Prison Policy Initiative. *World Incarceration Rates if Every State were a Country*. Accessed online on September 26, 2022 at [World Incarceration Rates If Every U.S. State Were A Country | Prison Policy Initiative](#) and Abramsky, Sasha. *The American Way of Poverty: How the Other Half Still Lives*. (New York: Bold Type Books, 2013): 151.

During that hearing, two African American women, Shaye Moss and Ruby Freeman, who were Georgia poll workers during the 2020 election, were accused of falsifying presidential votes in favor of Joe Biden. One of the witnesses testifying before Congress, Rudy Giuliani, remarked that the two women, who were mother and daughter, could be seen on surveillance video “passing around a USB port like it was a vial of heroin or cocaine.”³³³ The racist myth regarding black women sadly persists.

Caroline Jean Acker, an historian of medical history, links racism to the systemic poverty among non-white populations in the United States.

The history of poverty and the history of race are tightly connected in the United States. The economic effects of deindustrialization hit African American communities sooner than white ones. Residential segregation, sustained by public policy and private sector practice, contributed to a pattern in which poor African Americans were more likely than poor whites to live in neighborhoods of concentrated poverty. Urban renewal projects of the 1950s and 1960s cut freeway paths through African American communities and demolished African American neighborhoods to build convention centers or shopping malls. Given their damaged infrastructure, such impoverished African American neighborhoods were natural sites for markets in illicit commodities like heroin and cocaine in the mid to late 20th century. The easy availability of drugs, combined with structural barriers to economic opportunity, encouraged addiction among generations lacking significant career prospects.³³⁴

That American people of color have been systematically deprived of opportunity is a constant theme of the 1619 Project and critical race theory. This is not the place to debate these theories, but I do wish to point out that a crushing lack of opportunity has impoverished these populations and encouraged the spread of addiction.

³³³ January 6 hearing: Rudy Giuliani, Donald Trump accuse Shaye Moss, Ruby Freeman of 2020 election plot https://youtu.be/zy_UbpC7S-0. According to Ms. Moss’s testimony, she and her mother were sharing ginger candies, not cocaine or heroin.

³³⁴ Acker, Caroline Jean. *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control*. (Baltimore: Johns Hopkins University Press, 2002): 225. Dr. Acker is Associate Professor Emerita of History at Case Western.

Kathrine Pettus, a social policy advisor to the United Nations, has written a probing article regarding the most current American opioid crisis.³³⁵ In her analysis, she finds that one cause of the opioid crisis is the result of the effects of globalization. As she analyzes the multitude of legal cases presented because of the opioid crisis, she finds, “(t)he demographic most lethally affected by the crisis attracting current mainstream attention and large civil damage awards is majority ‘white’ and comprises what, at least until the turn of the twenty-first century was known as the ‘working class,’ now classified as ‘low income.’³³⁶ She points out the obvious racism behind this. For a century we have created a carceral state to imprison persons for drug offences – disproportionately persons of color. In contrast, when whites are affected in large numbers by opioid abuse, the legal suits filed demonstrate this white population consists of ‘victims.’ They are victims of unethical physicians and pharmacists, victims, of predatory “big pharma,” and victims of an inequitable economy.

Further, Pettus finds an ironic reversal in social status. According to an unspoken “Racial Contract,” whites of any sort, low-class, middle class, and upper class, held hegemony in American society prior to the beginning of the twenty-first century. Globalization has affected the Racial Contract. This is what she terms the “the crisis of whiteness.” She notes, “(t)hat Racial Contract perpetuated generations of white privilege in the US, even for the underclasses, and its inability to withstand globalization has resulted in the neglect and abandonment of communities that have outlived their usefulness in the brave new colorblind world that reifies profit over

³³⁵ Pettus, Katherine. “Whiteness, Scapegoating, and Scarcity: Medicalizing the ‘US Opioid Crisis,” *Journal of Illicit Economies and Development*, Vol. 21, No. 1 (2020): 29-37. Accessed online on February 15, 2022, at <https://jied.lse.ac.uk/articles/10.31389/jied.62/>.

³³⁶ Pettus, Katherine, “Whiteness, Scapegoating, and Scarcity: Medicalizing the ‘US Opioid Crisis,” 29.

whiteness.”³³⁷ In other words, she finds the sort of impoverishment and abandonment in white communities currently that Acker found in African American communities.

Such a situation requires a scapegoat – an idea we saw Thomas Szasz develop. “An inherently unstable practice with global credentials, scapegoating the *pharmakos*, the vulnerable outsider, through ritual brutalization in order to allay social and political tensions has long been an effective staple of American politics.”³³⁸ This situation in which white Americans are victims, not criminals, requires a host of legal suits against the Sackler family and big pharma. As opposed to the crack epidemic, which “ravaged and criminalized” black communities, white communities were *victimized en masse* by the pharmaceutical industry.³³⁹ She concludes, “(i)t is one thing for racially marginalized and criminalized populations in the US to suffer from lack of recognition of their essential human dignity and rights to the social and economic determinants of health; it is quite another for the postindustrial white working class to experience the consequences of damaged status and a crisis of recognition.”³⁴⁰ Her analysis of the impact of globalization on the opioid crisis, leads Pettus to conclude: “Until recently, American *whiteness* conferred mythical power, even on ‘poor’ whites, and legitimated both official and personal violence toward those who did not enjoy the privileged status.”³⁴¹

In 2021, a board of sixty-one bioethicists, philosophers, attorneys, and medical professionals, *Bioethicists and Allied Professionals for Drug Policy Reform*, released a vital document calling

³³⁷ Pettus, Katherine, 30.

³³⁸ 31.

³³⁹ Ibid.

³⁴⁰ 30.

³⁴¹ 31.

for the end of the Drug War and its racist underpinnings.³⁴² They find that the only way to achieve this end is to decriminalize and federally regulate all psychoactive substances and to mitigate the sentences of all those currently incarcerated for non-violent drug offences. They find this necessary for the following reasons.

According to the document: “Black people in the United States are disproportionately targeted, arrested, and incarcerated for crimes related to non-medical drug use, and this is one area where social reform is urgently needed.”³⁴³ So embedded is racism in our national drug policy that it must be deconstructed to be reformed. The article notes that the stated purpose of the war on drugs is to “protect people from harm and promote public health,” but in fact, the policies have worsened the circumstances of entire communities of color.³⁴⁴ For example, our current drug policies, equating to the phenomena observed during the Prohibition Era, have driven psychoactive substances underground where violence and the rule of gangs and drug cartels dominate, leading to dire consequences in local communities. The authors note that, “if and when problems with substance abuse, use, or misuse arise, these should be approached through healthcare programs and social support, not prison time.”³⁴⁵ We for decades have effectively used jails and prisons as treatment centers, a purpose for which they were not designed. Additionally, the authors write that “policymakers should directly involve current and former drug users and their social networks in the revision of relevant policy, while

³⁴²Earp, Brian D. et al. “Racial Justice Requires Ending the War on Drugs,” *The American Journal of Bioethics*, Vol. 21, No. 4 (2021): 4-19. Accessed online on June 30, 2022 at [Racial Justice Requires Ending the War on Drugs: The American Journal of Bioethics: Vol 21, No 4 \(tandfonline.com\)](https://doi.org/10.1177/0898010121102888).

³⁴³ Earp et al, “Racial Justice Requires Ending the War on Drugs,” 4.

³⁴⁴ Ibid.

³⁴⁵ Earp et al, 6.

implementing community building programs based on coherent, long-term strategies that meet the needs of those affected.”³⁴⁶

Further, the authors note that the current prohibition on psychoactive substances has the same criminogenic effect as the Prohibition Period. Drug prohibition creates issues with a full range of crimes, distracting law enforcement from more important work against crimes of violence. The criminalization of drugs exposes communities to disproportionate legal consequence, isolates the incarcerated from their families, thus generating “life-long personal, economic, and social obstacles, such as barriers to housing, employment, and welfare, as well as to the denial of voting rights.”³⁴⁷ Further, drug policies are “directly linked to police militarization and brutality,” as witnessed in countless acts, possibly most notably in the police homicide of Breonna Taylor in the spring of 2021.³⁴⁸

While the call to decriminalize psychoactive substances may seem radical, this policy has been adopted in Portugal since 2017. The effect of this policy has been that the use of all psychoactive substances after 2017 decreased, except for the use of marijuana, which increased.³⁴⁹ According to the authors, the Portugal example shows that:

(W)hen drug users do not fear criminal charges, they are able to seek out medical treatment, mental health care, and social support programs, and can access government-approved public information about the harms involved in drug use. In Portugal, the social institutions that focused on harm reduction instead of punishment were also able to engage and help more young people than the criminal system. Additionally, drug decriminalization enabled officials to more effectively deliver housing, health, and employment assistance to populations that would have been more difficult to reach under a prohibitive regime.³⁵⁰

³⁴⁶ Ibid.

³⁴⁷ 7.

³⁴⁸ 4.

³⁴⁹ 10.

³⁵⁰ 10.

Given the current political climate in the United States, it seems unlikely that we would learn from, much less implement the Portuguese solution. I do nonetheless consider this an urgent matter worthy of political and spiritual advocacy.

We have too briefly examined ways in which racism has informed our national policies, to include our drug policies. Much more could be said on this topic, but, while keeping these lessons in mind, I want to turn now to issues most prevalent in our local region. The question behind the next chapter is “Why did the opioid crisis emanate from Appalachia and why did Appalachian states suffer the most?” Answering that question will require us to consider how culture works and what it means to call ourselves Appalachian.

Chapter Ten

Appalachia and its Discontents

“The state of civilization in America at the present day offers a good opportunity for studying this injurious effect of civilization which we have reason to dread.”³⁵¹

Sigmund Freud, 1930

In Part One of this project, I attempted to provide a reasoned account of the current opioid crisis in America, its development and impact. We also looked at the mechanism of addiction to opioids and at possible treatments suggested by the Standard Account, the NIDA disease model. So far in Part Two we have looked at other perspectives on addiction, including some prominent voices that are in opposition to the Standard Account. We have done this to enlarge upon our understanding of addiction, with the goal of using this enlarged understanding to develop a pastoral theology of addiction. In this chapter, before we turn to the application of pastoral theology, I wish to consider another perspective, that of the culture in which our population of persons addicted to opioids live, work, marry, raise a family, and die. It is rather a unique subculture, Appalachia. How do we understand discontent in Appalachia?

Discontents

“The impression forces itself upon one that men measure by false standards, that everyone seeks power, success, riches for himself and admires others who attain them, while undervaluing the truly precious things in life.”³⁵² These are the opening words of Sigmund Freud’s seminal

³⁵¹ Freud, Sigmund. *Civilization and Its Discontents*. Translated by Riviere, Joan, (Mineola, NY: Dover Publications, 1994). Originally published in German as *Das Unbehagen in der Kultur*. (London: Hogarth Press, 1930): 2.

³⁵² Freud, *Civilization, and Its Discontents*, 1.

work, *Civilization and Its Discontents*, which was published in 1930 – eight years before the Father of Psychoanalysis would have to flee his beloved Vienna in the face of increasing Nazi aggression. In this work Freud turned his analysis from that of the psychological development of the individual toward a psychological understanding of civilization itself and civilization’s impact on humanity.

Freud bases his analysis on his theories of *Thanatos* and *Eros*, the death (or destruction) instinct and love (or the pleasure principle). The infant human develops an ego that knows no boundary, knows absolute liberty, until the instruction of parents and society enter in to regulate and limit the boundless ego. Thus, our first experiences of unhappiness are precisely those in which boundaries are set on our ego (or we would say today that boundaries are placed on our behavior).

As we grow in family settings, we are internally split between a desire to be in union with the family and an irresistible urge to make a break with family and its norms, to be an individual distinct from family. As we develop and age, we encounter three distinct sources of unhappiness and suffering: “the superior force of nature, the disposition to decay of our bodies, and the inadequacy of our methods of regulating human relations in the family.”³⁵³

In analyzing our oscillation between happiness and unhappiness, Freud comes to a startling conclusion – startling even to him. He writes that “our so-called civilization itself is to blame for a great part of our misery, and which should be much happier if we were to give it up and go back to primitive conditions.”³⁵⁴ His startling conclusion is that civilization itself is pathogenic, the abundant source of all our neuroses and pathologies. The limitations that civilization sets for

³⁵³ Freud, 19.

³⁵⁴ Ibid.

all for the benefit of the herd hurt deeply at the individual level, as our limitless and unbounded ego is drawn and constricted.

Liberty has undergone restrictions through the evolution of civilization, and justice demands that these restrictions should apply to all. The desire for freedom that makes itself felt in a human community may be a revolt against some existing injustice and so may prove favorable to a further development of civilization and remain compatible with it.³⁵⁵

Civilization takes steps to limit the aggressiveness and destruction of the unbounded individual, opposing in every way possible the death principle to eliminate threats to the pleasure principle as society defines it.

But Freud does not see that civilization has had the final word, that victory is on the doorstep. “The fateful question of the human species seems to me to be whether and to what extent the cultural process developed in it will succeed in mastering the derangements of communal life caused by the human instinct of aggression and self-destruction.”³⁵⁶ Everyday life, in this view, is a battle against our worst instincts and our drive for success, fame, fortune and power – at the expense of others if necessary. In doing so, we are “undervaluing the truly precious things in life.”

Despair

While conducting research on recent American economic trends, Princeton economists Ann Case and Nobel Laureate Angus Deaton noted a disturbing trend, which is explicated in their 2020 book, *Deaths of Despair and the Future of Capitalism*.³⁵⁷ Their thesis is deceptively

³⁵⁵ 27.

³⁵⁶ 70.

³⁵⁷ Case, Anne and Deaton, Angus. *Deaths of Despair and the Future of Capitalism*. (Princeton and Oxford: Princeton University Press, 2020).

simple, while the supporting argumentation is complex. In 2014 they had noticed that suicides among middle-aged (age 45-54) white Americans, primarily among those who do not have a college degree and are “working class,” were rising rapidly. In investigating that fact, they found that suicide was not the only type of death that was rising. Digging deeper they discovered that from 1999-2017 *all deaths* were rising among this group of middle-aged whites. Given the advances of science, death rates should fall, not rise. These peculiar deaths are what the authors term *deaths of despair* which have three causes: addiction, alcoholism, and suicide.³⁵⁸ Their disturbing discovery is about “that other epidemic, one that began to take lives in the early 1990s, killing 158,000 Americans a year by 2018.”³⁵⁹ That epidemic was one of deaths of despair, something Freud might understand as Thanatos, the death instinct.

The authors began to understand that these deaths had multiple causes, but the causes were interrelated. They write: “Our story of deaths of despair; of pain; of addiction, alcoholism, and suicide; of worse jobs with lower wages; of declining marriage; and of declining religion is mostly a story of non-Hispanic white Americans without a four-year degree.”³⁶⁰ One of the findings of the social determinants of health is that ‘your zip code matters more than your genetic code.’ That means that the fates of Americans “depend on when they were born, when they finish school, and when they started work.”³⁶¹

Findings about our Southern, primarily rural region of Appalachia are startling. Case and Deaton show that:

If we look across states at the changes in mortality rates for whites aged 45 to 54 from 1999 to 2017, we find the increases in all but 6 states, with the largest increases in death

³⁵⁸ Case and Deaton, *Deaths of Despair and the Future of Capitalism*, 4.

³⁵⁹ Case and Deaton, Preface to the Paperback, ix.

³⁶⁰ Case and Deaton, 4.

³⁶¹ 58.

rates in West Virginia, Kentucky, Arkansas, and Mississippi, all states with educational levels lower than the national average.³⁶²

Case and Deaton conclude that for many in America ‘things fall apart.’ What has held our lives together? Having a meaningful job, good family relationships with a spouse and children, and belonging to a church that helps address spiritual needs all help maintain a life that is worth living. Those are precisely the things that Freud calls “the truly precious things in life.” But the authors find that the increasing absences of these goods “among white Americans without a university degree is a disaster.”³⁶³

Important for our study in this area is that participating in a religion of choice is a protective factor. The authors find that “(r)eligion is an important part of life for most Americans, much more so than in other countries, at least with the exception of Italy and, to a lesser extent, Ireland. Religious people do better in many ways: they are happier, more generous, and less likely to smoke, drink, or use drugs. Friends make a good life better, and friends from church do so more than other friends.”³⁶⁴ Ripping the fabric of religious community has disastrous effects.

The practice of religion is itself in decline, as attendance has fallen across main-line churches. Prominent sociologist Robert Putnam finds that “over the last three to four decades Americans have become about 10 percent less likely to claim church membership, while our actual attendance and involvement in religious activities has fallen by about 25 to 50 percent...”³⁶⁵ What holds us together as a society is family, community, and religion.³⁶⁶ When this sense of community and family, of common values and shared goals disintegrates, then deaths of despair

³⁶² 33.

³⁶³ 100.

³⁶⁴ 175.

³⁶⁵ Putnam, Robert D. *Bowling Alone: The Collapse and Revival of American Community*. (New York: Simon and Schuster, 2000/2020): 72.

³⁶⁶ Case and Deaton, 183.

rise. This decline, however, has primarily occurred with a white population that is less educated and ‘working class.’

One constant theme of *Deaths of Despair* is that American capitalism as presently practiced has failed a large swath of American society. It has worked well at pushing income upwards, while eroding wages and benefits for masses of Americans. Income inequality has become a conversation point for journalists and TV presenters, but income is not the only way that the benefits of America flow upward. Education itself forms a meritocracy for those who have the opportunity and means to pursue a college education. For those who did not take advantage of university education, who did not have the means, opportunity, or desire, the result is striking.

Worse still, the widening gap has come not just through an increase in the earnings of the college educated but also through a *reduction* in the earnings of those without a four-year degree. Not only are the college-educated rewarded with higher earnings, but those who do not heed the incentive are punished with lower earnings. The winners get the prizes, and the losers get worse than nothing.³⁶⁷

Those without a college degree are stuck in a quagmire of decreasing wages, collapsing community, and limited prospects. Deaths of despair are rising among those who have been left behind. Jobs, which once provided income, meaning, and stability, are now decreasing in income, benefits, health care, meaning and stability. Workers in the jobs that remain “are effectively temporary stand-ins for robots, holding their slots until the programmers can teach their robots to replace them.”³⁶⁸

Case and Deaton advocate for free market capitalism, but what has developed in America is not a true free market. They reserve their greatest criticism for the American healthcare system. When they analyze deaths of despair, they find that “our candidate for leading villain...is the

³⁶⁷ 154.

³⁶⁸ Case and Deaton, 165.

American healthcare system.”³⁶⁹ America regulates the most expensive healthcare system in the world, but our health outcomes are below those of other educated nations. In addition, American health care is prohibitively expensive.

The vast sums that are being spent on healthcare are an unsustainable drag on the economy, pushing down wages, reducing the number of good jobs, and undermining financing for education, infrastructure, and the provision of public goods and services that are (or might be) provided by federal and state governments. Working class life is certainly under threat from automation and from globalization, but health care costs are both precipitating and accelerating the decline.³⁷⁰

Our current healthcare system is not sustainable, does not provide the outcomes we seek, and has a negative drag on the American economy.

Our current managed healthcare system operates in an environment that is decidedly not describable as ‘a free market.’ As Case and Deaton state: “Free-market competition does not and cannot deliver socially acceptable health care.”³⁷¹ American healthcare is not exceptional in providing health, but it is exceptional in its ability to generate profits and wealth for providers. Our health care system consumes eighteen percent of our Gross National Product, averaging a cost of \$10,739 per person.³⁷² In 2017, healthcare expenditures per person equated to “about four times what the country spends on defense and about three times what it spends on education” and are “needlessly eating away at workers’ wages.”³⁷³

We tend to think of employer-provided healthcare as a good, a ‘benefit.’ In actuality, the economists find that the “cost of employer provided health insurance, largely invisible to employees, not only holds down wages but also destroys jobs, especially for less skilled workers,

³⁶⁹ 186

³⁷⁰ 187.

³⁷¹ 192.

³⁷² 191.

³⁷³ Ibid.

and replaces good jobs with worse jobs.”³⁷⁴ What the uneducated worker is encountering is that healthcare is considered too expensive to provide to laborers and benefits are cut by shifting workers from full-time to part-time without benefits. This is particularly true in the growth of ‘temporary’ job agencies, which provide labor to the American market on a ‘temporary’ basis without benefits.

Case and Deaton’s argument is devastating:

Our argument is that the deaths of despair among whites would not have happened, or would not have been so severe, without the destruction of the white working class, which, in turn, would not have happened without the failure of the health care system and other problems of the capitalism we have today-particularly persistent upward redistribution through manipulation of markets.³⁷⁵

Not only is healthcare negatively impacting the market, it also has a less than beneficial impact on health, with the American opioid crisis being *the* prime example.

Health care systems should benefit health, not destroy it. Yet, physicians who have been too eager with opioid prescriptions, pharmacists who have been happy to fill the prescriptions, and manufacturers who were joyful at opioid profits, have triggered an epidemic that has sickened and killed tens of thousands of Americans. “This is an extreme example of direct harm to health, as well as of the process of upward redistribution in which those at the top got rich at the expense of everyone else, many of whom were put at risk of addiction and death.”³⁷⁶

For those at the lowest end of income as well as for the middle class, the last forty years have had devastating effects. The ties that bind us have become torn as individuals become separated from families and communities of support. Religion for many is no longer a solace and source of

³⁷⁴ 191.

³⁷⁵ 188.

³⁷⁶ 192.

joy. Rather, religion has faltered as “opioids became the opium of the people.”³⁷⁷ The authors note that laborers now serve the demands and interests of business and wealth, with the complicity of government and the legal system. The goods of religion are reversed as people now are more likely to drink, smoke, or use drugs.

One of my common tasks in a clinical setting is to complete the inpatient process with opioid addicted clients. In response to the simple intake question – “How many close friends do you have?”- most struggled to name one. They no longer rely on their families for support. Jobs are menial and meaningless. Unions, which once built pride and community, as well as protection for the worker, have faltered along with religion. Healthcare is non-existent, unless some measure is provided through Medicaid expansion, federal block grants, or Social Security.

This is the system of discontent we have built. When I was once in a discussion group with the Vanderbilt Medical School Bioethics program, the issue of the byzantine nature and exorbitant costs of the American healthcare system arose. In response, a senior physician and former head of a Children’s Hospital thoughtfully replied: “We have precisely the system that we want.” He meant that our system developed the way it has due to market forces and insurance and consumer demands. I would question now who the “we” is in his statement. Our healthcare system works terrifically for those at the top – providers, researchers, pharmacists, and pharmaceutical companies. But even a person with a college degree, a good job, and health benefits can face a labyrinth of healthcare that is difficult to access, understand, and pay for. This is especially true for our mental health system.

³⁷⁷ 118.

For many, primarily educated, white-collar Americans, our nation continues to be a land of promise, opportunity, and dreams. For an increasing underclass of less-educated Americans, the American dream is slipping away. And thus some, usually someone in social work or the social services, is left to try to pick up the pieces, to somehow help a client obtain what is virtually unobtainable – good health care, good training, good jobs, and a good future. The deaths of despair, and their precipitating factors, are an epidemic that has strongly affected our region, Appalachia. Understanding life for the less fortunate in our region is the foundation of any sort of pastoral care. We now focus on the particularities of our Appalachian home.

“Well, my cousin come up from
Knoxville,
And he taught me a thing or two.
Now I wander these hills forgotten,
With the Oxycontin Blues.”

Oxycontin Blues

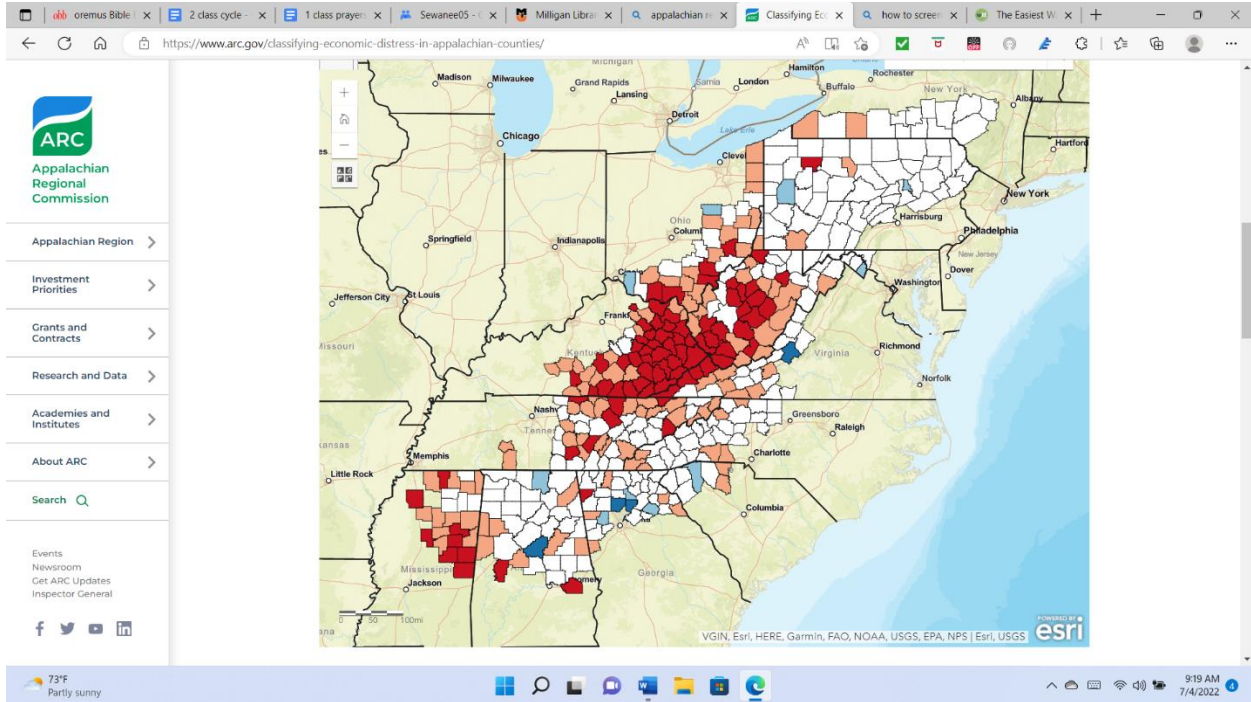
Song by Steve Earle

Washington Square Serenade (2007)

New West Records

Economic and Distressed Areas, FY 2023

Graphic from Appalachian Regional Commission³⁷⁸



Appalachia is a mountainous region whose ridge spans thirteen states from New York to Georgia. The region is a unique American subculture based on its frontier history, historic isolation geographically, and immigration patterns that include a mix of English, Scots, Ulster Scots-Irish, French Huguenots, and Swiss and German migrants, who exterminated or expelled Native American populations. Some Europeans brought African slaves to the region. This combination of immigration and geographical isolation has led to a unique situation in which Appalachia is largely “a self-contained culture similar to other minority groups such as Native

³⁷⁸ [Classifying Economic Distress in Appalachian Counties - Appalachian Regional Commission \(arc.gov\)](https://www.arc.gov/classifying-economic-distress-in-appalachian-counties/).

Americans and Amish communities.”³⁷⁹ Some of the socio-economic factors now present in the region include enduring and intergenerational high rates of poverty, underemployment in mining and non-union manufacturing jobs, and barriers to quality health care.³⁸⁰

Health care for substance abuse suffers particularly. Barriers to care in this region include lack of transportation, including underdevelopment of public transportation, a lack of service providers, and a lack of adequate insurance. A Virginia Tech study reports that central Appalachia (West Virginia, Virginia, Kentucky, and Tennessee) had “33% fewer primary care providers per 100,000 residents than the national average.”³⁸¹ Likewise, the number of mental health providers is thirty-five percent below the national average. One significant barrier to substance abuse and mental health care, as I myself found in clinical work, is a pervasive cultural stigma against those who are addicted and against addiction treatment, which is based largely on evangelical religious and moralistic ideologies.

Tragically, Appalachia has been the epicenter of the current opioid crisis. In part, this can be attributed to the fact that “pharmaceutical companies have targeted and influenced health care providers to prescribe narcotics to coal miners and factory workers, contributing to a widespread regional opioid addiction.”³⁸² Appalachia continues to suffer from the impact of addiction. “In

³⁷⁹ Moody, Lara N., Sutterwhite, Emily, and Bickel, Warren K. “Substance Use in Rural Central Appalachia: Current Status and Treatment Considerations,” *Journal of Rural Mental Health*, Vol. 41, No. 2 (2017): 123-135. Accessed online on February 17, 2022, at [Substance use in rural Central Appalachia: Current status and treatment con...: Milligan OneSearch \(oclc.org\)](#): 124.

³⁸⁰ Morgan, Amy A., Thomas, M. Evan, and Brossoie, Nancy. “Trauma-Informed Care (TIC) as a Framework for Addressing the Opioid Epidemic in Appalachia: An Exploratory Interpretative Phenomenological Analysis,” *Journal of Rural Mental Health*, Vol. 44, No. 3 (2020): 156-169. Accessed online on February 17, 2022 at [Trauma-informed care \(TIC\) as a framework for addressing the opioid epidemi...: Milligan OneSearch \(oclc.org\)](#): 157.

³⁸¹Ibid

³⁸² Morgan, Amy A., Thomas, M. Evan, and Brossoie, Nancy. “Trauma-Informed Care (TIC) as a Framework for Addressing the Opioid Epidemic in Appalachia: An Exploratory Interpretative Phenomenological Analysis,” 156.

2017, West Virginia, Ohio, Pennsylvania, and Kentucky had the highest rates of drug overdose deaths in the country.”³⁸³ Additionally, a history of chronic pain resulting from high-labor work conditions in the region is correlated with substance use, misuse, and overdose.³⁸⁴

Another Virginia Tech study focused on the substance use problem in Central Appalachia, finding that illicit drug use is a particular concern in this rural region. They find that counties in West Virginia, Southwest Virginia, Eastern Kentucky, Southeast Ohio, East Tennessee and Western North Carolina had the highest rates of use and overdoses across the United States.³⁸⁵ They also find that “people living in coalmining regions, specifically those with mountaintop removal, are at increased risk of developing substance use disorders.”³⁸⁶ Further complicating factors that impact substance abuse include “low education levels, high rates of unemployment, and high rates of job-related injuries.”³⁸⁷

The Appalachian Regional Commission reported in 2015 that “deaths due to ‘diseases of despair’ – such as drug overdose – in Appalachia occurred at a rate that was thirty-seven percent higher than the rest of the United States.”³⁸⁸ The prevalence of injection drug use also presents the possibility of the spread of infectious disease, such as HIV or hepatitis. In 2015, a

³⁸³ Ibid.

³⁸⁴Schalkoff, Christine et al. “The opioid and related drug epidemics in rural Appalachia: a systematic review of populations affected, risk factors, and infectious diseases,” *Substance Abuse*, Vol. 41, No. 1 (2020): 35-69. Accessed online on February 17, 2022 at [The opioid and related drug epidemics in rural Appalachia: A systematic rev...: Milligan OneSearch \(oclc.org\)](#): 37.

³⁸⁵ Moody, Lara N., Sutterwhite, Emily, and Bickel, Warren K. “Substance Use in Rural Central Appalachia: Current Status and Treatment Considerations,” *Journal of Rural Mental Health*, Vol. 41, No. 2 (2017): 123-135. Accessed online on February 17, 2022, at [Substance use in rural Central Appalachia: Current status and treatment con...: Milligan OneSearch \(oclc.org\)](#): 123.

³⁸⁶ Ibid.

³⁸⁷Moody, Lara N., Sutterwhite, Emily, and Bickel, Warren K. “Substance Use in Rural Central Appalachia: Current Status and Treatment Considerations,” 124.

³⁸⁸ Schalkoff, Christine et al. “The opioid and related drug epidemics in rural Appalachia: a systematic review of populations affected, risk factors, and infectious diseases,” 36.

congressional program designated Appalachia as a High Intensity Drug Trafficking Area.³⁸⁹ A resulting Heroin Response Strategy highlighted “the area’s status as a particularly important intersection of economic problems, unique cultural norms, and thriving drug trade.”³⁹⁰

In an analysis of drug overdose deaths, one study found that: “Between 1995 and 2015, overdose deaths in rural counties increased by 325%.”³⁹¹ The study found that the reasons behind the suffering included: increased availability of opioid prescriptions in this time frame, unfavorable economic conditions, as well as tight social connections that allow the growth of tight drug distribution networks. Tragically, the study also found that: “Residents of Appalachia are 63% more likely than the rest of the United States to die from a drug overdose.”³⁹² One systematic review found gender differences in opioid use. The study found that “among people in Virginia who died of an opioid overdose, female decedents were older on average than male decedents” and that, although most of these deaths were deemed accidental, “women were more likely than men to have committed suicide.”³⁹³ Women were also more likely to be ‘doctor shoppers’ – seeking a physician who is supportive of the patient’s need for opioids, while young males were more likely to divert prescription drugs, such as methadone, for illicit use.³⁹⁴

³⁸⁹ Ibid.

³⁹⁰ Ibid.

³⁹¹ Beachler, Taylor et al. “Community Attitudes toward Opioid Use Disorder and Medication for Opioid Use Disorder in a Rural Appalachia County,” *The Journal of Rural Health*, 37 (2021): 29-34. Accessed online on February 5, 2022, at [Community Attitudes Toward Opioid Use Disorder and Medication for Opioid Us...: Milligan OneSearch \(oclc.org\)](#).

³⁹² Ibid.

³⁹³ Beachler, Taylor et al. “Community Attitudes toward Opioid Use Disorder and Medication for Opioid Use Disorder in a Rural Appalachia County,” 64.

³⁹⁴ Ibid.

A 2020 Small Area Estimation project by Albright et al focused on the psychological distress and trauma that is a predictor of substance misuse.³⁹⁵ They isolated disturbing trends that are particular to female opioid users, finding that of women with a history of use had previously experienced psychological distress in their lives.³⁹⁶ The study found that in Kentucky, women were “more likely than men to start injecting drugs due to social pressure,” particularly from male partners, from whom they were more likely to obtain syringes.³⁹⁷

Why are Appalachian-Americans at risk? Virginia State researchers, studying the southwestern region of Appalachia, put the problem this way: “People living in rural communities are particularly at risk because they face the unique challenges of poverty, unemployment, lack of insurance coverage, accessibility to healthcare services, and socio-cultural beliefs in regard to seeking mental health services.”³⁹⁸ Remembering our lessons from the deaths of despair, these conditions directly contribute to the catastrophic consequences of substance use and overdose.

Researchers at East Tennessee State University (ETSU) describe the demographic background of Appalachia, finding that approximately forty-two percent of the population is rural, and eighty-three percent identify as white, non-Hispanic. In a qualitative analysis, the

³⁹⁵ Albright, David L., et al. “Small Area Estimation of Opioid Abuse and Comorbid Psychological Distress Among Females Living in the Thirteen Appalachian Region States,” *Traumatology*, A publication of the American Psychological Association, Vol. 26, No. 1 (2020): 61-67. Accessed online on February 17, 2022, at dx.doi.org/10.1037/trm0000202.

³⁹⁶ Albright et al. Small Area Estimation of Opioid Abuse and Comorbid Psychological Distress Among Females Living in the Thirteen Appalachian Region States,”61.

³⁹⁷ 62.

³⁹⁸ Thornton, Gwendolyn B. and Deitz-Allyn, Krystal. “Substance Abuse, Unemployment Problems, and the Disparities in Mental Health Services in the Appalachian Southwest Region,” *Journal of Human Behavior in the Social Environment*, Vol. 20 (2010): 939-951. Accessed online on February 17, 2022, at DOI: [10.1080/10911359.2010.516690](https://doi.org/10.1080/10911359.2010.516690): 940.

researchers identified three themes: the pervasiveness and severity of prescription drug abuse (PDA), routes for acquisition and distribution, and rationales for prescription drug abuse acquisition and distribution.³⁹⁹ In the first area, participants reflected that PDA was ‘everywhere,’ drawing a picture of rampant prescription drug abuse. In the second area, “most patients pinpointed the healthcare system, namely prescriptions generated by ‘doctors’ and healthcare facilities, as a central route of access to prescription drugs.”⁴⁰⁰ The third area discussed the underlying reasons for PDA, which included the cycle of tolerance/addiction, and use as a revenue source.⁴⁰¹ This qualitative study is important to this project as it was conducted by a local university with an interest in this topic.

Another ETSU study notes the stunning details of Tennessee’s opioid crisis. In 2010 alone, prescriptions were issued for 275 million hydrocodone tablets, 116 million alprazolam tablets, and 113 million tablets containing oxycodone.⁴⁰² This is enough for every resident over the age of twelve to receive fifty-one hydrocodone, twenty-one alprazolam, and twenty oxycodone equivalent tablets. In a survey of local prescribers, the study found that “17% of the controlled medication prescriptions they write are to individuals who are possibly abusing those drugs. These same prescribers responded that they thought 40% of other prescribers in the region are over-prescribing these medications.”⁴⁰³

³⁹⁹ Mathis, Stephanie M., Hagemeyer, Nicholas, Foster, Kelly, N., Baker, Katie, and Pack, Robert P. “It’s Took Over This Region”: Patient Perspectives of Prescription Drug Abuse in Appalachia,” *Substance Use and Misuse*, Vol. 55, No. 1 (2020): 37-47. Accessed online on February 17, 2022, at <https://www.tandfonline.com/doi/full/10.1080/10826084.2019.1654514>: 39-42.

⁴⁰⁰ Matthis et al. “It’s Took Over This Region”: Patient Perspectives of Prescription Drug Abuse in Appalachia,”⁴⁰
⁴⁰¹ 41.

⁴⁰² Click, Ivy A., Basden, Jeri Ann., Bohannon, Joy M., Anderson, Heather, and Tudiver, Fred. “Opioid Prescribing in Rural Family Practices: A Qualitative Study,” *Substance Use and Misuse*, Vol. 53, No. 4 (2018): 533-540. Accessed online on February 17, 2022, at <https://www.tandfonline.com/doi/full/10.1080/10826084.2017.1342659>: 533.

⁴⁰³ Ibid.

Carter County Snapshot

As I addressed in the autoethnography at the beginning of this project, I am primarily concerned about the opioid crisis and its impacts on Carter County, Tennessee. Carter County is home to 56,134 (2020 figures) persons, who live in 23,993 households.⁴⁰⁴ The population is 95.8% white, reflecting a population that has deep roots in the area. Hispanics make up 2.2% of the population. In terms of education, 85.9% of persons in the county have a high school diploma. Those who hold a bachelor's degree make up 18.5% of the population. The median household income was 40,820 in 2020 dollars.

According to the State of Tennessee Commission on Children and Youth, Carter ranks thirty-fifth in the state for child well-being, putting the county in the top one-third of counties statewide.⁴⁰⁵ The cost of housing in the county is low, compared to other counties in the state. The county has a low ranking in high school graduation rates. Child deaths are an issue, as the state finds that: “The fastest-growing cause of child and teen deaths in recent years has been homicide and suicide, often involving a firearm.”⁴⁰⁶ The county has a below-average percentage of third to eighth grade students rated proficient in state math and reading tests. The percentage of births to unmarried females in the county is 41.3%. In the county 20.9% of children live in poverty.

⁴⁰⁴ United States Census Bureau. *Quick Facts, Carter County, TN*. Accessed online on September 15, 2022, at [U.S. Census Bureau QuickFacts: Carter County, Tennessee](#).

⁴⁰⁵ State of Tennessee, Commission on Children and Youth. *Carter County Profile*. Accessed online on September 15, 2022, at [Carter County.pdf \(tn.gov\)](#).

⁴⁰⁶ Ibid.

According to a Living Wage Calculator produced by the Massachusetts Institute of Technology, a single parent with two children in the home in Carter County needs to make \$32.90 an hour to meet a living wage.⁴⁰⁷ The same family lives in poverty if the earned income is \$10.56 an hour or less. The federal minimum wage is currently \$7.25 an hour. This same family of one parent and two children would need to make \$58,893 after taxes to meet typical expenses. A person working in Home Health in the county makes approximately \$29,307 annually; a worker in social services makes \$45,989; a security guard makes \$40,061; and a sales representative \$30,430. The current unemployment rate is only 3.6%, although we should note that the calculated unemployment rate does not reflect the number of those who have simply stopped looking for employment.⁴⁰⁸ According to recent news reports, 15.9% of the population of Carter County lives below the federal poverty line.

The latest figures regarding drug overdose deaths in Tennessee were 2020 figures published by the Tennessee Department of Health on September 1, 2021.⁴⁰⁹ Medically, a drug overdose is referred to as drug poisoning. In Tennessee in 2020 3,032 persons died of a drug overdose. This represents a forty-five percent increase from 2019. Opioids, primarily fentanyl, were involved in seventy-nine percent of drug overdose deaths. Between 2016-2020 overdose deaths increased in all age groups over 18. Carter County recorded the following overdose deaths in 2020.

⁴⁰⁷ Massachusetts Institute of Technology. *Living Wage Calculator, Carter County*. Accessed online on September 15, 2022, at [Living Wage Calculator - Living Wage Calculation for Carter County, Tennessee \(mit.edu\)](https://livingwage.mit.edu/lwc/#?geo=US-TN-CarterCounty).

⁴⁰⁸ St. Louis Federal Reserve. *FRED Economic Data, 2022*. Accessed online on September 29, 2022, at [Unemployment Rate in Carter County, TN \(TNCART0URN\) | FRED | St. Louis Fed \(stlouisfed.org\)](https://fred.stlouisfed.org/series/TNCART0URN).

⁴⁰⁹ Tennessee Department of Health. *2020 Drug Overdose Deaths* (September 1, 2021). Accessed online on October 1, 2022, at https://www.tn.gov/content/dam/tn/health/documents/pdo/2020_Tennessee_Drug_Overdose_Deaths.pdf.

| | |
|-------------------------------------|----|
| All drug | 15 |
| Opioid | 12 |
| Pain Reliever | 7 |
| Heroin | 1 |
| Fentanyl | 4 |
| Stimulant (usually methamphetamine) | 3 |

Conclusion

Appalachia has many wonderful attributes: its natural beauty and abundant parks, close communities, and a rich historical heritage. Many live close family lives with extended networks of relatives. Many people do hold good employment and provide well for their families. As with any region of the country, it has its unique challenges. This project is devoted to the opioid abuse problem in Appalachia, specifically in Carter County, so the picture I paint, I am aware, is dark. That is true because the problem is large and bleak. I want to summarize some of the reasons why opioid problems particularly effect Appalachia:

- Prevalence of psychological distress and trauma, intergenerational trauma, intergenerational substance abuse
- Pain – in many cases caused by the high-labor work offered in the area, such as mining, construction, logging, and trucking

- Low rate of educational achievement
- Inordinately high rate of opioid prescribing
- Lack of insurance coverage
- Geographic isolation creates a lack of primary care providers and addiction specialists
- Significant social stigma impedes treatment
- High drug trafficking patterns in the region

Any practical attempt to provide coherent responses to these problems must make a whole-culture approach, considering the unique phenomena of opioid use in Appalachia. Pastoral responses cannot begin from a place of moralizing or sermonizing but should take a well-informed and empathic approach to persons in distress. In Part Three we will begin the construction of a pastoral theology of addiction and pastoral care.

Part Three
A Pastoral Theology of Addiction

“I do not call you servants any longer, because the servant does not know what the master is doing; but I have called you friends, because I have made known to you everything that I have heard from my Father.”

John 15:15

Chapter Eleven

The Practical Theology of John Swinton

Over the last seventeen years, the work of Scottish theologian and University of Aberdeen professor, John Swinton, has profoundly influenced my development as a chaplain and manager. Over decades Swinton has developed a body of work that advocates for the mentally ill, the disabled and the dying. Because I have derived this model of community mental health chaplaincy from Swinton, I want to give space here at the outset to exploring his body of work.



Dr. Swinton is a Registered Mental Health Nurse and Professor and Chair in Divinity and Religious Studies at the University of Aberdeen. He is a prolific and passionate author.

From Bedlam to Shalom

This 2000 work builds the theological foundation that Swinton has continued to develop over a long career as mental health nurse, pastor, and theologian.⁴¹⁰ Swinton has thought deeply about the implication for the Gospel message among the learning disabled and those who live with

⁴¹⁰ Swinton, John. *From Bedlam to Shalom: Towards a Practical Theology of Human Nature, Interpersonal Relationships, and Mental Health Care*. (New York: Peter Lang, 2000).

mental illness. His work, particularly with the learning disabled and those who live with the description of schizophrenia raised important theological issues, best summarized here.

On reading through some of the literature on theological anthropology, it became clear that for many thinkers, reason and intellect were the fundamental marks by which human beings were set apart from the rest of creation. Intellectual assent to verbal formulations of faith was, for the most part, the way in which the church traditionally communicated the gospel and expected its participants to respond. In that study the primary question that arose was: how does one communicate a gospel so dependent on words, to those who have no words?⁴¹¹

This question - How do we share the Gospel with those who have no words (or impoverished thought processes, or who suffer deep mental illness)? - drives Swinton's body of theological work.

One of Swinton's most profound responses is that of radical friendship. That radical friendship is to be distinguished from the clinical and therapeutic goals of the medical community.

Unlike counseling and psychotherapy, the 'goal' of friendship was not to deal with specific problems or difficulties, consequently, the 'healing' that friendship brought to people with learning disabilities was not the form of healing that is embodied within the framework of the medical model: an understanding of healing that seeks to identify a specific aetiology, and then apply particular techniques in an attempt to eradicate the particular 'bad spot' within the individual.⁴¹²

In other words, the medical model (and therefore therapy) looks to locate a problem and remove it, just as a surgeon might remove a cancerous tumor. Radical, gospel-based friendship is distinct from this approach. The goal of friendship in this model is – friendship.

Swinton identifies his theological intent as aligned with the field of Practical Theology.

Although much has been written on the field, Swinton provides one, very simple definition: "At

⁴¹¹ Swinton, John. *From Bedlam to Shalom*, 1.

⁴¹² Swinton, 3.

its simplest, *practical theology is critical reflection on the actions of the church in the light of the gospel and Christian tradition.*⁴¹³ Swinton's model of Practical Theology is best expressed in the idea that theology does not live in a vacuum; rather, theology is lived and experienced. Such theology is expressed as knowledge of the whole person.⁴¹⁴

Practical Theology is lived and expressed through radical friendship. The most profound biblical basis for this type of friendship is John: 15.15: "I do not call you servants any longer, because the servant does not know what the master is doing; but I have called you friends, because I have made known to you everything that I have heard from my Father." This is radical indeed – the Son of Man, the Second Person of the Trinity, calls his servants friends. Summarizing the Gospel, Swinton finds a God who: "befriends those whom society rejects and suffers with the least of humanity."⁴¹⁵

Swinton's theology, influenced by his Scottish Presbyterian background, is one rooted in the Reformed tradition. His model of God "finds its general routes within the Reformed theological tradition, its particular focus within a Trinitarian understanding of God understood in terms of a *social Trinity*."⁴¹⁶ He draws heavily on the Trinitarian thought of Jurgen Moltmann, particularly his work, *The Trinity and the Kingdom of God*. This places Swinton's work within a clearly defined theological context. The Trinity is expressed in eternal fraternity, and this fraternity is extended to humankind.

⁴¹³ Swinton, 7.

⁴¹⁴ Swinton, 11.

⁴¹⁵ Swinton, 6.

⁴¹⁶ Swinton, 39.

Genesis 1:26 declares that God created humankind in the image of God, but what exactly are we to make of this idea of the *imago Dei*? For Swinton the implication is that we are created in the image of *social* Trinity.

Human beings are not created in the image of an unknown, unknowable God. Human beings are created in the image of a *social* God. God *is* relationship and love, a fact which, as we have seen, adds a powerful relational dynamic to the whole of human existence and a fact which, as will be shown, radically affects any understanding of mental health and the church's praxis of mental health care.⁴¹⁷

The ramification of this thought is that we are called to live in this human world amidst all of its suffering, violence, and despair and thereby to befriend those who suffer. We also have responsibility in relations to others, to all life, and to all creation itself. Genesis 1: 28 calls on humankind to 'have dominion over everything that moves on earth.' That idea, though, that all of creation serves us and we are the masters of creation, has had disastrous effects.

The practical consequences of such an understanding of dominion reveal themselves within the modern world, in rising levels of global and personal violence, increasing pollution, the desecration of the rainforest, the continuing destruction of the ozone layer and unrealistic expectations that the medical and psychiatric professions will dominate disease and psychological distress.⁴¹⁸

For Swinton, dominion is better understood as *care*. We are called to care for creation, for animals, the air, the water, and for all humankind. As the COVID-19 pandemic has hopefully taught us, we do not have dominion over disease. We live alongside it.

Since we live in friendship with a social Trinity, sin is a breakdown in the divine/human relationship.⁴¹⁹ Through Christ, we are offered a cleansing of sin, a repair in the breakdown of relationship. Christ is not an abstraction, but rather the God-Man who extends the love of the

⁴¹⁷ Swinton, John. *From Bedlam to Shalom*, 43.

⁴¹⁸ Swinton, 44.

⁴¹⁹ Swinton, 54.

Trinity to all humankind, and I would add, to all creation. “According to Paul, it is Christ who is *himself* the image of the living God; the visible representation of God; the one who reveals the invisible God in tangible form, and whose redemptive mission it is to re-establish right relationships with humanity.”⁴²⁰

Jesus Christ offers the great Shalom of God to all humanity, as evidenced in the words of John: “A week later his disciples were again in the house, and Thomas was with them. Although the doors were shut, Jesus came and stood among them and said, ‘Peace be with you’” (John 20: 26). As Swinton points out, Ephesians refers to Jesus as Shalom: “For he himself is our peace, who has made the two one and has destroyed the barrier, the dividing wall of hostility” (Ephesians 2:14). “From this we see that shalom is not a distant utopian ideal. Shalom is a *person*.”⁴²¹ Peace comes to us in the form of a tangible person, Jesus, who is so tangible that he offers Thomas to see his wounds as evidence of his identity.

Humanity bears wounds: the wounds of war, famine, disease, the wounds of alienation and isolation in the throes of depression, schizophrenia, bi-polar personality disorder and so on to infinity. This leads us to consider what exactly we mean by the term ‘mental health.’ In the medical model, mental health is something we either possess or do not possess. If we present to a physician with a mental health disorder, it is the responsibility of the physician to help restore health. In this model, mental health is the opposite of mental illness.⁴²²

Or perhaps we could identify those who are mentally well by a societal norm if only we could define that norm. We could perhaps build a statistical model that says *this* behavior accords with

⁴²⁰ Swinton, John. *From Bedlam to Shalom*, 55.

⁴²¹ Swinton, 59 (my italics).

⁴²² Swinton, 66.

the societal norm, while *that* behavior does not. But who has the privilege of establishing the difference between mental health and mental illness? We could probably agree that murder and rape are out of bounds. But problems arise as we consider other, less egregious behavior.

By the norms of his time, Jesus, for example exhibited behavior that raised alarms, both in the religious community (Matt 12: 24) and in his own family (Mark 3: 21). Establishing a societal norm for mental health has an ominous nature. During the time of the Soviet Union, for instance, dissenters and protesters against the regime were, logically enough, deemed insane and sentenced to penal psychiatric facilities. If the Union was building the perfect tomorrow through certain methods (the norm), then to oppose that vision was clearly madness.

Swinton points out the problem of mental health in his consideration of those living with the description of schizophrenia: “Because their condition is interminable, they are destined always to be thought of as mentally unhealthy, and thus defined, understood merely as *objects* of treatment aimed at control, rather than as the *subjects* of relationships and the development of their personhood.”⁴²³ We see evidence of the relationship of physicians and therapists with the mentally ill, when we label them as mental health *providers*, which leads one to believe that mental health is something that they possess and are attempting to provide to those who do not possess it.

Rather, Swinton suggests that mental health is the strength required to be human, to live life even in the midst of suffering. This is what we do not provide as Swinton points out: “...people have lost the ability to develop communities that can absorb suffering and sustain the sufferer. In other words, *we have lost the ability to cope with sadness and suffering and to create health even*

⁴²³ Swinton, John. *From Bedlam to Shalom*, 67.

in the midst of pain and illness.”⁴²⁴ This then is what we need to work toward – communities that offer the Shalom of God to those who suffer. A mentally healthy person is based on strength – the strength to love, to maintain relationships with others and with God, despite adverse experiences.

Swinton provides a definition and a vision of what mental health is: “A mentally healthy mind is one which has enough *tension-capacity* to be able to live creatively within the existential polarities of the unseen inevitable sufferings of our present state, and the promised future hope revealed tentatively in the present in and through the gradual unfolding of God's shalom...”⁴²⁵ Further, in his life and ministry among us, Jesus is the paradigm for the Shalom that we seek to offer others. It is this peace, God’s well-being, that Christ brings into the world.

Resurrecting the Person

In this book (2000), Swinton issues a prophetic call that would guide his ministry and work, and I hope and pray, will inform this project.

This is a book about radical friendship. It is a call to the church to rediscover its prophetic roots in the life, death, and resurrection of Jesus Christ and to reclaim its identity as the friend and protector of the poor, the outcast, and the stranger. The book is a call for the church to remember the one who offered friendship to tax collectors and sinners, and to allow that *dangerous memory* to reshape its attitudes, values, and practices (my italics).⁴²⁶

It is definitively our mission and purpose to befriend and protect the poor, the outcast, the stranger, the mentally ill, and the addicted. I confess that I sometimes feel that the church at large

⁴²⁴ Swinton, John. *From Bedlam to Shalom*, 70.

⁴²⁵ Swinton, 71.

⁴²⁶ Swinton, John. *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*. (Nashville: Abingdon Press, 2000): 9.

has lost its way in this regard. Churches are important institutions that are concerned by growing the faith, typically by youth formation. Churches have important music programs and a gospel proclamation mission. Yet, throughout the Gospels we witness Christ befriending the poor, sinners, the ill, diseased and the infirm. Swinton is correct; the church is the church of Christ when it is eating with tax collectors and sinners.

Swinton's work resonates with Liberation Theology, which Swinton adapts to a pastoral theology of the disabled and mentally ill. "Liberation theologians have argued forcefully that the purpose of the biblical narrative is not simply personal salvation but the *rehumanization of the nonperson...*"⁴²⁷ How does the work of rehumanization take place? First, is a biblical response. When we read the bible, we typically can fall into the trap of believing that every message is *about us*. This is the natural process of resonating with the words of scripture. But the bible was produced by blessed forerunners with a different mindset, one of the bible speaking to communities and nations. The Abraham, Isaac, and Jacob sagas may find personal resonance, but they are primarily the sagas of the formation of Israel as a people.

When we let the bible speak in the context of rehumanization, we will hear the call to rehumanize those who have suffered dehumanization, whether by poverty, disease, or mental illness. The sense of isolation and alienation that such communities feel presses into their soul. Only hearing Christ's call to be resurrected, right now, today, in this life, can set them free.

Swinton develops a special focus in what he terms a ministry of noticing: "It calls for the church to regain its identity as a prophetic community that *notices* - a community that notices the sadness, deals with the loneliness, and fights for justice and liberation in the midst of oppressive

⁴²⁷ Swinton, *Resurrecting the Person*, 18.

social values and attitudes...”⁴²⁸ Sitting with the poor implies listening and witnessing. Seeing and dismissing, pastorally and theologically, the poor and poor in spirit does not accord with our Christian identity. We are called to *notice*, to observe, to take mental note, and to commit to vivid prophetic memory. If we take the pastoral time to sit for any length of time with persons who are living with addiction, legal problems, issues of poverty and loneliness, hounded by fear and sadness, then we will be called by Christ to fight for justice and liberation.

This act of witnessing is connected to our call to understand the phenomena that presents itself, to see clearly what we observe. “Mental health problems are therefore not so much phenomena that need to be *explained*, as human experiences that need to be *understood*.”⁴²⁹ The medicalization of all spheres of life, including addiction (from caffeine intoxication to chronic opioid addiction) has normalized the assignment of diagnoses from the DSM. Particularly for people who work daily with this population, it is hard to escape this compartmentalization of humans – but that is precisely what we must do. We are *witnesses and observers*, not for purposes of personal or clinical curiosity, but as a fulfilment of the prophetic call to align with the people whose lives we witness.

Where should the concerns of the church align – with the Age of Constantine or with the margins of society? Swinton could not be clearer in his response. “The task of the church is not to re-establish the reign of Constantine, but rather to live out the rule of Christ, the one who sat on the margins of society with those whom the world deemed to be unlovable.”⁴³⁰ I would concur that it is the primary mission of the church, not to struggle with self-growth, budgets, and

⁴²⁸ Swinton, *Resurrecting the Person*, 24.

⁴²⁹ Swinton, 28.

⁴³⁰ Swinton, 38.

institutional goals, but to align and grow with the poor of the world, with those who are poor in spirit or in fact. We should be incredibly wary of any attempt by churches to align with the state, with capitalism, or with the status quo – a status that impoverishes millions in the myriad ways in which impoverishment occurs.

In other words, we are called to be radical, apostolic, gospel friends of the population we serve. This clearly distinguishes the mission of the church from the professional mental health industry that has grown up in the last fifty years with the purpose of ‘care delivery.’ Swinton points out the difference: “The professional is *paid to relate to them*. They are there because they are paid to be there....As one social services manager astutely observed, "If your only friends in the world are a psychiatrist, a general practitioner, a community psychiatric nurse, and a social worker, how would your mental health be?”⁴³¹

The book concludes with an explication of the Community Mental Health Chaplaincy (CMHC) model which I discussed in the introduction. The purpose of this project is to study the feasibility of establishing such a model in Carter County, TN.

Spirituality and Mental Health Care

In his 2001 book, *Spirituality and Mental Health Care*, Swinton offers an overview of spiritual care in the field of mental health. This book is most applicable for our project, as it deals directly with the issue of whether the appeal to spiritual strengths can assist a person in terms of mental health. The author is clear that his intent is not to confront or replace current mental health care, but rather to augment and improve care.

⁴³¹ Swinton, *Resurrecting the Person*, 83-84.

In order to do this, we must understand how the medical model of care affects mental health outcomes. The problem as stated is this: “The mental health professions have been deeply affected by the influence of the medical model and the pathology-oriented worldview that accompanies it. Consequently, it is often difficult to focus on issues of mental health that may not fit within such an empiricist worldview” – with spirituality being one of the misunderstood elements that finds no fit.⁴³²

Positivism and empiricism operate by limiting knowledge to observable facts, the assumption being that there is a world that can be observed or measured by an *objective* observer. “In other words, if you cannot see it or sense it, it cannot exist in any kind of meaningful sense.”⁴³³ But of course, many of the most meaningful phenomena of life, the very things that make life worth living, cannot be observed in an empirical sense: love, hope, faith, friendship and meaning itself. The *joie de vivre* that wakes one up in the morning with a desire to live, the *drive to thrive* that makes life purposeful, Freud’s “truly precious things” – these do not willingly submit to empirical study.

The 1747 work, *Man a Machine*, by Julien Offray de La Mettrie, established the materialist philosophy that the human body is simply a complicated machine – a machine that functions beautifully when all systems are go, and a machine that faces frequent mechanical breaks. But this worldview, as helpful as it is in treating hip fractures and exhausted heart valves, brackets out some of the most significant elements of human life. This worldview which informs the modern medical model has a “tendency toward materialism, reductionism and a mechanistic

⁴³² Swinton, John. *Spirituality and Mental Health Care: Rediscovering a ‘Forgotten’ Dimension*. (London: Jessica Kingsley Publishers, 2001): 8.

⁴³³ Swinton, John. *Spirituality and Mental Health Care*, 47.

view of persons means that it is lacking in significant ways.”⁴³⁴ When we address mental health problems, including addiction, we do well to remember that more is involved than biology.

While the term *spirituality* can be so vague as to be meaningless, Swinton reclaims the term through a rigorous literature review of research into the role of spirituality in mental health care. While the medical model addresses the *matter* of life, spirituality addresses the questions of *what matters* in life. How do I make meaning from life? Why does suffering exist? What is my obligation, if any, to other humans? How do I maintain an intimate relationship with another? How do I live with chronic disease? How do I deal with the emotions I feel? What is the meaning of death? Is there life beyond?

Medical science may not only eschew the issue of spirituality, some believe that in fact religion is a form of psychopathology or the exhibition of neuroses. But the research that Prof. Swinton reports on in chapters three and four indicates a different result. Swinton finds that “religion provides a powerful worldview and a specific epistemological and hermeneutical framework within which people seek to understand and interpret and make sense of themselves, their lives and their daily experiences.”⁴³⁵

Spiritual issues pierce the human soul. The dimensions of the soul are evident as Swinton writes: “Spirituality is the outward expression of the inner workings of the human spirit.”⁴³⁶ I cannot help but compare this to the definition of sacrament provided by the Book of Common Prayer: “The sacraments are outward and visible signs of inward and spiritual grace, given by

⁴³⁴ Swinton, John. *Spirituality and Mental Health Care*, 51.

⁴³⁵ Swinton, 28.

⁴³⁶ Swinton, 20.

Christ as sure and certain means by which we receive that grace.”⁴³⁷

Under that definition, spirituality is the sacramental sign of the inner workings of the human spirit. For the religious, those inward signs are the very matter of life.

While Swinton reports on the many ways that spiritual care can assist mental health care, for issues of space I will take but one example, which is the issue of depression. Millions suffer daily with the absolute meaninglessness that can seize a person trapped in a downward spiral of depression. But that sense of meaninglessness can be addressed effectively through capable spiritual care that assists one in exploring what may *make* meaning for the depressed person.

This book has direct application for the project we have in mind with persons addicted to opioids. In partnership with an addicted person, a chaplain may help to explore issues of meaning beyond the urgent need for the next dose. One may help an addicted person explore the relationships that have been damaged and ways to begin to mend broken family and friendship systems. We can explore the goods of life and how to enjoy them. We can extend our hands to offer a Gospel-driven, apostolic friendship, such as many may never have experienced.

Raging with Compassion: Pastoral Responses to the Problem of Evil

On a blistering August day in Nashville in 2006, a young African American mother, with her triplet toddlers in tow, attended a large pool party at a friend’s house. In the late afternoon the adults were perhaps distracted when the triplets, one after another, jumped into the pool unobserved. One after another they drowned. Shortly after, my pager signaled with an emergency call, with a staff request that I attend the scene. When I arrived at Vanderbilt Medical

⁴³⁷ The Episcopal Church. *Prayer Book and Hymnal*. (New York: Church Publishing, 1986): 857.

Center, I found the mother sitting in a chair in the emergency room waiting area, face marred with pain, hair, and skin wet from weeping. She was literally speechless, seized with understandable horror. What in the world could a religious chaplain say to this woman? I did not even try. I sat with her, held her hand, listened to her shock and wailing, felt the rocking of her body in lament. That was all I could muster.

Swinton's 2007 book *Raging with Compassion* is one of the most profound and thoughtful works I have ever read. In it he proposes a pastoral correction to the idea of theodicy, which asks the questions: Why do the innocent suffer? And where is God in the midst of suffering? About this Swinton makes two major observations. First, theodicy has typically been a question asked and answered by professional philosophers in an academic setting. The problem is that such discussion is completely divorced from any pastoral accountability or oversight. Of this effort he writes powerfully:

What kind of God are we left with if we manage, through clever intellectual moves, to fit such obscene forms of cruelty and evil into a framework that somehow justifies it and draws it within the boundaries of the love and righteousness of God? When we try, we blame either the victim, for making bad choices..., or God and in so doing reduce both God's love and God's power.⁴³⁸

Based on this analysis, Swinton's second observation reframes the question of evil – not, What is evil and how does it exist?; but, rather, “What does evil *do*?”⁴³⁹ Indeed, to focus on evil and not on its effects, is “a line of questioning (that) cannot be sustained if one takes seriously the doctrines of grace, creation, redemption, and providence.”⁴⁴⁰ By reframing the question, Swinton sways the field to focus on the *effects* of evil, which is the realm of pastoral theology.

⁴³⁸ Swinton, John. *Raging with Compassion: Pastoral Responses to the Problem of Evil*. (Grand Rapids: William B. Eerdmans Publishing Company, 2007): 13.

⁴³⁹ Swinton, 30.

⁴⁴⁰ Swinton, 42.

Swinton also uses Augustinian thought regarding evil, by which evil is defined as the deprivation of the good. God creates all things to be good. Evil, then, is an action to deprive the world of the good that God has created.⁴⁴¹

What can the church *do* to counteract what evil *does*? Swinton's response is that the church is designed and built for resistance – and we must resist evil and suffering. He suggests four powerful resistance fronts. The first front is that of *lament*. Lament is a forgotten, and frequently shunned, art, but one that is necessary to Christian resistance to evil. In sixty-four years, I have never heard (nor have I preached) a sermon regarding the book of Lamentations, despite its richness and instruction for us today. Lament begins with silence in the face of horror – the sort of horror I witnessed in a mother who had just lost three toddlers. “Jesus’ silence in the presence of evil acknowledges the full numbing horror of suffering and legitimizes every sufferer’s experience. Jesus’ sense of alienation from God, which paradoxically was a mark of his experience on the cross, echoes the sense of alienation and disconnection that many people go through when they experience evil and suffering.”⁴⁴² Thus, our silence reflects Jesus’ silence on the cross.

After a period of appropriate silence, we move to lament, which is itself a form of prayer. “It is, however, a very particular form of prayer that is not content with soothing platitudes or images of a God who listens only to voices that appease and compliment.”⁴⁴³ Rather, our lament is a full-throated protest to God regarding the presence of evil and suffering, the suffering of the innocents, and the distinct absence of justice. Lament is the ability to live with questions that may never be answered in this life and the capability to live in the midst of evil and suffering

⁴⁴¹ Swinton, *Raging with Compassion*, 22-23.

⁴⁴² Swinton, 100.

⁴⁴³ Swinton, 104.

while maintaining a relationship with the Creator – even if this relationship is one of protest and unanswered questions.

The second resistance front is the Christian practice of forgiveness. In approaching this topic, I must skip to the end of Swinton’s comments on this idea: “*Without repentance, there is no possibility of redemption.*”⁴⁴⁴ I personally *need* this idea to come first before I can begin to talk about forgiveness. Swinton recognizes the pastoral dangers that can arise around the issue of forgiveness. To offer a personal example, four days after my mother’s murder, a Church of Christ pastor told my sister that she *must* forgive the murderer, or she would go to hell. It was a little early for such a pastoral demand. Such an insult as murder requires time (silence) to work through the consequences. On this topic Swinton asks an important question of us: “Is there not a danger, in taking Jesus’ word seriously and in making such forgiveness central to practical theodicy and, indeed to faithful discipleship, that we will create *victims of grace* - people who have been wounded by the experience of evil and now find themselves forced to forgive the very people who have done this to them?”⁴⁴⁵ My own response to this question is that of course it is a dangerously frequent practice, in which we create such ‘victims of grace.’

Having said this, the issue of forgiveness is central to the Christian faith. But how do we make it work? ‘I would fully agree with Swinton that “Christian forgiveness is both scandalous and unreasonable.”⁴⁴⁶ So how do we meet this demand with Christian faithfulness? Swinton first rejects the idea of revenge as incompatible with the faith. Although the urge for revenge is strong, we must recognize that “revenge makes all of us evil.”⁴⁴⁷ We may not respond to evil

⁴⁴⁴ Swinton, *Raging with Compassion*, 166.

⁴⁴⁵ Swinton, 132.

⁴⁴⁶ Swinton, 177.

⁴⁴⁷ Swinton, 136.

with evil, because the temptation to capitulate to revenge would indeed put us on the moral ground of the one who sinned against us.

Another normal human response is to make sinners the distant other, to ostracize them in order, through linguistic devices, to create monsters of them. We will encounter this frequently in working with those who are opioid addicted. But such a maneuver has a dangerous element. From referring to serial killers as ‘monsters’ to the Rwandan mass genocide in which the victims were ‘cockroaches,’ we are employing a strategy of turning humans into monsters. In so doing, “...we set up strategies to battle against the evil or to exclude it from our presence either physically via prisons or special hospitals or psychologically through the processes of labeling, distancing, and scapegoating... thus, we keep evil on the margins of our language and dehumanization.”⁴⁴⁸

As Christians we deal with evil and suffering by taking our lament to the foot of the cross, where Our Lord suffered tremendous suffering at the hands of a vicious mob. When we enter the work of forgiveness we do so with awareness. “That is not to say that we are called to forget past evil and let bygones be bygones. Christians are called to take their experience of evil, suffering, and rage to the foot of the cross and allow that event to reframe their response.”⁴⁴⁹ The foot of the cross is our social location. It is the source of our grace, our own forgiveness, and the forgiveness of others.

The third resistance front is *thoughtfulness*. What Swinton means by this is profound. He frequently draws on the work of Hannah Arendt and the idea of the banality of evil. The fact is that the people we think of as monsters are actually quite ordinary, even boring. They are not the

⁴⁴⁸ Swinton, *Raging with Compassion*, 146.

⁴⁴⁹ Swinton, 158.

monsters that inhabit the subconscious; rather, they are ordinary people who, through thoughtlessness, are “seduced into complicity with some of the hidden evils in our society.”⁴⁵⁰ Swinton uses an example from pediatric medicine. It is now possible to do prenatal tests to determine if a fetus/baby/unborn person/person has a disability, such as Down’s Syndrome. But what is the purpose of such testing? Without thoughtfulness we could be led into a type of pragmatic thinking that weighs the complications such a child would bring to a family versus ‘sparing’ the family of such a burden. Instead of such pragmatic devaluation of life, we must be careful to follow a practice of thoughtfulness that will lead us to value the gift of every child and the sanctity of the gift of human life in all its diversity.

The fourth resistance front is that of *friendship*. The sort of apostolic friendship that Swinton exhorts is one that follows the remembrance that the covenant people were once aliens in a foreign land. We follow the example of the meeting at the Oak of Mamre (Gen. 18. 1-15) for guidance in accepting and welcoming the stranger as friend. In doing so, we are guided by the principle that “*Salvation remains a possibility for all of us, no matter where we have been and what we have done.*”⁴⁵¹ We befriend others as Christ has befriended us (Matt. 11: 19; Luke 5: 20; John 15: 13-14.)

Finding Jesus in the Storm

Swinton’s 2020 book, *Finding Jesus in the Storm*, is a theological reflection on years of qualitative research into the issue of Christians who live with ‘mental illness.’ His work provides a corrective to the purely biological approach to mental illness: “Human beings are not simply a conglomerate of chemical reactions. Humans are persons, living beings who have histories,

⁴⁵⁰ Swinton, *Raging with Compassion*, 180.

⁴⁵¹ Swinton, 158.

feelings, experiences, and hopes, and a desire to live well.”⁴⁵² While I would not suggest that human interactions cannot take place between mental health providers and patients, usually providers work under a medical model with severe time constraints and budget concerns. Swinton points out the historical development of our (imperfect) knowledge of mental illnesses. “At any given historical or cultural moment, particular descriptions of the experience and explanations for its occurrence - that it is caused by demons, the subconscious, chemical imbalances, genetics, neurology - become elevated to the status of the ‘standard account.’”⁴⁵³ We know that our knowledge is still evolving. What causes schizophrenia? How do we treat it? How is it possible to use one term (schizophrenia) to cover an entire constellation of symptoms? What causes depression, or bipolar disorder? How are those conditions to be treated? The honest answer is that our knowledge is under construction. We understand more than we did fifty years ago, but science has not provided neat responses to the bane of mental distress.

Swinton astutely points out four problem areas in mental health care that lead us to “thin,” (that is a solely biological gaze), descriptions of persons living with mental illness. These include stigma, the Diagnostic Statistical Manual, a turn to biology, and the issue of spirituality in mental health care. The stigma of receiving a diagnosis, the stigma of living with a diagnosis, and even the stigma attached to seeking help in the first place, all lead to a thin description of a person. The person living with a mental health diagnosis is frequently reduced in the eyes of others to their understanding of the diagnosis. A person *is* schizophrenic. A person *is* bipolar, or clinically depressed.

⁴⁵² Swinton, John. *Finding Jesus in the Storm: The Spiritual Lives of Christians with Mental Health Challenges*. (Grand Rapids: William B. Eerdmans Publishing Company, 2020): 1.

⁴⁵³ Swinton, John. *Finding Jesus in the Storm*, 11.

The *Diagnostic Statistical Manual* provides its own tendencies toward thin description, as does any purely biological description. Swinton remind us that, “(t)he turn to biomedical descriptions and explanations of depression is partly caused by the influence of pharmaceutical companies who... tend to fund and publish research that supports the potency of their particular brand of medication.”⁴⁵⁴ Originally, the manual was intended to be descriptive, to categorize certain symptom manifestations into groups. The result was to standardize psychiatric language, so that a provider in San Francisco and a provider in New York can use the same language to discuss mental health problems. In that capacity, the manual is useful. “Diagnoses are shorthand descriptions of complex human behavior. Shorthand descriptions are very helpful within a system that is bounded and limited by the pressures of time.”⁴⁵⁵ The problem is that before long the shorthand description attached to a living person leads to a shorthand understanding of the person. The person is much more than the description of a disorder provided by the manual. “Schizophrenia is not like measles. One can *have* measles, but one *becomes* schizophrenia.”⁴⁵⁶

Swinton, who himself has had a good career in mental health chaplaincy, reserves strong criticism for the idea of spirituality as currently practiced in mental health care. Spirituality is problematic because on the one hand, exploring spirituality has been positively associated with the reduction of the severity of mental health disorders; on the other hand, what we end up with when we talk about spirituality is a uniquely Western, individualistic, and rationalistic understanding of what I would consider the most profound religious experiences one may have. Swinton zeroes in on the problem as he writes: “Researchers think about spirituality in this way in order to ensure that it is inclusive. Put slightly differently, this is a spirituality designed to

⁴⁵⁴ Swinton, John. *Finding Jesus in the Storm*, 76.

⁴⁵⁵ Swinton, 21.

⁴⁵⁶ Swinton, 31.

cater to people of ‘all faiths and none.’ It is non-denominational, open to the religious and the secular, and above all *individualistic* and *personal*.⁴⁵⁷ The result is a thinned-out, hollowed-out spirituality that appeals to all and none. In the West, we have created a system of ‘working with’ an idea of spirituality that is thin, “...the system itself shapes and forms the spirituality that is acceptable; it silently places boundaries, parameters, and brakes on the activities of spiritual care and articulations of spirituality and compels us to work with a thin model of spirituality that dovetails neatly with what is already there.”⁴⁵⁸ Instead of this view, Swinton urges us to remember: “*Human biological existence is inevitably, thoroughly, and unavoidably theological in its origin and intention.*”⁴⁵⁹

Swinton’s response is to ‘resurrect phenomenology.’ Swinton uses the work of Husserl and Gadamer to urge a new consideration of the field of phenomenology and reminds us that “...phenomenology urges us to remember that before there was a theory, there was an experience; before there was a category, there was a person having a meaningful experience.”⁴⁶⁰ We may appropriately provide a patient with medication for a mental health disorder, but the author reminds us that giving medication in and of itself is not the problem. The problem is that the provider may believe that medication is the *only* appropriate response. A resurrection of phenomenology is the cure to such a biological approach.

Walking with Jesus in Strange Places

Swinton’s latest book, *Walking with Jesus in Strange Places* (2022) is a retrospective of his vocations in life and an exercise in theological reflexivity, which expresses “the need to be aware

⁴⁵⁷ Swinton, John. *Finding Jesus in the Storm*, 34.

⁴⁵⁸ Swinton, 36.

⁴⁵⁹ Swinton, 105.

⁴⁶⁰ Swinton, 42.

of the way in which our own stories and experiences impact upon the decisions we make in research.”⁴⁶¹ In thinking about his own life, he sees that he has moved through a number of vocations: a marine biology lab assistant, a nursing assistant in a psychiatric ward, a registered psychiatric nurse, a student, a pastor and hospital chaplain, and finally an academic. I too am a person who has moved through a number of vocations, so Swinton’s reflection is valuable: “God is a God of surprises. *Vocation requires that we remain in the places God wants us to be at the times God wants us to be there*”.⁴⁶²

This reflection on God, place, and time necessarily impacts theology. “Theologians don’t just ‘turn up’ with a set of ideas. There is inevitably an element of context and to an extent, autobiography within all theologies.”⁴⁶³ We are humans and not God. We do not *understand* God. We, in community, may receive revelations about God’s movement in the world, but we do not know God perfectly. We require illumination to see the world in a different way, a way that is compatible with the movement of God. To accomplish this, we put three things in conversation: Scripture, tradition, and experience.

Swinton provides an example of knowing God in such a conversation, based on the prophet Jeremiah’s words about the ‘good king’ Josiah: “He defended the cause of the poor and needy, and so all went well. ‘Is that not what it means to know me?’ declares the Lord” (Jer. 22. 16). Swinton draws an important conclusion from this example: “Jeremiah does not say that Josiah knows God and as a consequence goes out and cares for the poor. *Caring for the poor is an*

⁴⁶¹ Swinton, John. *Walking with Jesus in Strange Places*, 33.

⁴⁶² Swinton, 28.

⁴⁶³ Swinton, 31.

aspect of knowing God.”⁴⁶⁴ This line of thought has direct implications for our ministry. We do not care for our population because we know God; rather, we know God through caring.

In his own vocations, Swinton has been drawn to work out a theology of care for the disabled and for those with mental health issues. By caring for those who are “marginalized, excluded, and unjustly treated,” he has come to know God in a richer fashion.⁴⁶⁵ He reflects on Jesus’ own ministry with those whom we call the marginalized: “...Jesus did not sit with those on the margins of society. *Rather, he moved the margins.*”⁴⁶⁶ When we consider the social location of Jesus’ ministry, we will find the social location of the church in every age as we offer friendship while God moves the margins of human society.

Together with Harriet Mowat, Swinton has written extensively about qualitative research and theological ethnography. Ethnography with a theological lens, “re-enchants the world, assuming that God’s work is not confined to history or the realm of the religious.”⁴⁶⁷ When we use a theological lens in research, we find that we have provided thus far an extremely thin description of those with disabilities and mental health issues. In working with those who suffer we rely on Old Testament lamentation to have a presence with our population. Through friendship, we call our population into the presence of God. This friendship is not “Sunday-only friendship” but a Christ-like friendship that entails being present, offering friendship, and listening to the issues

⁴⁶⁴Swinton, John. *Walking with Jesus in Strange Places*, 44.

⁴⁶⁵ Swinton, *Walking with Jesus in Strange Places*, 46.

⁴⁶⁶ Swinton, 49.

⁴⁶⁷ Swinton, 55.

that the population raises.⁴⁶⁸ This is, in effect, theological advocacy, as we offer Christ's love to those who feel quite unloved or even unlovable.

Conclusion

We have reviewed here Swinton's written body of work, which focuses on theological ethnography and an advanced theology of disability and care for those with mental health issues. This impacts our project profoundly for at least two reasons. First, this project is an attempt to draw a blueprint for a Community Mental Health Chaplaincy, based on a model in Swinton's work. Second, Swinton provides certain founding principles that may guide our work.

In summary, I want to name five ideas from the body of Swinton's work that form and shape the research that follows.

- 1) Radical friendship. The purpose of such friendship is to offer the means to resurrect the person, a social connection that engages the other at a loving, human level.
- 2) Radical friendship is rooted in the Social Trinity that models relationship and love.
- 3) Shalom is the gift we bring from Christ. Our purpose is to attempt to bring the holy well-being that can be found only in Christ.
- 4) Alignment is the movement of bringing ourselves alongside the values of Scriptures in our concern for the materially and spiritually poor. We remember the words of the Epistle of James: "Has not God chosen those who are poor in the world to be rich in faith and heirs of the kingdom which he has promised to those who love him?" (James 2: 5).

⁴⁶⁸ Swinton, John. 72.

- 5) Resistance to evil and suffering. Swinton details a battle plan for resistance in four resistance fronts.

Taken together, Swinton's work forms a firm foundation for the research and action that follow.

Chapter Twelve

Implications of the Opioid Crisis for Pastoral Theology

“It is daily becoming better known that opium, its derivatives, and cocaine are being used in alarming amounts all over this country. Various factors, such as the careless prescribing of these drugs by physicians, the spread of habit from person to person, the cupidity of druggists and patent medicine manufacturers, and vice and dissipation are responsible for the existing conditions.”⁴⁶⁹

C.E Terry

The American Journal of Public Health

1915

Up to this point I have attempted to provide an adequate understanding of the crisis that presents itself to us for pastoral and theological reflection and have reviewed the Practical Theology of John Swinton. I hope that I have sufficiently demonstrated the complex, multifactorial, and disputed nature of the opioid problem that presents itself for theological reflection. The rationale for my approach is summed up beautifully in a 2010 article in the *Journal of Human Behavior in the Social Environment*: “Direct service practitioners must acquire a higher level of cultural competency in providing services in rural communities. This includes an understanding of a client's race, ethnicity, cultural background, primary language, health practices, value systems, and a commitment to empowering rural clients in obtaining services and seeking to maintain their health.”⁴⁷⁰ In other words, before we can approach a

⁴⁶⁹ Terry, C E. “The Harrison Anti-Narcotic Act,” *American Journal of Public Health (New York)*, Vol. 5, No. 6 (New York, 1915): 518. Accessed online on April 23, 2022, at doi:10.2105/ajph.5.6.518

⁴⁷⁰ Thornton, Gwendolyn B. and Deitz-Allyn, Krystal. “Substance Abuse, Unemployment Problems, and the Disparities in Mental Health Services in the Appalachian Southwest Region,” *Journal of Human Behavior in the Social Environment*, Vol. 20 (2010): 939-951. Accessed online on February 17, 2022, at DOI: 10.1080/10911359.2010.516690: 949.

complex problem such as the opioid crisis, we must arm ourselves with as much knowledge as we can.

I offer one disclaimer. I have deliberately not delved into wider issues. I am only addressing the opioid crisis in the US, although it is a worldwide public health issue. This is particularly true in Canada, Australia, and Great Britain. Likewise, I have not addressed the heart-breaking instances of Neonatal Abstinence Syndrome (NAS), in which infants of mothers who are addicted to opioids are born addicted and suffer the horrors of withdrawal from opioids. The impact of COVID-19 on opioid use and treatment is worthy of a study in itself. Neither have I addressed the phenomenon of poly-substance abuse in which users mix a variety of drugs. Usually, this includes abuse of methamphetamine and marijuana. The history of the federal regulatory movement throughout this crisis is too large in scope to consider here. With these caveats, we can identify four major issues from the preceding chapters that constitute implications for pastoral theology. These themes are stigma, iatrogenesis, profit, and pain.

Stigma. Stigma is a researchable topic in and of itself. Here I simply want to consider the role of stigma in opioid use and treatment. In ancient usage according to Arndt and Gingrich, stigma was a mark or brand, as in “not only did the master put a brand on his slave....”⁴⁷¹ A stigma, then, was a visible mark, in this case to show ownership. Today the stigma is usually invisible, but prominent in a psychological way, a mark of disgrace. We find stigma particularly in the context of addiction.

⁴⁷¹ Arndt, William F. and Gingrich, F. Wilbur. *A Greek Lexicon of the New Testament and Other Early Christian Literature*. (Chicago: The University of Chicago Press, 1957).

In a leaked email from 2001, Dr. Richard Sackler gave instructions for Purdue Pharma’s defense against charges of culpability in the opioid crisis. He wrote: “We have to hammer on the abusers in every way possible. They are the culprits and the problem. They are reckless criminals.”⁴⁷²

Mr. Sackler would not be the first or only person to vilify persons addicted to opioids. Indeed, one study notes:

Confronting public stigma—stereotypes, prejudice and discrimination endorsed by the general population—is one of the greatest barriers to reversing the opioid epidemic and reducing the harm it causes to individuals, families, and communities. Historically, non-medical drug dependence has been the most stigmatized of all psychiatric or medical conditions. Compared to other conditions, drug dependence is disproportionately likely to be attributed to bad character and associated with violent and un-predictable behavior. People with drug dependence are perceived as more blameworthy, less deserving of help than those with other stigmatized conditions and are less likely to be accepted as neighbors, coworkers, or marriage partners.⁴⁷³

The rationale for such stigma can include a desire for social distance from our population and perceived danger. New studies point out that stigma may also be based on race, social class, and gender.⁴⁷⁴ But for years the population has been identified in our culture as:

- Scum
- Low lifes
- Despicable
- Addicts

⁴⁷² Zezima, Katie and Bernstein, Lenny. “‘Hammer on the abusers’: Mass. attorney general alleges Purdue Pharma tried to shift blame for opioid addiction,” *The Washington Post*. January 15, 2019. Accessed online on March 12, 2022 at https://www.washingtonpost.com/national/hammer-on-the-abusers-mass-attorney-general-alleges-purdue-pharma-tried-to-shift-blame-for-opioid-addiction/2019/01/15/4af25c4c-190c-11e9-88fe-f9f77a3bcb6c_story.html.

⁴⁷³ Perry, Brea L., Pescosolido, Bernice A., and Krendl, Anne C. “The unique nature of public stigma toward non-medical prescription opioid use and dependence: a national study,” *Journal for the Study of Addiction*, 115 (2020): 2317. Accessed online on April 6, 2022, at doi:10.1111/add.15069.

⁴⁷⁴ Wood, Emily and Elliott, Marta. “Opioid Addiction Stigma: The Intersection of Race, Social Class, and Gender,” *Substance Use and Misuse*, 55, No. 5 (2020): 818-827. Accessed online on April 6, 2022, at <https://doi.org/10.1080/10826084.2019.1703750>.

- Junkies
- Worthless
- Users

Sadly, these are only some of the terms applied to persons who, through whatever avenue, have become addicted to opioids and suffer the cycle of seeking today's dose to avoid at all costs the suffering induced by opioid withdrawal. In popular wisdom, "addicts" are the dross of society, not worthy of attention. They made their beds in an opioid den, and there they should lie.

In my own practice in chaplaincy and then as a manager in a methadone clinic, I cannot count the number of instances of 'blaming the patient' that I have personally witnessed. Even within institutions of care, stigma persists. I have sat in an emergency room for hours with a person suffering heart issues and severe withdrawal while his need was obviously ignored. In fact,

Among healthcare providers, there is further evidence that stigmatizing views toward various health conditions including psychotic disorders, mood disorders, substance use disorders, and combat-related post-traumatic stress disorder are associated with differential treatment, a lower standard of care, and in some cases the denial of care altogether.⁴⁷⁵

The issue of stigma is rampant and 'hammering the abusers' is fair sport.

The issue of stigma has a long medical history. In the 1902 medical handbook, *Morphinism*, which was one of the first to address the issue of opioid addiction, the author draws a distinction between upper-class and lower-class use of morphine.⁴⁷⁶ "Morphinism is often noted in the prosperous classes, while morphinomaniacs are seen lower down, among the tramps, criminals, and degenerates."⁴⁷⁷ Then as now, perhaps, the prosperous classes had the privilege of hiding

⁴⁷⁵ Brown, Robyn Lewis et al. "Opioid Use-Related Stigma and Health Care Decision Making," *Addictive Behaviors* March 28, 2018). Accessed online on April 6, 2022, at <http://dx.doi.org/10.1037/adb0000830>.

⁴⁷⁶ Morphinism was the term first used for addiction to morphine. Likewise, those addicted were termed morphinists.

⁴⁷⁷ Crothers, T.D. *Morphinism and Narcomanias from Other Drugs: Etiology, Treatment, and Medicolegal Relations*. (Philadelphia and London: W.B. Saunders, 1902): 45.

their addiction, while the tramps were left exposed to public view. Crothers goes on to offer some praise of morphin.

Morphinism is one of the most serious addictions among active brain workers, professional and businessmen, teachers, and persons having large cares and responsibilities. There is something very fascinating in the physiologic action of morphine which enables the judge who is nervous and confused, after the use of a single dose to regain his former clearness and self-possession; or for the tired physician suffering from unsteadiness and exhaustion to become strong again.⁴⁷⁸

Crothers states that the etiology of morphinism is genetic and divides the addicted into three classes of users. First, are those of the second generation of parents who are nervously exhausted by honest work: “hardworking physicians, clergymen, active businessmen, lawyers, teachers, and others who have been engrossed in their business.... are frequently followed by children who become morphine takers.”⁴⁷⁹ The second group is the descendants of “idlers, gourmands, and pleasure-seekers,” the degenerates who pass on their degeneracy in the form of morphinism to their children.⁴⁸⁰ The third group is comprised of the descendants of neurotics.

It is not my intent in offering these lines to show disdain for the work of Dr. Crothers. Quite the contrary, he is to be lauded as one of the first physicians to take the issue of opioid addiction seriously, to accept patients, and to write his findings. That he demonstrates the values and ideals of an educated man writing in 1902 is not surprising. My intent is simply to show how medical stigma against opioid addicted persons was born and passed on through medical training. Dr. Crother’s observations are just that - observations, but they are “scientific” observations that are charged with the values of his time.

⁴⁷⁸ Crothers, T.D. *Morphinism and Narcomanias from Other Drugs*, 44.

⁴⁷⁹ Crothers, 60.

⁴⁸⁰ Ibid.

I know that there are efforts in the medical community to attempt to destigmatize addiction, and I applaud those efforts. But stigma persists even against those who are in medication-assisted recovery – the very people who are trying to defeat a years-long chronic addiction to opioids. Methadone and buprenorphine patients are even shunned from traditional 12-step groups, precisely because they need medication to survive addiction. In response, a recovery group just for those suffering from opioid addiction formed Medication Assisted Recovery Anonymous (MARA) as a group that understands patients struggling with addiction.⁴⁸¹ Using the 12-step method, the group strives to care for its own, who are ostracized even from the larger recovery community.

I want here to offer a look at the relationships of stigma in the opioid crisis as I see it.

- Stigma of the Appalachian community toward drug users
- Stigma of some medical providers toward drug users
- Stigma of Appalachian community toward Medication Assisted Treatment (MAT)
- Stigma of Narcotics Anonymous groups toward persons in MAT
- Stigma from psychotherapists and some religious leaders who say they will ‘work with’ persons seeking treatment when they are ‘straight’ again
- Stigma of drug users toward the ‘straight’ community

This is an issue of pastoral concern because how we perceive persons who suffer addiction and how we talk about them is essential. Stigma affects the ability of persons to seek appropriate help and causes drug users to isolate further. For us religious - Were addicts formed in the image of God, or did they lose the image when they first began to suffer from withdrawal? Do they still

⁴⁸¹ <https://www.mara-international.org/>

bear a God image? Are they worthy of a response from Christian people? In a form of delayed grace, should we not just ignore them until they have fully recovered from addiction? Then we could talk to them about faith. Or should we respond somehow now, and live out the gospel call of our greatest healer, Jesus Christ? In the words of one United Methodist pastor: “The faith community needs to recognize the potential value of religion in the lives of individuals suffering from a variety of difficult problems, including persons in recovery from opiate addiction.”⁴⁸²

Iatrogenesis There are two main causes of opioid addiction. The first is through illicit use, which is what we generally picture when we think of opioid addiction. This is the person who obtains prescription drugs for non-prescription use. It is this avenue of addiction that we considered when we told the story of the Xalisco Boys. Illicit use takes advantage of black-market access to illegally gained, and frequently illegally manufactured, opioids. One example of an illegally manufactured opioid is the fentanyl that is frequently produced by large cartels using necessary chemicals typically produced in China.

The second cause is iatrogenic opioid addiction. This occurs when a patient under the care of a prescribing physician (or a physician or pharmacist herself) develops opioid addiction and manifests Adverse Events (AE), such as increased drug use, withdrawal syndrome, and harm to patient, including overdose. In fact, “(e)ven short courses of opioids prescribed in emergency departments for acute pain or after surgery and dental procedures may increase the odds of AEs including opioid use disorder (OUD).”⁴⁸³

⁴⁸² Weaver, Andrew J. “Chaplains need to be aware of increased Heroin Use in among Youth,” *Journal of Health Care Chaplaincy*, 14 (2) (2008): 149. Accessed online on March 8, 2022, at doi:101080/08854720802129144.

⁴⁸³ Makhinson, Michael et al. “The Iatrogenic Opioid Crisis: An example of ‘institutional corruption of pharmaceuticals?’” *Journal of Evaluation in Clinical Practice*, (2021) 27: 1034. Accessed online on March 8, 2022, at [The iatrogenic opioid crisis: An example of 'institutional corruption of ph...: Milligan OneSearch \(oclc.org\)](#)

Few studies have been conducted to date on the iatrogenic causes of the opioid crisis. This is likely due to the complexity of the subject and to the lack of a standardized methodology to undertake such a venture. The goal of such a study would not be to find fault and culpability but to learn from mistakes made so that they are not repeated in other public health emergencies, such as the current COVID pandemic.

One study published in the *Journal of Evaluation in Clinical Practice* has made a good first effort.⁴⁸⁴ The study undertook a systems approach to conduct a root-cause analysis of the opioid epidemic. The study grouped ‘influencers’ in five categories from important to lesser influencers. Because I believe their findings are important, I have summarized them here.

Category I (most important influencers)

- ❖ Pharmaceutical Industry (Pharma) – the study, along with others, found that Pharma falsely and aggressively marketed opioids to the public, delayed responding to reports of abuse, and influenced decision-makers, including physicians, through financial means. “Approximately one in 12 American physicians received opioid-related payments between August 2013 and December 2015, the top 1% of recipients getting 82% of the total.”⁴⁸⁵
- ❖ Political Systems – Legislators at nearly every level of government also received ‘contributions’ from opioid producers.
- ❖ Drug Regulatory Agencies – the study reserves some of its harshest criticism for the Federal Drug Administration (FDA). The FDA failed in its mission to protect consumers

⁴⁸⁴ Makhinson, Michael et al. “The Iatrogenic Opioid Crisis: An example of ‘institutional corruption of pharmaceuticals?’” *Journal of Evaluation in Clinical Practice*, (2021) 27: 1033-1043.

⁴⁸⁵ Makhinson, “The Iatrogenic Opioid Crisis: An example of ‘institutional corruption of pharmaceuticals?’” 1035.

by not critically appraising opioid products. While noting that the FDA is woefully underfunded, the FDA failed to control marketing of opioid products, yielded to public and political pressure, and engaged in financial conflicts of interest.⁴⁸⁶

Category II Influencers

- ❖ Pain Experts and Pain Societies – As we noted above, there was a revolution in patient care regarding pain, an increase in pain management practices, and open advocacy of more aggressive pain treatment. While intentions were in most cases well-intentioned, the study notes that “opioid-related payments from pharma may have influenced decisions of some experts and societies.”⁴⁸⁷
- ❖ Healthcare Publications – the study finds that the publication industry did not promptly correct or retract faulty studies or declare conflicts of interest where applicable.

Category III Influencers

- ❖ Accreditation, Licensing, and Regulatory Bodies – Chiefly among these is the Joint Commission. The study again notes conflicts of interest and the failure to recognize false pharma claims.
- ❖ Academic Institutions – “Of 58 teaching hospitals examined in the United States, 5.8% received opioid-related payments.”⁴⁸⁸

⁴⁸⁶ Ibid.

⁴⁸⁷ Makhinson, 1036.

⁴⁸⁸ Ibid.

- ❖ Funders – “Financial disincentives in both privately and publicly funded healthcare systems created and continue to create significant barriers, for the provision of effective care of chronic pain.”⁴⁸⁹

Category IV Influencers

- ❖ Pain Advocacy Organizations – in this category the study addresses the American Pain Association and its role.
- ❖ Frontline Professionals – Some frontline professionals, such as Arthur Van Zee, challenged pharma in early stages of the crisis. Others, however, were likely influenced by opioid-related payments. “Unsafe and unethical practices of some physicians, clinics, drug distributors, and pharmacists contributed to diversion for illicit use, as could have drug losses from hospitals and pharmacies.”⁴⁹⁰

Category V

- ❖ Patients and caregivers – These were likely influenced in one way or another by all the preceding categories. Patients and caregivers followed the medical advice of physicians who may have been influenced by pharma marketing.

This is an issue of pastoral concern because the population with which we work has been caught in a vice of influence that was largely invisible to them. I do not like the term ‘victim,’ but I must acknowledge that some of our population were indeed victims of unbalanced systems of medical power, profit, and influence. I do not believe most people set their minds toward the goal of

⁴⁸⁹ Ibid.

⁴⁹⁰ Makhinson, 1037.

becoming an opioid addict. I consider strong pastoral advocacy at many levels, including the political sphere, as an appropriate response to this imbalance of power.

Profit. We have covered a lot of material so far, so it should now be evident that one major factor behind much of these misdeeds is – money. In an industry that proclaims ‘do no harm’ as a guiding principle, harm, driven by motives of wealth, was unquestionably done. That harm includes chronic addiction, the destruction of families, overdoses, and thousands of overdose deaths. Pharma and health professionals benefited financially from pain management practices, both in direct income and by industry related conflicts of interest. Not only did the ‘healthcare’ industry become enriched by this opioid crisis, but it is also now re-enriching itself in the form of MAT and ‘recovery’ programs.

To emphasize one of the ironies of addiction treatment, I offer one anecdote. While working in a methadone clinic in 2018, one of my main responsibilities was to do an intake of new patients. This intake happened after a patient had seen the addictionologist and been accepted into treatment. Typically, the intake lasted one hour. During that hour I heard much of the patient’s life history and the history of their addiction. During one intake, I met with a man in his late-30s. He had just seen the physician and been accepted as a patient. That can be a stressful event for some, so I asked my standard check-in question, ““So how did it go with the doctor?”” and I expected a standard reply.

Instead, the patient dropped his head and snickered bitterly. “I’ll just be damned,” he said. “Do you know that ten years ago I had a bad car wreck. For months after I had this awful pain in my lower back, so I went to my regular doc. She referred me to a pain management clinic. And that’s where all this crap with opioids began. And do you know that when I go to see your doc

here to be treated for addiction, do you know what I see? *The exact same doc who ran that pain clinic, who gave me opioids in the first place!* And now here he is – gonna tell me about addiction. So, he’s making money at the front door and the back door. I just hope he has a nice house.” “A cattle farm,” I offered. In the words of Case and Deaton, “... it takes a strong stomach to watch pharma and their allies push MAT so that they can profit both by causing the epidemic and by curing it.”⁴⁹¹

In our society we venerate the medical profession, even to the degree, I suggest, of creating demigod status for physicians. Some of that praise is deserved. Physicians undergo a long course of training (like many others in other professions), work long hours, and face high expectations. They bear heavy responsibility for the outcomes of their patients. And they are well-compensated for these efforts. Some enter the profession for reasons that are noble-enough. Some manage to maintain that sense of nobility in their practice. Others do not. Just as we can say that there are bad ministers and priests, there are bad physicians. But the profit incentive should not be ignored as an influencer on health care.

According to the Centers for Medicare and Medicaid Services, National Health Expenditures (NHE) in 2020 grew 9.7% to \$4.1 trillion. This figure constitutes 19.7% of the Gross Domestic Product. National spending for health is projected to grow 5.4% annually to reach \$6.2 trillion by the year 2028.⁴⁹² Healthcare, among other things, is big business. That business model affects the type of care we all receive and its effectiveness.

⁴⁹¹ Case, Anne and Deaton, Angus. *Deaths of Despair and the Future of Capitalism*. (Princeton and Oxford: Princeton University Press, 2020): 129.

⁴⁹² Centers for Medicare and Medicaid Services. *National Health Expenditure Fact Sheet for 2020*. Accessed online on April 5, 2022, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>.

There is also what would seem to be an inappropriately close relationship between the healthcare industry and our organs of government. For example, in 2018, “the health care industry employed 2,827 lobbyists, more than five for each member of Congress.”⁴⁹³ In fact, the “industry spent more than \$567 million on lobbying in 2018, more than half from pharmaceutical companies. It is the largest spending industry, larger even than the financial industry, and spends more than 10 times as much as the *total* spent by organized labor.”⁴⁹⁴

To bring this a little closer to home, Case and Deaton single out a then-House Representative and now Tennessee Senator, Marsha Blackburn. “Congress passed the 2016 Ensuring Patient Access and Effective Drug Enforcement Act, whose language effectively *prevented* the DEA from stopping the flood of opioids in the US.”⁴⁹⁵ One of the bill’s sponsors was Representative Blackburn. Although Tennessee was one of the states most affected by the opioid crisis, Representative Blackburn and Representative Tom Marino of Pennsylvania, “fought against effective regulation, not for it; money and pro-business ideology subordinated the voices of those who had been addicted or were dying.”⁴⁹⁶ The Act turned into a national scandal, once the television news show, *60 Minutes*, investigated the close ties between these two representatives and the drug industry. The scandal, however, did not prevent Marino from becoming “drug czar” under President Trump, nor did it prevent Blackburn from being elected Senator.⁴⁹⁷

This issue is of pastoral concern if one believes that our faith cannot be separated from the actions of the polis. I happen to hold this position. What happens in the halls of Congress, frequently at the behest of well-funded and well-heeled lobbyists, affects our society. The

⁴⁹³ Case and Deaton, 210.

⁴⁹⁴ Ibid.

⁴⁹⁵ 125. My italics.

⁴⁹⁶ Ibid.

⁴⁹⁷ Ibid.

imbalance of wealth so much discussed in our society is reflected in the decisions made in Congress. The medical community holds and administers vast wealth and advocates effectively for their own issues. The issue has ramifications for pastoral advocacy and activism.

Pain. The fourth item is one that occupied a previous chapter, so I do not wish to cover the same ground. As we have seen, the experience of pain was one of the main drivers for patients to seek opioid relief. But we did not address the issue of pain pastorally. Those very people who sought relief from opioids *still* deal with pain and have *added* opioid addiction to their chronic problems. Some, after decades of pain management treatment still suffer greatly from the very pain they sought to relieve. As one who has lived with chronic pain for forty years, I certainly can identify with their desperation. Pastors should be willing to talk with their congregants and others about this desperation.

Keeping in mind these four lessons and all that we have covered, I wish now to move toward stating my own theory of pastoral theology and addiction. This will be based on the experiences I have had working in the addiction field for twenty years. It is also based on the rule of faith and our pastoral heritage.

Chapter Thirteen

Pastoral Theology of Addiction

“Wherefore there is no charity without hope, nor hope without charity, and neither without faith.”

Augustine of Hippo

The four issues of stigma, iatrogenesis, profit, and pain we discussed in the previous chapter highlight just four areas of concern for pastoral theology during a world-wide opioid crisis. In this chapter I will discuss ways in which we can address addiction pastorally. Before doing that, I want to offer my definition of addiction, which is modified from the American Society of Addiction Medicine definition.⁴⁹⁸ Addiction is a treatable, chronic biological process that involves complex interactions among brain circuit and genetics. Factors influencing addiction may include economic, sociological, genetic, racial, familial, public policy decisions and an intergenerational history of trauma. People who are addicted use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. To address addiction means treating all these factors: biology, economics, society, and trauma. This is the problem we attempt to address in a pastoral theology of addiction.

What I hope to emphasize is that if we address opioid addiction solely through the medical model, we will have failed at our efforts to offer healing. Healing addiction *includes* medical intervention, but medical intervention alone does not suffice. In fact, there are some who believe that medication assisted treatment is not appropriate at all. To recover from a national opioid

⁴⁹⁸ ASAM defines addiction: Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. [What is the Definition of Addiction? \(asam.org\)](https://www.asam.org/what-is-the-definition-of-addiction/).

crisis means addressing factors other than biological that led to addiction. Why did a person use opioids in the first place? Were there contributing socio-economic problems? Was the experience of chronic pain part of the addiction process? Is the person a product of the foster care system? What is the family history? Are there areas of trauma or alienation that need to be addressed? In other words, healing addiction is an all-community process that should address contributing factors of addiction.

One sphere that needs to be addressed is that of spiritual care. I am by no means an Augustinian scholar, but I have chosen to develop a pastoral theology of addiction by turning to Augustine of Hippo for two reasons. The first is a personal reason. When I was a youth recently returned to the faith, I took up *The Confessions*, which has become a well-worn text in my library. As a young man, I identified with the saint's checkered youth – and his honesty and frank nature. He is a giant of the faith and intellect, but even so I knew that he shared my human nature, that he was a real human being – precisely because of his early errors. That he made the turn from his life before Christ to his unwavering devotion as a pastor, scholar, and bishop encouraged me.

Second, as I have been thinking about this project and about pastoral theology, I returned to the *Enchiridion* because I believe it is the most succinct – and most profound – statement of the Rule of Faith that I have found.⁴⁹⁹ The small handbook is written to a Lawrence, about whom we know not much, but it is assumed he was a well-placed person in the system of the Roman Empire. To write the handbook, Augustine turned toward two basic elements: The Lord's Prayer

⁴⁹⁹ Augustine of Hippo. *Enchiridion de Fide: Faith, Hope, and Charity*. Translated by Bernard M. Peebles. In *The Fathers of the Church: Augustine, Vol. 4*. (New York: CIMA Publishing, 1947): 355-472.

and the Apostle's Creed. Incidentally, one of the classes I have taken at Emmanuel concerned the history of Biblical interpretation. In researching the history of the Slavic bible, I found that Frankish missionaries in the eighth century were the first to missionize the Slavs. Little is known about this history, except that they clearly began their mission work by teaching two basic elements: The Lord's prayer and the Apostles Creed. It seems to me a wonderful place to start.

In my previous work with this population, it has occurred to me that providing pastoral care is first and foremost a teaching ministry. Like me, many were raised in a church and schooled in the basics of the faith, and like me they strayed far from those roots. Those who had any upbringing in the faith, generally possess no more than a third-grade level of biblical literacy. Many with whom I have spoken may have a fond memory of a particular kindly pastor or of the church building itself. To bring them back to a consideration of the faith requires an element of teaching and evangelization. I would approach teaching within a chaplaincy context by stressing the Rule of Faith, with special focus on the Lord's Prayer and the Apostle's Creed. We will base a pastoral theology on these two elements, with the help of St. Augustine.

Augustine's Enchiridion

Augustine's first point in the *Enchiridion* is important to theology generally but is particularly important to a pastoral theology of addiction. He raises the question of the relationship between good and evil. Can we, for instance, say that a man is evil? We can agree probably that in our time Hitler, Osama bin Laden, Saddam Hussein, and Vladimir Putin have done evil acts, but are the men themselves evil?

Augustine asks, if the LORD God created all things, and if the LORD declared all things very good, then how can evil enter in? Augustine's response is to define evil as a privation of good.⁵⁰⁰ However, since the LORD created good at no point can we say that evil depletes and extinguishes good. "But the diminution of good is an evil, even though, howsoever it be diminished, somewhat of good must necessarily remain, to be the source of its being, if it's being is to continue."⁵⁰¹ If we said that evil had completely and utterly overtaken good, then what the LORD created no longer has existence – and this cannot be. Likewise, a person who is addicted, who may have committed crimes, is not irredeemably evil or bad. The good that God has given can never be extinguished.

Many of the Christian faith believe that humankind is fallen and only restored by the faith of Christ. I believe that it would perhaps be more accurate to say that evil has diminished, but not extinguished the good in us. Through the faith of Christ, we are restored to the good. This point is of particular importance for us. In my many conversations over the years, I have heard many reasons to give up on 'addicts.' They have lost their humanity and have engaged in evil behavior. They have been cast off from 'polite' society. They have 'gone off the reservation.' 'They have made their bed, let them lie in it.'

Yet the teaching of Augustine should nuance our understanding. Without a doubt, many who are addicted have engaged in behavior we find reprehensible and have seemingly defied that which we consider good in life. Evil has diminished them. It is, admittedly, quite difficult

⁵⁰⁰Augustine, *Enchiridion de Fide: Faith, Hope, and Charity*, Translated by Bernard M. Peebles, 376.

⁵⁰¹ Augustine, 377.

sometimes to see a child of God in the person sitting across from me. But it is a powerful lesson that, although diminished, the good in the person is not, cannot be, extinguished.

Not every human error is a sin, as Augustine points out in a colorful anecdote from his own life. “For example, it once befell me to take a wrong turn at a crossroads and thus not to pass by a certain place where, expecting me to come, an armed band of Donatists lay in wait for me. The result was that I reached my destination, but by a long detour. On learning of the plot, I congratulated myself on my mistake and gave thanks to God.”⁵⁰² I am certain, that I too have taken some long detours in my own life, as is true with others. On three occasions, it could have been said that I had completely lost my way. Through the grace of God, I took an exceptionally long detour, not recognizable as such at the time, but eventually regained my bearings, because it is the LORD’s “power and goodness such that even out of evil He can do good.”⁵⁰³ I believe the same can be true for others. A wrong turn is not the dead end of grace.

But how are we to define that which is good and that which is evil? Again the saint of Hippo provides an answer: “...the cause of the good things in which we are concerned is none other than the goodness of God, while the cause of evil things is a desertion from the unchangeable good on the part of the will of the changeable good...”⁵⁰⁴ Others could provide a different answer to this question of good and evil, but as people of faith, good is defined as that which proceeds from the LORD, while evil is anything which would try to diminish this good. While it is not the aim of the type of chaplaincy that I propose to evangelize relentlessly those who first

⁵⁰² 382.

⁵⁰³ 376.

⁵⁰⁴ 391.

need to hear some basic good news, we should be frank and honest about the source of our hope and stand ready to provide a defense of that hope.

The method through which we approach a discussion of our faith with those who are addicted is important. The short documentary film *Heroin(e)* follows the efforts of three women from different fields who all have a common goal to combat opioid overdose in their community of Huntington, WV.⁵⁰⁵ If West Virginia is the epicenter of the opioid crisis, Huntington is the epicenter of the crisis in West Virginia. It has the highest overdose death rate in the nation.

One of the women is a pastor who runs *Brown Bag Ministries*. She relates that her original idea had been simple. She would pack a brown bag lunch, take some Gospel tracts, and find one of the many addicted prostitutes on the streets of the city. She would offer them a brown bag lunch, tell them to sit down, and hand them the gospel tracts. She says that she thought that by this method she would bring the ladies to Jesus. She laughs recalling her naivety and says, “That’s just not how this works.”

It is not how it works. What works is in fact a lot of work, patience, prayer, and persistence. In Northeast Tennessee I find it hard to believe that there are people who have not ‘heard the gospel.’ (I will check this assumption in the qualitative research that follows). I assume based on my experience so far, that many if not most have at least a passing acquaintance of the faith but have not had an adult experience of the church’s teaching. Many will have a basic Sunday school

⁵⁰⁵ *Heroin(e)*, is a short documentary by director Elaine McMillon Sheldon. Release date was September 3, 2017. The documentary follows three women who respond to the overdose crisis in Huntington, WV. Huntington is known as the overdose capital of the U.S.

or Vacation Bible School level of training in the faith. This is why I would want to return to the basics – to the Apostle’s Creed and the Lord’s Prayer.

If we are addicted, it would be easy to believe the lie that sin has vanquished us. We all lie in a state of sin, but that is not the LORD’s last word.

Yet the goodness of the Creator does not fail to supply even to the evil angels that provision of life and quickening-power without which they would perish; nor for men, springing though they do from a corrupted and condemned state, does he fail to form and vivify their seed, just lead to dispose their bodily parts, and in all changes of season and place to enliven their senses and give provision of food. He judged it better to bring good out of evil than not to permit evil to exist at all.⁵⁰⁶

Indeed, not only are we provided our daily bread and delivered from evil, the LORD even promises to lift us up and make us the commanders of angels. This is possible through the LORD’s will, never through the works of humankind.

⁵⁰⁶ Augustine, 392-393. “Deliver us from evil.”

Because flesh, humanity, is important to and redeemable by the LORD, Christ came into the world, born of the Virgin Mary, to restore humanity to good in Christ.⁵⁰⁷ Taking on our human nature,⁵⁰⁸ Christ is fully man and fully God.⁵⁰⁹ He is in this unique position to be our greatest mediator (Hebrews 8: 1-13). Through Christ's assumption of humanity, humanity is raised "into the unity of the person of the only son of God."⁵¹⁰

This is tremendously good news. Through Christ, even sinners, through repentance and restoration, can be raised into the nature of Christ and into the heavenly places. There is wretchedly little good news

in the world of addiction, where the addicted stumble from one theft to another to support their habit; where they, with blinders on, seek the next injection, where they betray the love of family and friend. In a world devoid of purpose except addiction, what gives life meaning? It is little wonder that coroners cannot determine whether an overdose death was in fact a suicide. What do we say to those who do not even know they need good news? We start from the foundation, from the basics of faith. If in our ministry we find those who have not been baptized, if they are

The Apostle's Creed

I believe in God, the Father Almighty,
maker of heaven and earth;

And in Jesus Christ his only Son, our
Lord;
who was conceived by the Holy Spirit,
born of the Virgin Mary,
suffered under Pontius Pilate,
was crucified, dead, and buried;*
the third day he rose from the dead;
he ascended into heaven,
and sitteth at the right hand of God the
Father Almighty;
from thence he shall come to judge the
quick and the dead.

I believe in the Holy Spirit,
the holy catholic church,
the communion of saints,
the forgiveness of sins,
the resurrection of the body,
and the life everlasting. Amen.

⁵⁰⁷ 400.

⁵⁰⁸ Philippians 2: 5-7.

⁵⁰⁹ Creed of Chalcedon: Born of the Virgin Mary, the mother of God, according to the manhood; one and the same Christ, Son, Lord, Only-begotten, to be acknowledged in two natures, without confusion, without change, without division, without separation; the distinction of natures being by no means taken away by the union, but rather the property of each nature being preserved, and concurring in one person and one subsistence, not parted or divided into two persons, but one and the same Son, and only begotten, God the Word.

⁵¹⁰ Augustine, 401

willing, we have a Christian duty to catechize and baptize.⁵¹¹ For those who have been baptized, we remind them of the faith of Christ and the faith of our mothers and fathers, handed on to us in a line of succession for two thousand years. We call them to confession, repentance, amends and to a new life in Christ – if they will but have ears to hear.

From the first day that I worked as a chaplain in a methadone clinic at the Menlo Park Campus of the Palo Alto VA (2001) to this very day, I have heard a constant refrain from the addicted persons with whom I worked. It goes roughly like this. “I can forgive anyone for anything they have done to me, but I can never forgive myself for the things I have done.” That was a thematic statement that I pondered. What does that mean, actually? At first, I took it as a statement of hubris. MY sins are so much greater than yours that I cannot be forgiven. That is still a possibility, but I have decided to give a more charitable reading. It, among other things, is a cry of deep despair – the sort of despair that we learned of from Case and Deaton. It is a despair that cries out for good news.

Regarding the Church’s role in the forgiveness of sins, Augustine reminds us that we should never despair in offering God’s mercy even to “crimes howsoever great.”⁵¹² The grief and despair of the sinner may not be evident to all, but it is certainly evident to the LORD Almighty, who “does not despise a contrite and humbled heart.”⁵¹³ Indeed, one of the Church’s most vital roles is to hear confession, to lead to repentance of sin, to encourage amends of ill done, and to proclaim the good news of restoration and resurrection.

⁵¹¹ 407.

⁵¹² 424.

⁵¹³ Ps. 50. 19.

What Augustine has to say regarding the role of the Church is so important that I want to present it in its entirety.

The whole Church is to be understood here, not only that part which is in pilgrimage on the earth, from the rising of the sun to the going down of the same praising the name of the Lord and singing a new song after its old captivity, but also that part which is always in heaven, which ever since its foundation has always remained steadfast to God and has never experienced any evil consequent upon a fall... The two parts will make one fellowship in eternity and now are one in the bond of charity, ordained together as a whole for the worship of God.⁵¹⁴

The whole Church, in heaven and on earth is united in charity, and it is charity that I would hope from the Church in its approach toward those who are suffering from opioid addiction. As I tried to convey from the opening quote of this chapter, charity and hope are linked together, and neither is possible without the faith of Christ. That faith is present here on earth, but is upheld and encouraged by the heavenly Church, by the faith of those who have preceded.

For Augustine, the daily recitation of the Lord's Prayer has a critical place in our life.

For these can say "Our Father who art in Heaven," Since to such a father they have been born again of water and the spirit. This prayer completely washes away very small sins of daily life. It also washes away those sins which once made the life of the believer very wicked, but which, through penance changed for the better, he has given up, provided that as truly as he says: "Forgive us our debts," (Since there is no lack of debts to be forgiven), so truly does he say: "As we also forgive our debtors..."⁵¹⁵

According to Augustine, then, the Lord's Prayer contains the essence of the Christian faith, and its recitation provides forgiveness of sins, but just as importantly, a reminder that others have also forgiven us. The saint also reminds us: "Now what sins are trivial and what are grave it is for divine judgment, not human judgment, to decide."⁵¹⁶

⁵¹⁴ Augustine, 416-417.

⁵¹⁵ 429.

⁵¹⁶ 435.

Of the nature of sin, Augustine writes that there are two causes, “either through not yet seeing what we ought to do, or through not doing what we have already seen ought to be done.”⁵¹⁷ I believe this is vital in assisting the person who would say, “I can forgive anyone what they have done to me, but I can never forgive myself.” In this case, it would be helpful to lead the person to see what they ought to do, or what they knew they should have done, but did not do. I believe in this regard that the teaching of the Twelve Steps regarding making amends is of first importance. It is not enough simply to say, ‘forgive me.’ I must seek out the persons I have harmed and find a way to make amends. This step is also embedded in the Church’s pastoral office of Confession.

I should point out that in my experience some of those who are addicted are recalcitrant. Some will be unwilling to abide by any discussion of spirituality or faith. We must accept that some will remain in this state to their death day, and we must entrust them to the mercy of God. We do not compel faith. We can guide, lead, encourage, but the choice regarding faith, in the end, is between our friend and God.

This brief introduction with Augustine as a guide points out the importance of the Lord’s Prayer and the Apostle’s Creed as a basis for theology, in our case, pastoral theology. If I should be able to make another attempt of working with an addicted population in a pastoral role, after I had probed their level of faith and understanding, I would start by teaching the Lord’s Prayer. Here I want to explicate the Lord’s Prayer in order to say ‘out loud’ what the prayer means to me. It, I believe, summarizes concisely what Jesus believed and what he wanted to teach his disciples. The prayer is a condensed and powerful statement of faith, whose words are sometimes

⁵¹⁷ 439.

deadened by rote recitation. An explication of our understanding of the prayer is one attempt at countering rote recitation.

The Lord's Prayer

Our Father We are bold to make this claim. First, we should note the plural possessive pronoun. 'Our' emphasizes community over individual. The LORD is not 'mine.' We share as a community in the ability to call God 'Father.' The Father is mine, and yours. It logically follows, then, that you and I, and our believing population, are brothers and sisters. It indicates that we are indeed brothers and sisters of Jesus himself.

That Jesus identified God as Father impacts deeply the way that we see God. God is not, for instance, a thunder god, or a fertility god. God, in Jesus' teaching, is a father. That claim can be disturbing for those for whom a father is not a positive image - for those, as with those of our population, who grew up with an absent or abusive father. I am also aware that for some women the idea of addressing God through male imagery alone is an obstacle. So, this would be the first starting point for a conversation. What does Jesus, who appears not to have even *had* a biological father present for *his* life hope to convey by identifying God as Father? He states his meaning in the next phrase.

Who art in heaven – Ah, *that* father, completely distinct from any other we have known. This one dwells in heavenly places. Father is the head of *that* household, and by implication, ours. This father, it would seem, is far, far away from us, in emotional distance; yet this father cares enough about the household of earth, that *this* father sends a son to take on our human nature, by which we are redeemed. Distinguishing between the earthly fathers we have known and our Father in heaven may help some of our population to abandon the grudges and bad memories

that they nurture. For those who are earthly fathers, who have children, we point the way to the good, true father from whom we derive goodness.

Hallowed be thy NAME – Hallowed is an odd word for the modern ear, but we retain it perhaps precisely because of the specialness it conveys. We may speak of Gettysburg as hallowed ground, for instance, but even this significance falls short of the holiness of the NAME. The NAME has special significance in our tradition, as well as in the Jewish and Muslim traditions. So holy is the NAME that we do not know it and cannot pronounce it. We are not on a ‘first name’ basis with God. The LORD is not a pal, but the creator and redeemer of all creation. God alone is holy. We have a name, known by God. The LORD is holy, while we strive toward perfection, seeking the face of the LORD through a dark glass.

Thy kingdom come – John the Baptist (Matt. 3. 2) and Jesus (Mark 1. 14) began their ministries with a proclamation of repentance because the kingdom of God is at hand. In Mark, Jesus’ proclamation is connected to “the gospel of God.” Jesus’ call to proclaim this gospel follows his temptation in the wilderness, and he leaves that place charged to heal and to teach. When Jesus commissions and sends out the twelve (Matt. 10. 7) and the seventy (Luke 10. 9) he does not instruct them to proclaim, “Jesus Christ and him crucified” (1 Cor. 2.2). For Jesus, the gospel is that the kingdom of God has come near.

We pray daily across the world for the kingdom to come, which implies that the kingdom of God is on the tips of our noses, and yet in a distant land. The kingdom of God is already-here-and-not-quite-yet. The kingdom of God is like a semicolon in the history of the salvation of humankind; One thought has started, to be continued in another clause.

But what does it mean to pray for the kingdom? Tertullian somewhat spiritualizes the meaning when he says that we pray for the kingdom to come, “*In us*, of course.”⁵¹⁸ This meaning is of course essential to the prayer. The prayer should change the believer. And in the adage of the church, ‘praying shapes believing.’ So, the prayer has power at the individual level. Bring your kingdom in me now.

There is, I believe, another level to the meaning of thy kingdom come, that is echoed in one of the first ejaculatory prayers of the church, “Maranatha,”- Our Lord, come (now) (1 Cor 16. 22).⁵¹⁹ We know that the Lord will come in a great apocalypse riding on the clouds to establish his kingdom forever to put all foes under foot (Daniel 7.13). That sense of the kingdom coming in a final victory is both liberating and terrifying, because it signifies the end of the world as we know it. Even if this world is quite broken, it is still the brokenness with which we are acquainted. The kingdom coming in an already-here-and-claiming-the-world-forever sense also includes a final judgment, when we must stand and make an account of our life and faith.

In this sense, to pray for the kingdom to come is to pray for the end of human time, a quite staggering thought. It is one of the reasons we warn the congregation liturgically before we commence the recitation of the Lord’s Prayer, “And now, as our Savior Christ has taught us, we are *bold* to say...”⁵²⁰ We *are bold* to pray the Lord’s Prayer, to make the claim that we are the children of the Most High, and to pray for the kingdom to come at this instant in time.

⁵¹⁸ Tertullian. “Treatises Regarding Prayer.” Accessed online on July 19, 2022, at [Tertullian : Souter, A. -- Tertullian's treatises Concerning Prayer.](#)

⁵¹⁹ Alternatively, The Lord has come.

⁵²⁰ The Episcopal Church. *Prayer Book and Hymnal*. (New York: Church Publishing, 1986). Eucharistic Prayer A, 363. My italics.

The boldness of this claim is exemplified for me in a personal incident that occurred in 1995. After my mother's murder and her funeral, I stood outside Tetrick Funeral Home in Elizabethton with one of my most favorite people in the world, my uncle Ronnie. Ron is a veteran of the Vietnam War and served in Danang in the middle of the Tet Offensive. He is acquainted with loss, death, terror, and horror. Yet we were both stunned by my mother's loss. We stood quietly while Ron smoked a cigarette. It was a moment of solemnity and revery. Suddenly a hot rod pulled around the corner and blazed past us with music blaring, breaking that moment of peace. I looked at Ron, who shook his head and said, "Life goes on, Kevin," - and after a moment of thought he added, "but it shouldn't."

Yes, life as we know it goes on, and it should not. That is the already and not yet. I want this world to end, for the Lord to come so that the Savior can establish *that* kingdom, the one I am praying for. I am praying for an end to the broken world I know and asking for the Lord's world to come.

Oddly enough, I see that as good news. Our population knows all too well the brokenness of this world. They know depression, loss, and despair. They know the endless cycle of addiction: search, score, use, withdraw, search, score, use, withdraw. They feel lost in that shadowy underworld of crime and obeisance to an opioid master. What would put that world right? We place hope in medical inventions and interventions, but even the most effective treatment will not make the world right. Our population will always carry the trauma of their addiction experiences. What puts the world right? What puts a period at the end of our sentence? 'Thy kingdom come.'

Thy will be done – The kingdom comes because God’s will shall be done. Not my will, for heaven’s sake. Not the will of a preacher, or a political leader, or a military savior. Only the will of the Most High can initiate the kingdom we pray for.

That wisdom - that my will alone will ruin my life and that of others - is enshrined in the Twelve Step movement. The second and third Steps are: (2) Came to believe that a Power greater than us could restore us to sanity and (3) Made a decision to turn our will and our lives over to the care of God as we understood Him. Not my will, but the will of the Lord Most High; in this is the way of wisdom.

Many of our population will be familiar with the steps through attempts at sobriety in the Celebrate Recovery or Narcotics Anonymous movements. “Restoration of Sanity” is one of the most apt descriptions of a new life without drugs that I can find. Indeed, the life of those who live with addictions of all sorts is a world out of control. To paraphrase a Yeats’s poem, the falcon has flown farther and farther from the center, out of control, far from the will of the falconer.⁵²¹ We pray to return to the center, to the will of the Most High.

On earth as it is in heaven – During a spiritual retreat at Nashotah House, a seminary of the Episcopal Church in Wisconsin, I was taught to say, ‘here on earth as it is already being done in heaven.’ That interpretation emphasizes a ‘two-world’ sort of understanding of our existence. We live our daily lives – rise in the morning, shower, get dressed, eat breakfast, go to work, work, eat lunch, come home, eat supper, spend some time with family or friends, go to sleep, rise in the morning and repeat. Sometimes we are quite content with our lives. For some period,

⁵²¹ Yeats, William Butler. “The Second Coming.” In *The Collected Poems of W. B. Yeats*. (New York: Macmillan Publishing, 22nd Printing, 1976): 184-185.

perhaps years, we can live our lives in peace. But for some, insanity in many forms breaks into our routine. Events we cannot control – the death of a loved one or friend, the loss of job and vocation, chronic illness, and most recently the threat of the COVID-19 pandemic – seem to exert their will over us. At those moments, perhaps more than at any other, we want to know our goal in life. What is the meaning of this routine?

While we are living our lives there is another life, the life of the LORD in heavenly places running parallel to ours. That is the end, the world we are striving for. The promise is of a kingdom where peace rules, where we know who is in charge, and that One has our interests in mind. That world is eternal, this world will last for us for 70, maybe 80 years.

I was once on an elevator at the Vanderbilt Medical Center. I was wearing clericals because I had been called as a chaplain to a case in the Burn Center. On one floor a physician joined me in the elevator as we rode up. He looked at me quizzically and then said, “You know, we get them for maybe 80 years. You get them for eternity.” I remember that as a nice expression of what it is we believe. Many millions of human beings have preceded us in life. Many millions more will possibly live after us. We live now with a certain cohort of the alive, all living at the same time in different places. But we are always accompanied by a host of saints in heaven. This understanding offers both an end (to our lives here) and a beginning with a communion of saints.

Give us this day our daily bread – There are times when I might like to spiritualize this petition. Give us, for instance, the daily bread of Holy Communion. Grant me the bread of prayer to nourish my spiritual life. But generally, I pray for bread, warm from the oven.

The Russian anarchist, historian, and revolutionary Prince Peter Kropotkin (1842-1921), drawing on his experiences of revolutionary movements, wrote an entire book dedicated to the

provision of bread for the revolutionary masses, *The Conquest of Bread*.⁵²² It is an appeal to fellow revolutionaries that they should not be so overcome by revolutionary fervor that they neglect the practicalities of life: bread, food. Many a revolutionary effort has been lost because, in the end, the revolutionaries failed to provide for structure, for food, drink, shelter, and labor, all distributed equally. He bewails the social divisions that make rich and poor and says, “All belongs to all.”⁵²³ When they demonstrated in marches, Russian revolutionaries carried placards with one simple word, ‘Bread.’ A simple plea for the most basic provision of life. So important is this that Kropotkin writes, “bread must be found for the people of the Revolution, and the question of bread must take precedence over all other questions.”⁵²⁴

Jesus, our spiritual teacher and healer, was quite aware that he and his disciples must provide for the practicalities of life, for daily bread. In fact, the ‘Feeding of the 5,000’ is the only miracle recorded in all four gospels (Matt. 14. 13-21; Mark 6. 31-44; Luke 9. 12-17; John 6. 10-14). Responding to his disciples’ appeal to send the crowds away, crowds who had spent a long day in remote places to hear the teaching of Jesus, Jesus responds to his disciples, “You give them something to eat” (Matt. 14. 16; Mark 6. 37; Luke 9. 13). Jesus in the miracle of the 5,000 has compassion on the earthly lives of those who follow him, providing food. It is no small matter.

Indeed, food and drink are a constant theme of the gospels, from the feeding of the throngs to the provision of wine for an ill-planned wedding (John 2. 1-11), to his disciples’ harvesting wheat heads (Matt. 12. 1; Mark 2. 23), to grilling fish by the sea (John 21. 9). Any movement

⁵²² Kropotkin, Knyaz Petr Alekseevich. *The Conquest of Bread*. (New York: Vanguard Press, 1926 Kindle Edition.)

⁵²³ Kropotkin, Petr, *The Conquest of Bread*, 27

⁵²⁴ Kropotkin, 62.

following Christ should then provide both for the spiritual needs of followers and for the earthly, practical needs of food and drink.

For years that provision of food and drink has been a cornerstone of my own ministry. Providing meals for the homeless brought together homeless men and church people, forming, at least for a time, a communion. Working in Harlem with persons with serious mental illness, whose primary defense mechanism was isolation, I learned that I could bring them together to celebrate a simple meal. Any future ministry, including this chaplaincy effort, should center, of course, on the Good News, but part of the good news is the human communion and sustenance to be found in a common meal.

And forgive us our trespasses – Two lines of the Lord’s Prayer concern forgiveness, one of the most profound teachings in our tradition. The order is important. First, we ask forgiveness for all our trespasses, debts, sins, peccadilloes, and crimes. This is important because in asking forgiveness we realize that none of our sins can exhaust the inexhaustible font of forgiveness, grace, and mercy, which are the properties of God. Nothing I have done is unforgiveable in God’s eyes, but I must take the first step. I must petition the LORD. I can only do that from a place of profound humility, in some cases even humiliation. I can only do so if I acknowledge that the LORD’s power is greater than I.

As we forgive those who trespass against us – ONLY when we have asked for forgiveness for ourselves, can we THEN draw on this font of mercy and grace to forgive others. I believe this is the fundamental problem my clients have encountered when they say they can forgive others but not themselves. This is more than a procedural issue. I only learn about forgiveness because I have first been forgiven. Then and only then do I begin to understand the power of the LORD’s forgiveness so that I can then begin to draw on my own small pot of grace to forgive others.

I feel I must comment from personal experience about forgiveness. Sometimes the church can be cruel in demanding immediate forgiveness for incredible crimes committed against us. I am thinking of the parents left standing after losing a child in a school shooting or like abominable crime. We cannot demand immediate forgiveness. In fact, that is cheap forgiveness, a purely procedural forgiveness, usually the kind that satisfies a pastor's or congregation's need for a structured world, not the need of the one who has suffered.

Sometimes immediately after a shooting, a victim's loved one is interviewed on television and *the day* of the murder says, "I forgive." As well-intentioned as that is, and as well-scripted as that is by a pastor, I know from personal experience that this forgiveness was a toss-out, a conditioned response. I believe that if we returned to that same person six months later, a year, or ten later we would most often find a person who has struggled internally with the idea. How DO you forgive someone for the death of a child or loved one?

No, forgiveness is, should be, hard work. We must do the work of forgiveness, beginning by examining our sins first, by repenting, making amends, and seeking forgiveness by the LORD's miraculous grace. In my own tradition in the liturgical *Reconciliation of a Penitent*, the penitent uses this form:

I confess to Almighty God, to his Church, and to you, that
I have sinned by my own fault in thought, word, and deed, in
things done and left undone; especially _____. For these
and all other sins which I cannot now remember, I am truly
sorry. I pray God to have mercy on me. I firmly intend

amendment of life, and I humbly beg forgiveness of God and his Church, and ask you for counsel, direction, and absolution.⁵²⁵

From this form and from the Catholic and Lutheran equivalents, we see the work that must be done. We confess our sin to the Church in the person of the pastor. We ask for the LORD's mercy. And the church demands amendment of life. That step is important. Typically, the pastor, having expressed the LORD's forgiveness, must ask the penitent to make amends. If the penitent has stolen \$100, then \$100 must be returned to the wronged. If the sin is more spiritual in nature, then the pastor will assign a spiritual act for the penitent to complete. And then the penitent *begs* forgiveness from God and the Church, asking for counsel, direction, and absolution.

Forgiveness, which is one of the often-preached themes of the Church, is, I believe, one of the least well-practiced. Jesus, in this teaching to his disciples, emphasizes the importance of forgiveness, first of ourselves, and then of others. We pray for the LORD to grant us the grace to act from the grace that the LORD first granted us.

And lead us not into temptation – Jesus was led into temptation. According to Mark, immediately after the baptism of Jesus, “And the Spirit immediately drove him out into the wilderness. He was in the wilderness for forty days, tempted by Satan; and he was with the wild beasts; and the angels waited on him” (Mark 1. 12-13). By defeating the tests of Satan, the Lord is empowered to go forth in his mission of preaching, teaching, and healing. I am too weak to do in like manner – and Christ knows this. No human, not even the most practiced spiritual being, can undergo the test the way that Jesus did. I have the power to overcome some daily temptations – not to eat

⁵²⁵ The Episcopal Church. *Prayer Book and Hymnal*. (New York: Church Publishing, 1986): 444.

foods that are bad for me, not to spend the time the LORD has granted me by staring at my phone. But I do not believe this is the sort of temptation Jesus speaks of. Lead us not into the sort of temptation by which Jesus was tried, because we are unable to conquer Satan on our own, without the power of Christ standing by us.

But deliver us from evil – I recall a line from memory of the Steinbeck classic, *The Grapes of Wrath*, when one of the characters, a former preacher, Jim Casy, who, in his journey west with other ‘Oakies’ believes that he has come to a spiritual awakening. In thinking about evil, he says that evil, “is just the bad things men do.” I believe that to be a deep and common-enough error. I do believe there are powers of evil in this world. Jesus certainly believed that we are engaged in a war against the powers of evil. One of Jesus’ primary functions was to “bind the strong man” (Mark 3.27). I believe our common error is to believe that we are delivered from evil because there is no such thing in our modern world as evil.

I have seen the ‘bad things that men do.’ As an intelligence analyst, I am keenly aware of the horrors perpetrated on civilian populations in acts of war. I have also witnessed acts that have no explanation, acts that I can only name and understand as evil. There is a temptation to name the bad things men do as evil, but we should do so with spiritual discretion. Not all bad things are evil, but when we are truly confronted with evil, we pray that we may be delivered.

For thine is the kingdom, the power and the glory – This is a spiritual affirmation of all that has preceded. The Lord’s Prayer, which seems simple enough on the surface, and which we recite liturgically by rote, is one of the most profound teachings of Christ. It is worthy of our devotion, but also of our sincere practice, with spiritual understanding, made possible only because the LORD alone is LORD.

This chapter has attempted to state a theology of care, which is rooted in two basic elements: The Apostle's Creed and the Lord's Prayer. I believe that in these two elements we find a concise yet profound statement of the faith. It is from this faith that any ministry of healing springs. Stating our faith now grounds us to move forward to consider what healing means to a population addicted to opioids.

Chapter Fourteen

Healing

A week later his disciples were again in the house, and Thomas was with them. Although the doors were shut, Jesus came and stood among them and said, 'Peace be with you.'

John 20: 26

In the last chapter we made a modest effort to formulate a pastoral theology of addiction based on the restoration of sanity through the good news of Jesus Christ and we focused on a teaching ministry to the lapsed and a catechetical ministry to the unbaptized based on the Lord's Prayer and the Apostle's Creed. 'Resurrecting the person,' to recall Swinton, includes healing, as Jesus demonstrated in his own ministry. In this chapter we will focus on the healing ministry of Jesus to understand better what Scripture means by healing. We will compare that meaning of healing with medical treatment. We will find some significant differences. The differences between healing and treatment, I believe, are significant. That difference should drive our project.

Gospel Healing

Jesus' earthly ministry was expressed in itinerant preaching, teaching, and healing. It is this last ministry, that of healing, that I want to focus on in this chapter. In this short essay, we will examine the acts of healing recounted in the Gospel of Mathew.

For over thirty-five years, I have pondered Jesus' acts of healing. I can understand the expression of his ministry in preaching and teaching, and particularly appreciate his use of parable to instruct his followers. But why did Jesus walk from town to town, healing people, seemingly randomly? What did that healing signify? If he is Lord, why could he simply not

banish all disease, paralysis, blindness, epilepsy, and loss of function to the outer regions? Why could he simply not restore the world and why did he heal in instantiated, personified episodes?

I suppose that my questions about healing are rather like questions posed by those masses who followed Jesus, that they perhaps are like the questions that Job's interlocutors present, or resemble even the questions of Jesus' tempter in the wilderness. Could you not just solve hunger of the world (and Jesus' own) by turning all these stones into bread? (Matt. 4. 2-3). Is he not the king that we imagine, and can he simply not set up the Davidic kingdom that we have awaited? I propose to explore my questions by an exegesis of the healing events presented in Matt. 4.23-9.35

Matthew seems to have formed an *inclusio* that stretches from Matt. 4.23 to 9. 35, being set off by the bookend comments *healing every disease and every infirmity* (see table below). If the writer intended this literary device, then the writer did so to set apart this text for special consideration, as it summarizes Jesus' teaching and healing ministry. If this is true, then we should pay close attention to the *inclusio*.

Before we look at the specific instances of healing, we should set them in some context. According to Matthew, Jesus is baptized in the Jordan by John the Baptist (4: 13-17) and a voice from heaven claims Jesus as beloved son. Immediately after this experience Jesus "was led up by the spirit" to be tempted by the devil (4: 1). This temptation lasted forty days. Jesus clearly wins the contest with "the tempter" (4: 11) and angels minister to Jesus. After the arrest of John the Baptist, Jesus left Nazareth and 'dwelt' in Capernaum by the sea (4: 13). It is then that Jesus begins his preaching career, proclaiming specifically, as John had, that the kingdom of heaven is at hand and calling for repentance (4:17). We will now turn to look at Jesus' ministry of healing within the bounds of the *inclusio*.

| Verse | Passage | Comment |
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| Matt. 4: 23 | Jesus went throughout Galilee, teaching in their synagogues and proclaiming the good news of the kingdom and curing every disease and every sickness among the people. | The phrase ‘ <i>healing every disease and every infirmity among the people</i> ’ is repeated at 9.35. We will return to this in the commentary. |
| Matt 4: 24 | So his fame spread throughout all Syria, and they brought him all the sick, those afflicted with various diseases and <i>pains</i> , demoniacs, epileptics, and paralytics, and healed them. | We looked in detail at the relationship between pain and the opioid crisis. I believe this is the only mention of Jesus healing pain in Matthew. This is a specific list of the types of disease and infirmity Jesus heals. |
| Matt 8: 2-4 | And behold a leper came to him and knelt before him saying, ‘Lord, if you will, you can make me clean.’ And he (Jesus) stretched out his hand and touched him saying, “I will. Be clean.” And immediately his leprosy was cleansed. And Jesus said to him, ‘See that you say nothing to anyone but go, show yourself to the priest and offer the gift that Moses commanded, for a proof to the people.’ | We should note that the leper <i>petitions</i> for healing, to which petition Jesus responds favorably. Jesus also insists on complying with ritual patterns of the Temple. There is a binary here of clean/unclean that will be useful to keep in mind regarding our population. |
| Matt 8: 5-13 | As he (Jesus) entered Capernaum, a centurion came forward to him, beseeching him and saying, ‘Lord, my servant is lying paralyzed at home, in terrible distress. And he said to him, ‘I will come and heal him.’ But the centurion answered him, ‘Lord, I am not worthy to have you come under my roof; but only say the word, and my servant will be healed. For I am a man under authority, with soldiers under me; and I say to one, ‘Go!’ and he goes, and to another, ‘Come!’ and he comes, enter my slave, ‘Do this!’ and he does it.’ When Jesus heard him, he marveled, and said to those who followed him, ‘Truly, I say to you, not even in Israel have I found such faith. I tell you, many will come from east and West and sit at table with Abraham, Isaac, and Jacob in the Kingdom of heaven, while the sons of the Kingdom will be thrown into the outer | The Gospel dedicates significant literary space to this pericope. Here we see that even a Roman officer can appeal to Jesus, and Jesus responds. Clearly it is the centurion’s faith in Jesus that motivates Jesus to an act of healing. The servant seems to have been healed by word alone. |

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| | darkness; their men will weep and gnash their teeth.’ add to the centurion Jesus said, ‘Go! Be it done for you as you have believed.’ And the servant was healed at that very moment. | |
| Matt 8: 14-15 | And when Jesus entered Peter’s house, he saw his mother-in-law lying sick with a fever; he touched her hand, and the fever left her, and served him. | This is one instance where there appears to be no petition. Jesus enters, sees the situation, and heals the mother-in-law. |
| Matt 8: 16-17 | That evening they brought him many who were possessed with demons; and he cast out the spirits with a word and healed all who were sick. | Healing also entails exorcism. Jesus needs only speak to heal. |
| Matt. 8: 28-31 | And when he came to the other side, to the country of the Gadarenes, two demoniacs met him, coming out of the tombs, so fierce that no one could pass that way. And behold, they cried out, ‘What have you to do with us, oh son of God? Have you come here, to torment us before the time?’ Now a herd of many swine was feeding at some distance from them. And the demons begged him, ‘If you cast us out, send us away into the herd of swine.’ And he said to them, ‘Go!’ So they came out and went into the swine; and behold, the whole herd rushed down the steep bank into the sea, and perished in the waters. The herdsman fled, and going into the city they told everything, and what had happened to the demoniacs. And behold, all the city came out to meet Jesus; and when they saw him, they begged him to leave their neighborhood. | Here there is not only no petition, but fierce opposition to the will of Jesus. Their only petition is to be cast into a herd of swine. Just like the centurion who says ‘Go!’ to one of his men, Jesus commands the demons to depart. This ‘healing’ is not appreciated by the locals. |
| Matt. 9: 1-8 | And getting into a boat he crossed over and came to his own city. And behold, they brought to him a paralytic, lying on his bed; and when Jesus saw their faith he said to the paralytic, ‘Take heart, my son. Your sins are forgiven.’ And behold, some of the scribes said to themselves, ‘This man is blaspheming.’ But Jesus, knowing their thoughts, said ‘Why do you think evil in your hearts? for which is easier to say, ‘Your sins are forgiven’, or to say ‘Rise and walk’? But that you may know that the son of man has authority on earth to forgive sins he then said to the paralytic, ‘Rise, pick up your bed and | There is a flurry of healing activity reported throughout Chapter 9. The Pharisees wish to argue a point of theology; Jesus wishes to heal. Healing in this instance entails forgiveness of sins. |

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| | go home.’ And he rose and went home. When the crowds saw it, they were afraid, and they glorified God, who had given such authority to men, | |
| Matt. 9: 18-26 | While he was thus speaking to them, behold, a ruler came in and knelt before him, saying, ‘My daughter has just died; but come and lay your hand on her, and she will live.’ And Jesus rose and followed him, with his disciples. And behold, a woman who had suffered from a hemorrhage for twelve years came up behind him and touched the fringe of his garment; or she set to herself, ‘If only I touch his garment, I shall be made well.’ Jesus turned, and seeing her he said, ‘Take heart, daughter; your faith has made you well.’ And when Jesus came to the ruler’s house, and saw the flute players, and the crowd making a tumult, he said, ‘Depart, for the girl is not dead but sleeping.’ and they laughed at him. But when the crowd had been put outside, he went in and took her by the hand, and the girl arose. | The healing ministry of Jesus extends even to resurrection of the daughter (who is presumably twelve) and the spiritual resurrection of a woman who has hemorrhaged for twelve years. In both cases faith initiates the act of healing. |
| Matt. 9: 27-31 | And as Jesus passed on from there, two blind men followed him, crying aloud, ‘Have mercy on us, son of David.’ he entered the house, the blind man came to him; and Jesus said to them, ‘Do you believe that I am able to do this?’ they said to him, ‘Yes, Lord.’ then he touched their eyes, saying, ‘According to your faith be it done for you.’ And their eyes were opened. And Jesus sternly charged them, ‘See that no one knows it.’ But they went away and spread his fame through all that district. | This healing is based on a petition from the two blind men, but Jesus asks for a commitment of faith. Having received this, he heals by touch and word. |
| Matt. 9: 32-34 | As they were going away, behold, a dumb demoniac was brought to him. And when the demon had been cast out, the dumb man spoke; and the crowds marveled, saying, ‘Never was anything like this seen in Israel.’ but the Pharisees said, ‘He cast out demons by the Prince of demons.’ | “The dumb man spoke” is a short phrase, but how remarkable it is for a man who has never had the facility of speech. The Pharisees lay a charge against the foundation of Jesus’ healing claiming that he does so only by the power of the evil one. |
| Matt. 9: 35 | And Jesus went about all the cities and villages, teaching in their synagogues and | A summarizing statement, with the bookend <i>healing</i> |

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| | preaching the gospel of the Kingdom, and <i>healing every disease and every infirmity.</i> | <i>every disease and every infirmity.</i> |
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Jesus' earthly profession matters, partly for what he was not. He was not, for instance, a political leader, an army commander, a composer, or an author. His life appears closely connected with the sea, so much so that he seems more affiliated with fishing than carpentry. Most importantly, his earthly mission was characterized by teaching, preaching, and healing. This last profession raises a lot of questions. When was he first aware that he had a gift for healing? Did this gift appear after his baptism and temptation, as the biblical account suggests, or were there earlier hints? What did he himself think of this gift?

Whatever the answers to these questions, one thing is clear. In Jesus' 'inaugural sermon' according to Luke (4: 16-22), Jesus returned to Nazareth and attended synagogue, as was his custom. There, he stood up to read from the prophet Isaiah:

"The spirit of the Lord is upon me; Because he has anointed me to preach good news to the poor; he has sent me to proclaim release to the captives and recovering of sight to the blind, to set at liberty those who are oppressed, to proclaim the acceptable year of the Lord."

The Gospel of Matthew (11: 2-6) reports that John the Baptist sends his recruits to Jesus to inquire whether he is the one they have been awaiting, or should they wait for someone else. Jesus replies: "Go and tell John what you hear and see: the blind received their sight and the lame walk, lepers are cleansed and the deaf hear, and the dead are raised up, and the poor have good news preached to them. And blessed is anyone who takes no offense at me."

Healing, then, is a prophetic act. Healing is a manifestation of Jesus' fulfillment of prophecy. He has been chosen and anointed to come into the world to fulfill prophecy; that prophecy demands that the wrongs of disease and infirmity be set right. Jesus blesses those whom he encounters as he travels from village to village with this prophetic gift of healing.

But what does the prophecy itself imply? If we recall St. Augustine, he believed that evil is the diminution of the good. I would suggest that the prophecy affirms this idea. Blindness is a diminution of a human's full gift of humanity. It must be put right. Poverty is a diminution of the full human capacity for life. Leprosy diminishes a person's social value, forcing one to ostracize from society, in a place where she suffers silently. Likewise, mental 'illness' ex-communicates one from 'normal' ('straight' and clean) society. All the named instances of healing are the manifestation of Jesus' prophetic gift to restore humanity to the image as God the Father intended.

When Jesus healed a person, the healing was not only of a physical malady. It was a restoration of the LORD GOD's vision for humanity. Healing in and of itself was a form of preaching. Jesus affirmed John the Baptist's message that the kingdom of God has come near, by offering proof of the fulfillment of the prophecy in his inaugural sermon.. By healing the masses, Jesus was making the proclamation that the kingdom of God is on the tips of our noses. So near, in fact, that the lepers are cleansed, the lame walk, the blind see, the deaf hear, and the dead are raised to life. It is no wonder then that Jesus' healing mission caused such a stir among the people - and blessed are those who take no offense at the healing. The fame of Jesus' gift of healing spread quickly and widely, as his seemingly miraculous wonderworking was 'noised abroad.'

Some believers tend to use the term, 'miracle-working,' to refer to accounts of Jesus' healing. While not detracting from the miraculous nature of Jesus' ministry, I want to examine the instances from Matthew from another perspective. Whatever else we may say about the healing ministry, it had a decidedly temporal nature. By this I mean that all of those whom Jesus healed

and resurrected eventually died. Even Lazarus tasted a second death. The healing took place in a particular society at a particular time and space with particular people, usually unnamed.

This perspective forces me to think about those healed, those who were contemporaries of Jesus. While to receive one's sight or be cleansed of leprosy was certainly miraculous, it had another effect. Jesus restored to the blind and speech-less the full gifts of life that the LORD GOD had always intended for them. Jesus restored the ill, the diseased, the disabled, and the mad to the full gift of life.⁵²⁶ For the lepers, Jesus not only removed their disease but restored them ritually to their home, community, and religious life.

Whom did Jesus heal? Referring to the table above, we see that Jesus healed not only those of his own nation (4: 23), but he healed outside in Syria (4: 24), and the country of the Gadarenes (8: 28-31). He crosses 'to the other side' of the Sea of Galilee, meaning to Gentile territory (9: 1-8). He even heals the servant of a Roman centurion (8: 5-13). Seemingly Jesus used a residence in Capernaum as a base of operations. Capernaum is also the scene of numerous healings, including the centurion's servant (8: 5-13), the mother-in-law in Peter's house (8: 14-15), and those whom the faithful brought to Jesus there (8: 16-17).

We should pay attention to the issue of petition in Jesus' healing ministry. Jesus, it appears, did not walk into town looking for sick people to heal. This could explain the seemingly 'random' nature of his healing ministry. He appears even to withdraw from people at times in the boat or in the mountains. He did not set out a shingle saying, 'Healing for hire.' His healing power was freely given. This is true in every instance in the table of healing events, save one.

⁵²⁶ One of my former vocations was as Disability Advocacy Manager. In working with the 'disabled' I am aware that a deaf person, for instance, would protest this view and assert that their deafness is in fact a gift.

That is when he enters Peter's house and sees the mother-in-law with fever. Maybe from close association he simply chose to exert his powers to raise her up.

In thinking about this it seems clear that we must petition the Lord for healing. That means an appeal for better health, but I think more importantly it means being restored to community. Chronic disease, such as asthma in my case, can keep us away from church attendance. My prayer should be not only for help in finding the right specialist who can treat my symptoms, but relief from a disease that keeps me away from those I love.

These instances of healing occurred more than two thousand years ago, and we take no offense at them. They remain miraculous, not only for Jesus' time but for ours. They are miraculous in our time primarily because they are fulfillment of the LORD GOD's prophecy of the restoration of creation for all people and all of creation. That is the good news that I take from the healing accounts.

This is but a brief attempt to look at Jesus' healing ministry. Much more can and has been said by New Testament scholars. My aim in this short essay has been specially to consider the ideas of prophecy, petition, the particular instances of healing, and the pattern of Jesus' ministry. The healings are indeed miraculous, but not only for the restoration of health but for the restoration of the whole person and the whole community of the Lord.

Medical healing

It is perhaps unfair to compare gospel healing and medical treatment for several reasons. Medical treatment has no regard for prophecy, and while there are attempts at 'public health' there is little regard for what constitutes a community. Jesus healed as part of his mission,

without taking a fee. Medical healing is a ‘pay-as-you-go’ treatment; in fact, medicine is an enormously profitable field.

Medical practice also works on petition. A ‘patient’ makes a presentation of a specific complaint (one per session) to a physician. The physician is trained to maintain personal boundaries, usually seeming somewhat distant, in order to be a fully objective observer. The physician considers the specific symptoms presented (What brings you in today?). The physician treats the symptoms presented, usually offering a prescription for medication. It is a medically effective system, but it is less than a perfect form of healing from a ‘patient’ perspective.

Allow me a personal reflection to illustrate. I live with chronic asthma. I have a wonderful asthma specialist, who has worked with me to control the symptoms of my disease. I am endlessly thankful to him and have proffered my thanks to him. Over time he has accumulated a wealth of biological data about me. In my chart are the results of breathing tests, graphs of my respiratory capacity, a record of the improvement or worsening of my symptoms, records of treatment plans and medications issued. Nowhere in my chart, however, will you find an answer to the question, “What does it mean to you to live for years with a chronic disease?”

One could say the answer is not the concern of a physician, but I believe this is the profound difference between healing and medical treatment. My own answer to the question should be of some concern medically, because it would demonstrate what motivates me for treatment, what motivates me to continue living with not one, but three chronic health conditions. If there is any medical regard for the issue of meaning, then it is typically relegated to a medical chaplain, who could explore this and other issues. A chaplain could ask how my conditions affect my religious life, which is important to me. A chaplain can explore what tools I have spiritually and emotionally to live with my diseases.

One frequently hears of the ‘whole person concept’ of healing, but having worked in the field, I know of only two places where such an approach is taken effectively. One is in the best cancer hospitals in the nation where not only the whole person is taken into view, but one is even treated, I must say, with love. The second is in hospice. There a good chaplain can assist a dying person in exploring her life, if she wishes, by means of deep listening, sometimes for hours, to a life review. I always asked one question. “If you could still address one thing in your life that would make you rest easier, what would that be?” Typically, a response was in regard to the restoration of a broken family, so if possible, I mediated a family meeting. Not all broken relationships could be restored, but some progress could be made. This all took place in a medical setting with the ‘permission’ of a medical facility, but it is not in and of itself medicine. It is, I believe, healing.

To return to our purpose in discussing opioids, medicine can treat opioid addiction, but does such treatment heal? My position is that medicine is not equipped to heal the multifactorial *causes* of addiction, or the *consequences* of addiction. Medical treatment in the form of replacement therapy is designed to address one issue: the biological addiction to opioids. For a ‘compliant’ patient who wills to end addiction, medical treatment can reduce craving and provide some support for the one addicted as the intake of opioids is steadily decreased. That is no small accomplishment, and such work is worthy of praise. While this biological repair work is being conducted, a team of counselors and social support providers can assist in the hard work of addressing the many problems that the addicted face. But that work is under a strict medical model with severe time constraints.

I must note one significant exception. The Veterans Health Administration is the largest medical care system in the country. The administrator is a member of the President’s Cabinet.

While no system is perfect, the VA comes as close as I have seen in my life to a system that regards the whole person, the whole veteran. As a rule, providers are driven with a passion for the care of veterans and to being guardians of what President Biden has called America's 'one truly sacred trust.'

Our house is on fire

I am not the only critic of our system of medical care. A somewhat more eminent critic, the former director of the National Institute for Mental Health (NIMH), Thomas Insel, writes cogently and passionately of the problems and possible solutions to improve mental health care in his 2021 book, *Healing: Our Path from Mental Illness to Mental Health*.⁵²⁷ As one of our nation's eminent physicians he admits to being endlessly optimistic about the progress of technology and science. As Director of NIMH, he believed that part of his responsibility was to travel to communities across the nation to highlight medical research achievements. This included copious PowerPoint presentations that highlighted the intricacies of 'miraculous' progress. It took one angry father to burst this bubble of optimism. Insel recounts that in a community question and answer after a detailed PowerPoint presentation, the father rose and said, "You really don't get it. My twenty-three-year-old son has schizophrenia. He has been hospitalized five times, made three suicide attempts, and now he is homeless. Our house is on fire and you are talking about the chemistry of the paint."⁵²⁸

⁵²⁷ Insel, Thomas. *Healing: Our Path from Mental Illness to Mental Health*. (New York: Penguin Press, 2021).

⁵²⁸ Insel, Thomas. *Healing: Our Path from Mental Illness to Mental Health*, xvi.

Ever the optimist, Insel was shocked. He began to think about the systemic problems of mental health care 'delivery' in the US. And those problems are significant. Significantly for our topic, Insel notes:

Mental health also demands more than a medical solution. Healing includes a focus on equity, trust, and meeting people outside of traditional health care. This is not to downplay the need for medical solutions. Put simply, the mental health problem is medical, but the solutions are not just medical -they are social, environmental, and political. We not only need better access to medical treatments; we need to include people, place, and purpose as part of care.⁵²⁹

We will discuss the importance of people, place, and purpose in a moment, but we should note how much humility it takes for a notable physician and researcher to recognize that the solutions are not just medical.

Insel was compelled to face one dismal fact. "It's a pretty safe bet in most of medicine that if you treat more people, death, and disability drop. But when it comes to mental illness, there are more people getting more treatment than ever, yet death and disability continue to rise. How can more treatment be associated with worse outcomes?"⁵³⁰ Our house is indeed on fire.

It is absolutely an issue that must be addressed, but it seems an enormously difficult task – one that requires participation from all sectors of our society. Insel finds that the mental health community has suffered a deficit of quality care and a lack of accountability and coordination.⁵³¹ He draws a conclusion that can only be similarly drawn from the OxyContin crisis: "In terms of mental health care, the last four decades have been much better for the Pharmaceutical industry than the public."⁵³² To state the obvious, healthcare in this country is a business. I would add my own belief that it embodies out-of-control, profit-driven, predatory capitalism. Mental health care

⁵²⁹ Insel, Xx.

⁵³⁰ 19.

⁵³¹ 100.

⁵³² 45.

is based on a system that resolves crises but not life in between crises. Over the years since the Reagan administration, our nation's thousands of jails and prisons have effectively been turned into poorly functioning and woefully unfunded mental health hospitals. Even the effect of the Diagnostic Statistical Manual has meant that we are "(p)utting a label on human suffering (that) pathologizes normal variation and medicalizes this human experience."⁵³³

Mental health care providers, as in other branches of medicine, are trained to treat symptoms. It is one thing, however, to treat a broken bone, pneumonia, or COVID. But treating mental health by this system is not enough. As Insel writes: "It's not just relief of symptoms. It's finding connection, sanctuary, and meaning not defined or delimited by mental illness. Unfortunately, the sole aim of our care system is the relief of symptoms. That's important, but it is not enough."⁵³⁴ This is what Insel means by people, places, and purpose.

People means putting in place a network of social care around the patient, which means that the patient ceases to be a patient. By this I mean finding others who do not respond to you based on the stigma of diagnosis. One of my most dismal tasks in the clinic was to ask the question, "How many friends do you have?" (It was a state-required question.) Insel phrases the question more helpfully. "Who could you call if you were sick or scared in the middle of the night?"⁵³⁵ Moving from "no one" to being able to name more than one person would be a significant marker of healing. Places means a secure place to live, a place surrounded by social services. Purpose means whatever the person means by the answer to the question, "What gives your life

⁵³³ 139.

⁵³⁴ 160.

⁵³⁵ 162.

meaning?” The answer at first could be simple. “My cat.” But it could also include my spouse, my job, my home. These are all signs of healing.

Insel, in the last part of his book, makes several, sometimes technical, recommendations for changes to our mental health care system. The main meaning for me of the book, however, is this suggestion of finding other-than-medical solutions to medical problems. I think this applies most powerfully to the treatment of addiction. Addiction is a medical, biological problem. But the treatment of addiction so far has had less than hopeful results. That may change with advances in medications, but for now we rely on replacement therapy.

I wish to conclude this chapter with a statement of my own vision of a pastoral approach to addiction. Having stated these principles, we will turn in the next chapter to address our qualitative research.

Founding Principles

Jesus healed. So should we. Addiction care is rightly a concern of the church. I consider it an ethical obligation of churches to study the scope of the addiction problem in their communities. At a minimum, pastors and leaders should put on the full armor of knowledge regarding opioid addiction and what treatment would look like. Invite Christ into this sphere of activity and let Christ do what the Christ is known to do – heal.

Churches should have adequate and appropriate access to persons in treatment. While maintaining appropriate confidentiality and privacy of patients, churches should be allowed to offer what they do best.

Addiction problems are medical in nature, but many solutions lie outside the medical sphere. We are by nature social creatures. We thrive in community; we fail in isolation. True healing is

community in action. We are grateful for medical approaches, and we are by no means hostile to medical efforts, but medicine does not ‘own’ the field. We all have a role to play.

Healing entails healing a community. Addiction has ravaged communities throughout Appalachia. It has ravaged family systems, finances, employment, faith, and trust. Healing in the context of opioid addiction means healing communities.

Healing is prophetic work. Our hope abides by the faith of Christ. Christ pointed the way by healing in accordance with prophecies of his tradition. That prophecy abides. Every act of healing is testimony to the continuing revelation of prophecy.

Healing is the work of martyrs. The primary work of a martyr is to bear witness to the truth. When I refer to my experience in the field, I am primarily referring to the fact that I (sometimes forcibly) bore witness to what I observed and experienced. Usually no one thanks me for that; indeed, some may take offense. But we all must survey the field before us and bear witness to the reality that we see, not the rosy optimism we would like to impose.

Healing is the work of advocacy. We must be bold in advocating for solutions for persons and communities affected by addiction. This means that we must remain on top of developments in the community and of research in the field, and that we speak from a position of faith and knowledge.

Healing is work in the polis. None of our work is done in secret; rather, we must engage the polis. That means that healing has a political nature and in part we seek political solutions. This means engaging government at the local, state and national levels to seek responsive action. One example in Appalachia, for instance, would be to create Supportive Housing (Housing First) solutions in our local area. This is a proven method that has not been implemented effectively in

Northeast Tennessee. Another example is in the field of training and education for those in recovery.

Healing means implementing programs that put people, place, and purpose into play. These are the three building blocks of recovery. This ministry should be one of coordination. We will provide our best efforts to find the best people to surround our healing community. This may simply be finding mentors or best friends. Veteran connections, to give one example, can have a powerful effect on healing. Advocates, friends, companions, and witnesses are all important pieces of recovery. All people in recovery deserve appropriate, drug-free housing where recovery can happen. One example of this, as I mentioned above is Supportive Housing. We cannot provide purpose, but we can help persons explore what is meaningful to them. What gives life meaning?

All our work must have the best interests of the addicted community in mind. I adhere to a “Nothing about us without us” approach. The community suffering must be one part of their own healing process. This entails deep listening to understand what they truly want and need.

We must therefore be accountable to oversight. Ensuring that our process is honorable and in compliance with the highest ethical standards, the ministry must be accountable for oversight. I would envision eventually a board of directors that has an interest and investment in the ministry.

We must advocate for an end to the devastating War on Drugs. This fifty-year project has been an abject failure that has disproportionately affected communities of color and turned our nation into a carceral state.

Incarceration centers are not mental health or substance abuse treatment facilities. Jails and prisons are over-crowded and underfunded. The justice work of these facilities should be of first

importance. We must advocate for successful diversion programs, such as drug courts, and for the implementation of Veteran Treatment Courts.

Abstinence-only programs traditionally have only a 19% success rate. New abstinence-only programs do not have years-long experience of tracking their clients. While I would not wish to denigrate new programs with good intentions, using an old, discredited method is not a best practice. Let the history of the 1920s Narcotics Farm guide us.

Our best-known approach is a medical one, that is surrounded by support from outside stakeholders. Treatment centers should be accountable and responsive to the communities they serve. Recovery is an all- community effort.

Chapter Fifteen

Qualitative Research: The Opioid Crisis in Carter County, Tennessee

We have finally reached our destination, which is to begin qualitative research and to report the results of that research. Three questions have driven my interest in this project.

- 1) What role does/can spirituality play in offering strength to those who are in recovery?
- 2) What is the church's responsibility to those who are addicted to opioids?
- 3) What responses can the church offer?

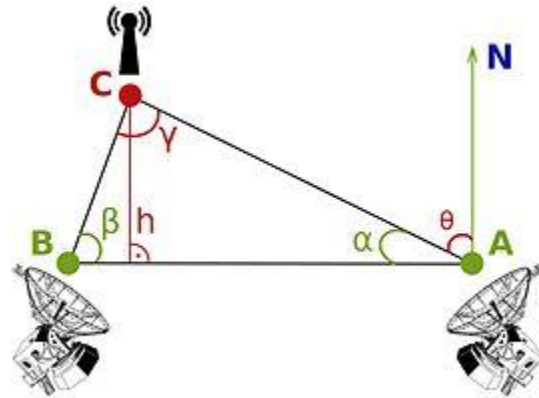
I did not initially have the answers to these questions, which is the purpose for research. The role of qualitative research, then, is to explore the idea of spirituality to find whether it may provide strength and meaning in recovery. Only pastors in local churches may answer the second and third questions. I hope that in the course of this work I have laid out clearly my own theological beliefs. I provide my own answers to these research questions in the summary of this chapter.

Research Methodology

Qualitative research aims to 'triangulate' sources of information to make a thick, or at least a thicker, description of the phenomena we observe. Triangulation is a metaphor which I understand from my own work with the field of Radio Direction Finding (RDF).⁵³⁶ RDF, developed during World War I came to full fruition in the Battle of Britain during World War II. I had the honor of serving at an intelligence station in England that had been key to locating German bombers by RDF during that conflict. The idea is that (ideally) three radio receivers

⁵³⁶ RDF graphic from [Direction finding - Wikipedia](#).

placed around the face of a compass can locate a radio transmitter by triangulating it as in the graphic below.



Analogically, qualitative research ‘listens’ to sources in order to locate and triangulate information. By this we mean that we will use at least three methods of investigation to ensure that we have provided the clearest, thickest description possible. In a sense qualitative research is ethnography, in that we are studying a particular population of people, in this case, the community of people in Carter County who are addicted to or affected by opioids.

To that end I have chosen three methods of investigation. First, is to provide four case studies of persons who are in recovery. The four persons I have chosen are all people I have known and worked with for at least two years. My aim here is to report the results of hours of listening and interaction to provide a rich description of their life stories. Second, I have interviewed three providers who are active in battling the opioid crisis. I have chosen this method to gain a different perspective on the crisis.

Third, is to interview eight persons who have been affected by the opioid crisis. Again, the purpose is to listen deeply and to report their stories. In this second effort I have asked permission to record the interviews. I use no names in these interviews. Instead, I assigned one-up numbering beginning with 451. Once I have an audio file, I run it through a transcription program that will create a text document. After I have edited that transcription, the audio file is destroyed. Once a text transcript has been created, I remove any identifying features, so that the interviewee's anonymity may be preserved.

I had researched several qualitative research software packages, the best of which by far, in my opinion, is NVivo. The cost of the program (\$1300) is prohibitive for a study as small as this but would be appropriate for continued or larger studies. NVivo does have excellent customer support, including Zoom training sessions. I also tested a free program, ELAN 6.4, which was developed by Tübingen University. It appears to be robust, but the learning curve was very steep and there was a lack of instructional information about the program. There are many other packages available, but I have not thoroughly tested others.

The greatest challenge was the transcription of interviews, which is an incredibly laborious and time-consuming process. After transcribing two interviews, I finally found an excellent software program that I used for the remainder of the transcripts. This program is *Avrio*, available at www.avrio.com. The program allows one to drag and drop audio files into the program online. Once uploaded, the program provides an accurate transcript within one minute in a very presentable format. The program is able to distinguish between speaker voices. The transcripts created in the *Avrio* format produced large files, averaging thirty pages per interview. Because the files are so large and because they are based on Active-X controls that Word would not incorporate, I face the challenge of how to present the transcripts in this work. For the

purposes of this current document, I have tabulated themes and presented the results of the interview, but not the transcript itself.

The transcripts were exceptionally informative, but I realize readers will not have the time to read all of them. If a reader is interested, I would recommend looking at one interview in particular, #454. This speaker was eager, cooperative, frank, and helpful. He was also eager to see a chaplaincy formed in Elizabethton. One other feature of this interview is that he provided the most graphic description of opioid withdrawal that I have heard.

Once the three methods I outlined above are completed, I analyzed all the transcripts to find common themes. NVivo is capable of both producing an accurate transcript and of analyzing the texts created, but I only used this program for the seven-day free trial. One advantage of using this type of software is that it removes the researcher from the equation of analysis as it provides a meta-view of the documents and identifies common themes. In lieu of a program, I did the analysis myself. The common themes identified are reported out in the Research Results section after each interview. Due to the scale of the task, I only analyzed the eight interviews presented below. Six of those interviews were conducted at Elizabethton Health Services, the largest Suboxone practice in the city, located at 405 Hudson Drive. I am immensely grateful for the staff's collegiality. In these interviews I have followed the clinical practice of referring to interviewees as 'clients.' In this written project I have only provided basic demographics, along with impressions of client presentation and speech.

I. Case Studies

(Note: I have here assigned names to the persons I described. I have changed some facts to maintain anonymity.)

'Cora'

Cora is a 37-year-old white female who was born and raised in Carter County, but in adulthood has lived in Johnson City, TN and in various locations in Sullivan County, TN. She was born into a broken home. Her father left the home at an early age but lived nearby. She has no siblings. Cora remembers her father as abusive during her childhood but now maintains a positive relationship with him. At various troubled times in her life Cora has turned to her father for sanctuary. She states that he shields her, but that she cannot live with him long term. Cora dropped out of high school at the age of 15.

Cora's mother, who raised her, was a chronic alcoholic. She frequently brought strange men home, but none presented a permanent presence. Cora was a strikingly beautiful youth, so her mother early realized her potential. When Cora was thirteen, her mother began prostituting her to an endless chain of men. To gain Cora's compliance the mother and the men began to ply her with a variety of drugs, that included marijuana, crack cocaine, powder cocaine, methamphetamine, an assortment of pills, and eventually, heroin. At age 16, Cora was introduced to the intravenous use of heroin. Cora never developed a taste for alcohol except for the occasional beer. As prostitution is all that Cora has ever known, she has continued to prostitute herself in adulthood.

In early adolescence Cora began to demonstrate a series of psychiatric symptoms. This included symptoms of early onset schizophrenia. She reports hearing voices over the years, usually what she describes as evil, satanic voices that urge her to do 'bad things.' She expresses deep fear and dread of the return of the voices. She also has struggled with major depression and mania. When stressed, she exhibits symptoms of dissociation. She has experienced a long 'career' of treatment for mental illness since adolescence and reports that she believes she knows

every therapist and mental health provider in the community. She also has had numerous long-term residences in mental health and recovery institutions, including several residences in state psychiatric hospitals. Because of her psychiatric symptoms, some providers believe she presents an unreliable report of her life.

Given her long history of drug abuse, mental illness, and prostitution, Cora has somehow avoided criminal charges, except for a few drug possession charges. She was not spared, however, from the effects of criminal activity. She reports a series of traumatic events over the years that are connected to major crime. As a prostitute, she tended to be the favorite of several local crime bosses, and she reports witnessing brutal, traumatic events. Cora has no significant arrest record. Because of her drug and prostitution career, she has given birth to three children. All those children have been placed in the foster care program and she maintains no contact with any of them.

Cora has sought help for opioid addiction as well as other mental health issues and is able to advocate successfully for herself. She has tried every treatment program imaginable, including 28-day recovery programs, crisis intervention, methadone, suboxone, and abstinence. She states that she will always use marijuana and considers marijuana intoxication to be a 'steady state' in her life. Her recovery has tended to be short-lived, as she has been plagued by a series of relapses. Some relapses are short in nature, while others descend into months-long experiences, usually due to heroin use. She reports that Narcan (an anti-overdose drug) has been used on her several times to recover her.

Although working with Cora presents definite challenges, including frequent relapses, she is well-liked by most providers, although some male providers express fear of her overly sexualized and provocative presentation. Most recently Cora began working with a local

physician in suboxone practice. For whatever reason, this time the treatment seems to be effective. Cora has now known a period of sobriety (except for marijuana use) of more than one year. She presents now as pleasant, affable, and committed to recovery, although she unintentionally can be wildly inappropriate in her speech. Cora plans to remain in suboxone treatment as she and others have noted her good progress in recovery.

I assisted Cora in applying for and receiving disability benefits and related Medicare. She says that this has changed her life for the better, and now she does not have to rely solely on prostitution for money. She also now has adequate healthcare.

Cora was never raised in church, but her grandmother, with whom she had a close relationship, was a very devoted Baptist. It was from the grandmother that Cora learned what she knows of the Christian faith. Cora is eager to read together from the bible and actively participates in a prayer group. She says that faith is very important to her and her recovery.

'Brent'

Brent is a 42-year-old white male. He currently resides with a female partner, with whom he has a male child. Brent was raised in a remote, mountainous region of Carter County and has resided in the county his whole life. He is very personable, even charming by some measures. As a youth he demonstrated certain athletic ability and excelled at baseball. He was something of a sports hero in his small rural high school. He never showed promise in academics in school and describes himself as 'not that bright.' He did, however, complete high school, but never sought additional education. He reports that women have always found him attractive, and he has moved through a series of relationships, but has never married. He has only one child and seems committed to being a parent.

Brent is an only child but has exceedingly strained relationships with his parents. His father has largely given up on Brent because of his drug use and other behavior. The father is vehemently opposed to any form of replacement therapy and makes this view known to providers. The mother remains in relationship but expresses natural exasperation with her son. I have made several home visits to her, and the family presents as hard-working, orderly, and faithful. They faithfully attend a local Church of Christ. Brent seems to respect their faithfulness but has so far not found any strength or support from the faith. He is indifferent, at times hostile, to any attempts to discuss spirituality.

Since Brent grew up in a small community, he has some acquaintance with a host of former friends and relatives. He says that he was popular in high school, but his closest friends began to distance themselves from him because they had initiated drug use. He reports being hurt by his friends because they made fun of him as a 'straight jock.' This was painful because he had grown up with his friends and known them his whole life. As a senior he relented to peer pressure and began drug use. At first this involved marijuana use, but since the age of 17 he has tried every drug conceivable, including opioid pills, and then heroin.

Brent has been unable to find and maintain suitable employment. He states that he 'gets confused' easily by work requirements and always ends up being let go because of poor performance. He has worked a series of menial jobs. He applied for disability benefits, which were not granted. Because of his employment difficulties Brent has sought to make money in several illegal or questionable ways. In his twenties he was arrested for distributing drugs and served a five-year sentence in state prison. He has a significant arrest record for a series of misdemeanors and felonies. He is currently on probation, although he faces new felony charges.

When he was released from prison Brent soon went back to drug use. He reports that he was able to obtain and use opioids while in prison. In the last ten years, Brent has made attempts at recovery from opioid addiction. He has been through several recovery programs, to include suboxone locally and methadone from a clinic in North Carolina. To providers, his recovery seems half-hearted. Brent continues heavy drug use and does not seem to make progress so far toward recovery. He still is in a methadone maintenance program in North Carolina.

Because he has had several long-term stays in the Carter County jail, he has been through several imposed periods of abstinence, which he refers to as 'pure hell.' In his latest extended stay, he prepared himself physically and emotionally for abstinence. He requested that his methadone clinic taper him from methadone so that his withdrawal symptoms would not be so severe.

Because of his heavy polysubstance use, Brent has been through a number of overdose events. One of these overdoses was in my presence. He is aware of the danger but is indifferent to it. His clinic supplies him with his own Narcan kit for use on himself or his friends in the event of overdose. His attempts at recovery are half-hearted, and he has been ejected from several clinics because of his continued heavy use. He always returns for care, but no approach so far has been effective. Because of his unemployability, poverty, and heavy drug use without serious efforts at recovery, his prospects for the future are not good.

'Maddy'

Maddy is a 28-year-old white woman from out of state. She has been married for three years to a man who is also in opioid recovery. Both participate in suboxone replacement therapy through a local doctor. Although the relationship has been broken at times, both parties seem

committed to being together. Maddy has one son, who is in foster care. Maddy maintains a strong relationship with her mother, who is a faithful Christian and is supportive of Maddy's recovery. Maddy and her husband now reside in Kingsport.

At the age of twelve Maddy began to demonstrate distressing psychiatric symptoms that included depression leading to deep despair or alternately a manic state. As an early adolescent she made a suicide attempt, after which she was hospitalized at a state psychiatric hospital. Once when discussing her mental health, she stated that it was difficult to explain and asked if she could bring me some of her medical records. At the next visit she presented with a file folder approximately five inches thick, detailing all her psychiatric treatment since the age of 12.

Looking through her records, I discovered what I refer to as 'diagnostic soup.' Over the years, based on whatever symptoms presented at that time, she had been variously diagnosed and treated as exhibiting symptoms of bipolar disorder, suicidality, major depressive disorder, schizoaffective disorder, and borderline personality disorder. She had made a number of suicide attempts over the years, usually with pills. She began using opioid pills in high school, seemingly to mask her symptoms, and over time developed addiction. She occasionally uses methamphetamine, which she regrets immediately. She plans not to visit 'people, places, or things' that would lead to methamphetamine use. To her great credit, despite all her difficulties, she graduated from high school and even completed one year at a local state university. She is able to state a goal of wanting to complete her university education if her symptoms could be controlled. She is normally 'medication compliant,' but when her symptoms are not managed, she begins to spin out of control psychiatrically.

I should say that I never knew the Maddy that would walk through my door, as her demeanor could change from one visit to the next. When she was doing well, she presented as breezy and

pleasant, attractively dressed and maintained, talkative, and purposeful. When she was not doing well, the depth of her despair was on display. Normally, those periods of despair required stabilization in a hospital setting. Although she had occasional relapses, she seemed committed to controlling her addiction. She worked well with me and all staff. Art was important to her, and she frequently shared pictures that she had drawn.

Maddy had several strong supports in her life. Her relationship with her mother was endearing. The mother understood her daughter and her problems and always advocated well for Maddy's care. Her husband was a continual strong support, and since he was in recovery himself, he was fully supportive of her efforts at recovery. More than any person I worked with, Maddy was devotedly religious. She at times brought a bible with her to our visits. She faithfully attended and participated in a spirituality group. While she does not attend a church, Maddy considers her Christian faith and prayer life as essential to recovery.

Unlike most other patients with whom I worked, Maddy did not suffer financial difficulties. Her husband made a good living and provided for the couple. I assisted Maddy in applying for disability benefits and Medicare, which she did receive. I believe financial security provided a level of stability that she had not known before.

'Gregg'

Gregg is a 67-year-old white man who resides in Elizabethton. He is a widower with several adult children and grandchildren. He maintains good relations with his family. He relates that he has a 'normal' story, except for his drug use. As he came of age in the 1970s, he experimented broadly with a range of drugs, to include marijuana, LSD, and cocaine. He graduated high school

and worked at the same factory job until retirement. He also receives Social Security and Medicare benefits.

Regarding recovery he stated that his marijuana use was ‘not negotiable.’ He has used marijuana since high school and will not surrender that habit. In fact, he said with some pride that he had not paid for marijuana in more than thirty years, because he maintains a hidden ‘grow’ in the mountains of Carter County. His use of opioids began with care in a pain management clinic. Because his factory work was hard labor, in his forties he began to experience chronic pain in his back and neck. He was prescribed oxycodone, but when supplies became restricted because of new federal regulations, he sought relief from illicit purchases on the street. Although he considered himself dependent on opioids at the time, he was not concerned about addiction.

That changed twelve years ago. His mother, with whom he was very close, was diagnosed with end stage cancer. She moved in with Gregg and consented to home hospice care. Hospice treated his mother aggressively for cancer pain, which meant morphine was kept in the home. The presence of morphine in the home was too much temptation for Gregg. He began to ‘dip into’ his mother’s morphine supply. Although morphine is tracked by the hospice, Gregg was able to evade discovery. When his mother eventually died, he stole her remaining morphine supply and reported that his mother had used it all. The supply of morphine was great enough to last more than one year.

At the end of that year when the morphine ran out, Gregg realized he had a major addiction problem. No amount of opioids from the street satisfied his deep craving. He entered methadone treatment in another state and has maintained that treatment for several years. He is compliant with his program and is considered stable in recovery, although his marijuana use continues.

(Note: in the next two sections I have summarized the transcripts, which are presented in a separate folder.)

II. Interviews with three providers

A. Interview with Ms. Laurie Street

Clinical Director, Overmountain Recovery, Gray TN
November 29, 2022

| Theme | Comment |
|---------------------|--|
| Abstinence v MAT | We talked about the new abstinence-only residential center being opened at Roan Mtn and Recovery Soldiers Ministry in Elizabethton |
| Parenting | One goal is to help the addicted become better parents |
| Prevention | Importance of education for youth |
| Hepatitis | Also an epidemic |
| Success stories | These are as important for providers as they are for patients |

B. Interview with Ms. Barbara Cook

Office Manager at Elizabethton Health Services, a Suboxone practice

December 1, 2022

| Theme | Comment |
|---------------------|---|
| NAS | Prevalence in the population |
| Family relations | Broken families, poor parenting |
| Mental illness | Estimates 60% of population lives with mental health disorder |

| | |
|-----------------|--|
| Fentanyl | Prevalence in population, patients chasing ‘good’ fentanyl, known in prison slang as ‘The Good-Good” |
| Cannabis | As ‘background noise’ to a life of drug abuse |
| Boredom | As a reason for first use, lack of activities in CC |
| Intergeneration | Both in trauma and substance use |
| Success stories | These are as important for providers as they are for patients |
| Overdose | Prevalence, use of Narcan |
| Hepatitis | Also an epidemic, app. 60% test positive |
| Stigma | Of the addicted toward one another, or the medical community and community at large against the addicted |
| Pain | Frequent initiation of opioid use |

C. Interview with Ms. Shawna Burrow, LCSW

Counselor for Elizabethton Health Services, a Suboxone practice

| Theme | Comment |
|-----------------|---|
| Anxiety | Prevalence |
| Depression | Prevalence |
| COVID | Effect on clinical practice |
| Relapse | Frequent phenomenon |
| Family | Broken, intergenerational trauma and substance use |
| Success Stories | These are as important for providers as they are for patients |
| Cannabis | As background noise to life of substance use |

| | |
|--------------|--|
| Boredom | As reason for first use, lack of activities in CC |
| Trauma | Sexual and physical, intergenerational |
| Stigma | Of the addicted toward one another, or the medical community and community at large against the addicted |
| Pain | Frequent initiation of opioid use |
| Iatrogenesis | Physician responsibility for addiction |

III. Interviews with persons living with opioid use disorder

(Note: I have provided basic demographics and summarized interviews.)

A. 451F

Female, 27 years-old, unmarried but has partner

Has two children, partner (452) has four, but two are not in his custody. I have known 451 for over one year.

Interview date December 7, 2022

Analysis

As with many of the community, the ability to narrate in a coherent manner is impaired.

Presentation: Relaxed, eager to talk. Was accompanied by her partner, #452.

Speech: Racing, pressured speech. Speech could not keep up with racing thoughts.

Appearance: Clean, age-appropriate dress in jeans and sweater.

| Theme | Comment |
|---------------|---|
| Broken family | See all of question 1. |
| Sexual abuse | Sexually and physically abused by brother |

| | |
|----------------------|--|
| Foster Care | Client later reported that she had over 40 foster care placements and placements in juvenile detention, primarily for conduct disorder |
| Faith | Reports being raised Baptist |
| Trauma | There were moments in her speech where she seemed to disassociate momentarily, which I have presented as ellipted speech |
| GED | |
| MAT | In suboxone and Subutex therapy |
| NAS | Her second child was born with Neonatal Abstinence Syndrome (NAS), meaning he was born withdrawing from opioids. She states this was a 'mild case,' but the infant was retained in hospital care |
| Tobacco | Age 13 |
| Alcohol | Reports being a light drinker |
| Relationship issues | Never married, in at least two serious relationships. |
| Pain | Initiated opioids under treatment for pain |
| Transition to street | When her physician 'cut her off' from opioids, she transitioned to street purchase |
| Overdose | Not personally, but a litany of family members and associates |
| Suicide | Ex-boyfriend used, then drove his truck at 90 MPH into a tree in front of her house. Boyfriend's sister later committed suicide. |
| Incarceration | Driving without license |
| Poverty | |
| Fentanyl | Reports history of chewing fentanyl pain patches, but had no idea at the time of the danger of fentanyl |
| Legalize | Cannabis |

B. 452M

34-year-old male

One previous marriage of 12 years, currently unmarried, lives with 451. Has four children but two are not in his custody. I have known 452 for more than one year. He holds a contractor's license and prides himself on his work ethic. Because the license requires frequent drug testing, he avoids drug use now.

Interview Date: December 7, 2022

Analysis

Presentation: Relaxed, was accompanied by his partner, #451.

Speech: Some impoverishment of thought noted. Slow, thoughtful speech. Humorous.

Appearance: Clean, age-appropriate dress in jeans and sweatshirt.

| Theme | Comment |
|------------------------|---|
| Incarceration | Father incarcerated; client has several incarcerations for misdemeanor offenses |
| Broken home | Due to father's incarceration. Picture concerning mother unclear. Raised part of time by grandmother. |
| Faith | Affiliates with Baptist, but no serious involvement |
| Abuse | Physical in home, by uncle |
| Impoverished education | 7 th grade education |
| Social | One friend |
| Opioids | Heavy pill use through mid-90s to roughly 2010. |
| Racetrack | First mention of Bristol Motor Speedway as conduit for drugs |
| Juvenile detention | Several stays |
| Poverty | |
| 1 st drug | Marijuana |
| Tobacco | Age 13 |
| Legalize | Cannabis |

(Note: the remainder of the interviews were conducted at Elizabethton Health Services, 405 Hudson Drive, Elizabethton, TN.)

C. 453M

41-year-old male

Married, three children

Interview Date: December 14, 2022

Presentation: Business casual dress, clean, professional presentation

Speech: Educated, measured

| Theme | Comment |
|--------------|---|
| Church | |
| Strength | Faith as strength in recovery |
| Easy access | To drugs in CC |
| Pain | Initiated to opioids after dental surgery, then broken foot |
| Work | Manager |

| | |
|------------------|-------------------------|
| Tobacco | First use at 13 |
| Fentanyl | Chewed fentanyl patches |
| Methadone | Used orally |
| Narcan | Familiar with use |
| Legalize | Cannabis |
| No opportunities | In CC |

D. 454M

39-year-old Male

Married, 4 children

Interview Date: December 14, 2022

Presentation: Jeans, long coat. Chest-length hair. Eager, excited.

Speech: Racing, imaginative, verbose, rambling thought, extremely cooperative, humorous

| Theme | Comment |
|---------------|--|
| Parenting | Poor parenting as a theme for CC |
| Trauma | Violence, physical abuse. Still has trauma reaction to loud sounds |
| Mental Health | As common issue for CC |
| Depression | |
| Anxiety | Takes Xanax |
| Pain | Initiated opioid use after catastrophic car wreck. Was on extremely high dose of opioids for four months, then dropped with no taper |
| Cannabis | “not a drug” |
| Tobacco | First use at 15 |
| Withdrawal | Horrific description, see below |
| Church | Baptist, excited about prospect of CMHC. See below |
| Boredom | Factor in drug use |
| Strength | Faith as strength, although does not attend church. |

Withdrawal description: “Was, it feels like every bone in my body was, was just seized up and tight. And the muscles almost felt like, almost like glass, like fragile. If you, if you fell, you'd break. Um, however, the worst part of the withdrawal with me was the mental aspect of it. Because I know in my mind that I, I suffer from depression anyway and things like that. And when you're going with, through withdrawal, like your brain will, it's like having a thousand thoughts in your head and not being able to get one forward. It's just like a car crash. And, um, and that is, it really is hell on earth.”

Description of suboxone effects: “When I take it, I'm not depressed, but I don't, of course, I've been taking it for like eight years now. Okay. So, it's like, you know, I don't get anything from it anymore. It just, it makes me feel normal. Yes. I don't have any depression. You know what I mean? It really helps my depression. It does. Okay. Um, I don't even take the anxiety medicine that I get really, you know what I mean? Like, it's just really the Suboxone. But I can go two days without it.”

Describes withdrawal from suboxone as worse: (relates that he wanted to go cold turkey, so he rented a cheap apartment to isolate from family) “The, as much as you can because it's gonna get ugly. Yeah. Cause you can, I mean, with through withdrawal you become violent. Sometimes you can even become verbally abusive. Uh, the least little things can set Yeah. Things off, you know. And, um, I laid there for 32 days, 32 days. And on a 32nd day I started having seizures. I almost died. Yeah. No, no. Like that. And, um, I tried, I tried to quit a cold turkey and I could, I, I really, and I got so lost in my mind that I thought when I came back, like, and to this day, I think if I ever go that far out there again, when I come back, I won't be myself. Like I'll lose something. Okay. Yeah. Um, so it is imperative that like, you know, I don't know, you know, exactly what you're gonna be getting into.”

454 On Church.

Kevin: Do you think church leaders in this area are open to working with people?

454: Absolutely not. Yeah. <laugh> because I mean, and, and that sucks to say it really does man. It's the church relationship. Yeah. Because what's the point of saving the saved? I mean, God didn't put the churches here for the people that's already saved. He wants to get out here and save the sinners <laugh>. Yeah. And um, I went, that's why, you know, I've not been into a church probably in 16 years.

Kevin: Do you think if there were a service where someone worked with people who are addicted and could kind of steer them to a church and work with a church? Yes. Do you think that would be,

454: I think that would be an amazing idea. Almost like a kind of, you know, revolves around a lot of faith basically. But I think it might be good to call it that, you know what I mean? To have a place to where, you know, people can come there and not worry about if they got holes in their shoes. Yeah. Or, because I mean, people that are just struggling and I know there's a lot of people that use the, that.

Kevin: If, if there were a service in Elizabethton that worked with addicted people and the churches, what would you call it? Would you give it a name?

454: Yeah. Yeah. It's Grace. Okay. Yeah.

E. 455F

43-year-old female

Not married, 3 children, 2 grandchildren

Interview Date: December 15, 2022

Presentation: inappropriately dressed for age. Many tattoos. Obviously in withdrawal during interview.

Speech: Impoverished speech and thought

| Theme | Comment |
|--------------|---|
| Divorce | Parents divorced when she was 13 |
| Pain | Opioid initiation after childbirth |
| Church | Baptist, now attends a Pentecostal church in JC |
| Friends | Zero |
| Resources | Cites lack of resources in CC |
| Tobacco | At age 11 |
| Depression | |
| Anxiety | |
| Low IQ | |
| Overdose | 2x |

| | |
|------------|---|
| Withdrawal | Actively in withdrawal during interview |
|------------|---|

F. 456M

36-year-old Male

Not married, in relationship. Two children from previous relationship

Interview Date: December 15, 2022

Presentation: Extremely slender, heavily tattooed. Obvious prison influence. Jeans below his waist. Extreme dental issues common to methamphetamine use.

Speech: Halting. Very odd accent, almost African American, possibly a speech affect from prison influence

| Theme | Comment |
|--------------------|--|
| Faith | Family is Baptist. Reports praying |
| Juvenile Detention | |
| Pain | Opiate use initiated after chest surgery |
| Mom | Who would you call |
| Friends | No friends, just acquaintances |
| Overdose | 2x |
| Narcan | Responders used NARCAN to revive |
| Incarceration | Imprisoned 11 years at Trousdale, reports no problems in obtaining opioids in prison |
| Withdrawal | Describes what it was like |
| Tobacco | First use 12 |
| Cannabis | Believes we should legalize cannabis, but all drugs also |

G. 457M

45-year-old Male

Single, two children

Presentation: Clean, well-dressed, expensive clothes and shoes. Six-inch silver crucifix pectoral cross

Speech: Clear, well presented

| Theme | Comment |
|--------------|---|
| Military | The only person I interviewed who had served in military. Was a 'military brat,' then served 4 years in AF. Honorable discharge |

| | |
|-----------|--|
| Church | Baptist, family very committed. Father and brother are deacons |
| Work | Has a great job |
| Strength | Faith. Wears a crucifix, almost as if Jesus is physically with him |
| PAIN | Opiates initiated after facial surgery. Miserable after care left him addicted |
| Mom | Importance of mother |
| Tobacco | Started at age 12 |
| OD | Graphic description of roommate who overdosed |
| Narcan | Had no idea what Narcan was |
| Marijuana | Should be legal. Better than alcohol |

458F

46-year-old Female

Divorced, 2 daughters, 5 grandchildren

Interview Date: December 15, 2022

Presentation: professionally

Speech: Normal

| Theme | Comment |
|-----------------|--|
| Pain | Initiated opioids after work-related injury as a nursing aide, back injury |
| Early pregnancy | At 16 and 18 |
| Iatrogenesis | Physician overprescribed, practice was shut down, Pharmacy never said anything about the over-prescription. Transitioned to street use |
| Tobacco | At 13 |
| Withdrawal | Description |
| Stigma | From pharmacies in particular |
| Mom | As first contact |
| OD | Lost best friend, aged 18 |
| Cannabis | Should be legal |

IV. Discussion

In this section I have tabulated the themes listed above by frequency. I have them listed them from most frequent to least frequent themes.

Tobacco (all 8) – If there is truly a ‘gateway drug’ that drug would appear to be tobacco. All eight interviewees mentioned using tobacco and all eight initiated tobacco use as a teen or even ‘tween.’ The earliest noted initiation was at age eleven. Most noted that they had attempted tobacco cessation unsuccessfully and were not open to the idea of ceasing the habit. Given the proven health danger of tobacco use, this would appear to be one area of public health that still needs emphasis.

Cannabis (8 of 8) – Cannabis use is a steady state in this population. All eight interviewees believed that cannabis use should be legalized. Most stated that they would prefer to see cannabis legalized and alcohol criminalized. Most see alcohol as grossly more dangerous than cannabis.

Pain/iatrogenesis/transition to street use (7 of 8) – All but one interviewee (#452) initiated opioid use following treatment for pain. Iatrogenesis roughly means ‘caused by a physician,’ which was indeed the case. After a physician ceased prescribing opioids, the patient was left with an addiction problem that she did not have the resources to overcome. Seeking relief from the addiction, seven of eight transitioned to purchasing opioids of all sorts on the street.

I began this project by stating that it was not my purpose to assign blame. I would like now to make one exception. In the interviews I conducted and in the hundreds of ones I have conducted over the years, I have heard a too common story – so common that I am able to present a composite story.

A patient turns to surgical care for a serious, often painful, but not life-threatening problem. The surgeon recommends surgery to remediate the problem. After what could very well be a brilliant surgery, the surgeon alleviates the patient’s surgical pain by prescribing opioids. In many cases Percocet was prescribed, with several interviewees stating that they were prescribed three a day for four months, with a total of 360 opioid pills consumed. After four months the

prescription stopped. A week after the prescription stopped, the patient began to feel unfamiliar symptoms, those of opioid withdrawal. The patient returned to the surgeon with a complaint about the symptoms. The surgeon listened but based on her training explained that she was a surgeon, even a brilliant one, not an addiction specialist. She referred the patient to her primary care physician. In other words, the patient was treated for a serious, non-life-threatening surgical condition, but was left without resources to face a life-threatening condition – that of opioid addiction.

I have heard this or similar stories so many times in the last fifteen years that I think I am qualified to express outrage at this medical practice. It is a practice that must be addressed and stopped. In the past decades, patients have frequently turned to ‘pill mills,’ unethical medical practices that turned out opioid prescription after prescription, profiting immensely by such practice. That was matched by unethical pharmacies that were all too willing to sell the medication, although it was eminently clear that this practice was harmful to patients. While the federal government has now heavily regulated the prescription of opioids, the damage, I fear is already done. In recent years, with a federal emphasis on closing pill mills, the vacuum created was filled by illicit fentanyl.

Church/Faith (7 of 8) Seven interviewees expressed at least some upbringing in a church, usually Baptist. Many were at least willing to consider how faith could be a strength for recovery. Two of the interviewees stated that they now attend a local church. Several, while open to the idea of faith, were wary of crossing the threshold of a church, for fear of stigma. There was enough interest, I believe, to warrant a Community Mental Health Chaplaincy to explore the connection between faith and recovery.

Overdose (6 of 8) – Six interviewees had either experienced overdose themselves or had known someone who had overdosed. Death from overdose was mentioned several times. The growing presence of fentanyl was likely responsible for many of these. To my surprise, there seemed to be little familiarity with the anti-overdose medication Narcan, or with its proper use. None of the eight reported carrying a Narcan kit themselves. Narcan is so important, especially given the fentanyl epidemic, that I consider it a vital part of chaplaincy to see that Narcan is made widely available, both to those who are addicted and to the public at-large, and that people are trained to use it.

Parenting/family/trauma/intergenerational abuse/Foster Care (5 to 7 of 8) – Four interviewees reported coming from broken homes characterized by divorce and turbulent relationships. One reported that he awoke to arguments every day of his childhood. Trauma, both sexual and physical, was frequently discussed. This trauma generally was intergenerational in nature. One reported more than forty foster care placements. If society wishes to make an impact, it logically follows that we should expend the resources necessary to provide a stable first four years of life and parenting support and training.

Mental Health/Anxiety/Depression/Suicidality (5 of 8) – There is a now an obvious mental health crisis in our population. My former supervisor at Frontier Health referred to the growth of mental health crises post-COVID as a ‘mental illness tsunami.’ Many people turn to substances of one form or another, most prominently, perhaps, alcohol, to numb the presence of mental health symptoms. This was an obvious strategy in the population I have interviewed.

Incarceration/Juvenile Detention (at least 4 of 8) – Given the criminal nature of illicit opioid use, many reported at least some brush with law enforcement. Two reported being held in

juvenile detention for behavioral issues. One reported being imprisoned for a term of eleven years.

Withdrawal () – I only late in the interviews took an increasing interest in the phenomenon of opioid withdrawal, so I do not report numbers here. I would like to mention that two people described in some detail the challenge of withdrawal and the desire to end withdrawal symptoms by virtually any means possible. Many have continued MAT for years, primarily because they fear withdrawal. There appears to be a need to discuss withdrawal with patients and to help patients understand and cope with withdrawal symptoms.

Summary – In response to the first research question at the beginning of this chapter, according to interviewee statements, faith and church *can* be a strength for recovery, but clients need help, mentoring, and guidance in accessing spiritual resources. I hope that my statement of pastoral theology and the need to reach out to our population made it clear that the church carries a moral responsibility for our population (Question 2). In response to the third question, (What responses can the church offer?), I believe the church has to make it explicitly clear that persons struggling with addiction are completely welcome to be a part of the congregation. I would look to the full inclusion of the LGBTQ community by several denominations over the last twenty years as guidance. In that effort, many churches made it explicitly clear that the LGBTQ community was welcome by making statements in church bulletins and sign boards, and in some instances by flying a rainbow flag. That sort of explicit welcoming message needs to be extended to the poor and those struggling with addiction.

I believe the research results outline the need for a comprehensive, societal response, not only to the opioid crisis now facing us, but to issues of mental health care to include trauma-informed care, parenting skills, and prevention. Many, when asked why opioid use was so

prevalent in Carter County, pointed to poor parenting, peer influence, intergenerational substance use, boredom, and a distinct lack of activities and resources for youth. While I have not focused on public health policies, providers noted that approximately sixty percent of their clients live with hepatitis, which is treatable, but there seems to be a need for a more a broadly available treatment regimen. Because of the prevalence of injection methods of opioids, the issue of endocarditis is also one of concern.

Chapter Sixteen

Conclusion

Writing in the centennial edition of the scholarly journal, *Foreign Affairs*, William Macaskill, an Associate Professor of Philosophy at Oxford University, makes a startling observation. We are, he observes, at the very beginning of human history. “For every person alive today, ten have lived and died in the past. But if human beings survive as long as the average mammal species, then for every person alive today, a thousand will live in the future. We are the ancients. On the scale of a typical human life, humanity today is barely an infant, struggling to walk.”⁵³⁷ We are at the beginning of our human history – if we learn to survive.

If we are to grow as a species from our current malicious, angry toddler phase, then we must navigate and conquer a vast range of challenges to the species: war, climate change, famine, pandemic, vast inequalities in ‘the wealth of nations,’ threats to liberty and justice – and the scourge of addiction. Addiction is a global issue, but I have focused in this project on the nature of the current opioid crisis in the United States, spotlighting the genesis of the problem in Appalachia, and researching the manifestation of the crisis in Carter County, Tennessee.

As I write in the closing days of the year 2022, the problem of opioid addiction is worse, not better – despite the heroic efforts of treatment providers and workers and the expenditure of vast national resources on the problem. In recent days newspapers and television anchors have splattered the news: in 2022 more than 107,000 Americans have lost their lives to opioid

⁵³⁷ Macaskill, William. “The Beginning of History,” *Foreign Affairs*, (2022) Centennial issue, September/October: 10.

addiction. This number is an unfortunate record in opioid deaths. Most of those deaths happened under the influence of fentanyl, a cheap and powerful synthetic opioid that kills in microscopic doses.

Combatting the opioid crisis involves different spheres of society, and thus there are at times radically different perspectives on addiction. At a minimum, addressing the crisis involves parenting, schools, prevention, the medical community, researchers, law enforcement, penal institutions, government organs, public health policy, immigration policy and border interdiction, and the addicted themselves. I have attempted humbly to portray the enormous complexity and long history of the problem.

In Part One of this work, I addressed the epigenesis of the current opioid crisis. We looked at the issue of pain, as pain treatment is frequently the pathway to opioid addiction. I then presented what is referred to as the standard account of addiction, that of the disease model so prevalent in our thinking today. We looked at the way in which addiction works, because the mechanism of opioid addiction is powerful, lasting, and frequently lethal. Following this, we considered the ways in which opioid addiction affects the brain systems of users and whether these consequences are permanent in nature. We briefly considered treatment options currently available.

In Part Two, I deliberately attempted to complexify the standard account. My rationale in doing so is that the disease model is not universally accepted. I reasoned that if the disease model is accurate, then why is it that our attempts to treat addiction so often end in failure? Why is the incidence of death from opioids increasing, not decreasing? I looked at the issue of control, expressed as medical control over addicted persons. My one regret in this is that I did not believe I had the space to include the work of the prominent French philosopher, Michel

Foucault, whose development of the concept of medical control and the ‘gaze’ has profoundly impacted the consideration of medical practice. Likewise, I did not have space to consider the recent work of Quebec physician, Gabriel Mate, on addiction and mental health. We considered the issue of our institutional and national racism, which has powerfully affected our very understanding of addiction and our response to addicted persons. I closed Part Two by taking up a survey of the genesis of the opioid problem in Appalachia. In this I was most affected by the work of Case and Deaton and their explication of deaths of despair.

Peppered throughout this work are cultural artefacts from literature and music regarding the issue of addiction. My premise is that musical and literary artists frequently perform a prophetic function in alerting the culture to the presence of danger. My approach to Parts One and Two has been shaded by my own interest in the field of history, as well as by my training in medical history and bioethics. For better or worse, my own twenty-year history of working with addicted persons as chaplain and social services manager has either informed or biased my work.

In Part Three, I returned to my home stadium, where Pastoral Theology is practiced. I acknowledge the profound influence that the Practical Theologian, John Swinton, has had on my own thinking. I am deeply indebted to him and grateful to Prof. Bonnie Miller-McLemore for introducing me to his body of work. The guiding principle of my work has been that Swinton’s conceptual framework of Community Mental Health Chaplaincy could be applied practically to serve the addicted in Carter County, Tennessee.

In the conception of this project, even before I put one sentence together, I thought of those who have suffered from opioid addiction as my own congregation. They are my parishioners, my choir, and my advising body. In the beginning, I even toyed with the idea of naming them

the Church of St. Jude. While I thought better of that idea, I have continued in my own mind to approach the addicted as if they were Jesus' own.

In Part Three I attempted to form a pastoral theology of addiction and ventured to express that theology in written form. I believe this is the most personal part of my work, as I have attempted to express my own faith and beliefs with special emphasis on ministering to those who are addicted. I also attempted to make a clear distinction between medical treatment and healing, believing that healing is best guided by a pastoral systems approach.

I want to close this project by relating what I believe to be my own greatest learning from the research and practice presented here. This concerns the (modernist) approach that medicine takes toward treatment, in this case, treatment of the opioid addicted. In the reigning model of medical care, a 'patient' 'presents' to a physician with a particular complaint and set of symptoms. The physician, ever the unmoved observer, records and considers the symptoms, and then provides a working diagnosis and a treatment plan. This may include the prescription of medication but will in any case involve instructions to the patient.

This approach is reigning because over the last one hundred years it has been mostly effective. Whether I present with symptoms of diabetes, high blood pressure, or a broken bone, the unbiased observer can diagnose and treat. This approach is also modernist in philosophy, in that embedded in the approach is the belief that any observer or instrument of observation can be unbiased. The seeming remoteness of the physician is intentional. The observer is enabled by not allowing the influence of emotions.

I now believe this modernist approach to the treatment of addiction is deeply flawed, for reasons I will explain. If I believe that I 'have' an addiction I may turn to a physician. That

physician's approach is no different from her approach to a broken bone. The physician will seek to isolate the addiction and may prescribe medication assisted treatment, such as suboxone or methadone. The effort is to 'remove' the addiction, as a surgeon would remove a tumor. The physician will issue a treatment plan, will 'follow' the patient over time, and will check to ensure the patient's 'compliance' with the plan. The problem, in the field of addiction at any rate, is that this form of treatment frequently fails, as we saw in the case of the Narcotic Farm. Relapse is frequent, patients are ever non-compliant - and rarely patient. The physician's expectations of the patient's gradual improvement and eventual abstinence and return to 'normal society' are 'oft turned to naught.' But why does this approach to addiction frequently fail?

A partial answer, I believe, came as I was re-reading a classic sociology text, *Social Selves*. The eminent sociologist, Ian Burkitt, opens the work with a statement of his project.

The view of human beings as self-contained unitary individuals who carry their uniqueness deep inside themselves, like pearls hidden in their shells, is one that is ingrained in the Western tradition of thought. It is a vision captured in the idea of the person as monad – that is, a solitary individual divided from other human beings by deep walls and barriers: a self-contained being whose social bonds are not primary in its existence, but only of secondary importance. This understanding of people as monads creates one of the central problems of the social sciences, a problem that has become known as the division between society and the individual. What, it is often asked, is the relationship between society and the individual?⁵³⁸

Burkitt's project is to prove the fallacy of this last question. The question assumes that we can separate the individual from society and its many influences.

⁵³⁸ Burkitt, Ian. *Social Selves: Theories of the Social Formation of Personality*. (London: Sage Publications, 1991): 1.

I want to argue that the current medical treatment of addiction suffers from treating the addicted person as a monad, and not as one who has developed under a vast web of familial and societal influences. Theories of personality have multiplied since Burkitt wrote these words, but I return to this core issue. A physician, the objective observer, typically treats the addicted person as a self-contained unit that carries addiction as a “uniqueness deep inside themselves.” The truth of the matter, as I have discovered over and over again, is that addiction displays all of the problems of society, from the issue of the importation of illegal drugs and law enforcement, to broken family and faith systems, to mental health, unemployment and underemployment, poverty, health care, the encounter with pain, and so on and on. Unless and until we begin to approach the issue of chronic addiction by addressing these societal issues we will continue to fail. I, however, hold out hope that, through the help of God and the best efforts of the species, we can begin to design a society that adopts a systems approach to the issue of addiction. *Deo Volente.*

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