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**ECOLOGIES OF CARE:
WHITENESS, CLINICAL POWER, AND POST-OPIOID FUTURES**

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ABSTRACT OF THE DISSERTATION

Ecologies of Care: Whiteness, Clinical Power, and Post-Opioid Futures

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This project seeks to reveal and dismantle the many consolidations of power (racial, capital, ethical, affective) that structure and vitalize systems of clinical care in the U.S., both currently and historically. Attending to such consolidations of power exposes the ways in which individual harm and collective crisis function as forms of currency and value in U.S. clinical medicine today. These forms of currency and value are differentially distributed depending on one's proper relation to the state and to key markers of difference—race in particular. As such, the contemporary sphere of U.S. opioid politics serves as a key backdrop for theorizing racial difference generally and whiteness more specifically as specific kinds of clinical and cultural capital in current systems of care. By examining U.S. opioid politics alongside three keywords – Pain, Crisis, and Recovery—this project ultimately seeks to track the ways in which available mechanisms for recognizing and responding to the supposed “fact” of pain in U.S. clinical medicine have resulted in the un-even enfolding of white bodies into the protective structures of the clinic under false promises of endless re-capacitation, while

communities and bodies of color are systematically denied such access. Ethnographic research with participatory, peer-to-peer recovery communities in Franklin County, Massachusetts demonstrates vital alternatives for theorizing and enacting care otherwise by centering those who have largely been excised from institutional and state protection in the work of community-directed healing. Ultimately, this project argues that only by coming to terms with—and by becoming accountable to—the histories of violence and extraction that vitalize and securitize bodies of U.S. clinical power will we be able to imagine and then generate other systems and praxes of well-being and of care moving forward.

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It is a pleasure and a privilege to finally turn this work out to the world—to take a deep breath and to let it live outside of the porous yet wholly protective shell that has nurtured it, fed it, and helped it to grow in ways I could never have conjured on my own. Thank you for meeting us here, where we are at.

A dissertation is, it seems, an exercise in endurance. It pushes us and also *permits* us to remain enthralled in what Octavia Butler calls “positive obsession” in Verse 39 of *The Book of the Living*:

*God is Change,
And in the end,
God prevails.
But meanwhile...
Kindness eases Change.
Love quiets fear.
And a sweet and powerful
Positive obsession
Blunts pain,
Diverts rage,
And engages each of us
In the greatest,
The most intense
Of our chosen struggles.¹*

In the midst of the ongoing traumas precipitated by the U.S. state and in the midst of the collective push to look directly at, turn out, and then re-figure all of the histories of

dispossession that lay at the heart of what it means to “belong” in the United States, a “sweet and powerful” positive obsession such as this work has been, quite often, a very welcomed respite.

Over and over again, this project has encouraged me to turn away from the structures and stories we’ve been invited (compelled, even) to invest in about the roots of harm and the labor of care. It has likewise encouraged me to turn towards, listening deeply to all those who believe that other worlds are in fact possible. I listen, and I learn, and in these pages, I try to apply the critical and emotional tools I’ve honed to the work of unraveling what we have been given and weaving something else from the refuse.

If a dissertation is an exercise in endurance, one that has facilitated for me the pleasure of positive obsession—it is also, in many ways, a birth. It is a coming-to-term of a mash-up artifact made from what is inside me, blended and stirred together with infinitely generous offerings from all of the people, places, ideas, and lines of flight that comprise these words and these arguments. The energy of the gratitude I hold for such a birth is tremendous.

First and foremost, I want to begin by expressing external gratitude to the two folks who believed in this project wholeheartedly from its very beginning: my mentors and committee co-chairs Dr. Carlos Decena and Dr. Kyla Schuller. I was first exposed to Kyla’s brilliant mind and incredibly supportive and dedicated mentorship during my first semester as a PhD student in the Department of Women’s and Gender Studies at Rutgers in the core seminar “Technologies and Poetics of Race, Gender, and Sexuality.” As a fresh-faced first year, I was immediately inspired by an incisive theorist who also demonstrated critical, ongoing commitments to the domains of feeling, sensation, and

affect. Later, as Kyla's Research Assistant throughout the production and publication of her brilliant first book, *The Biopolitics of Feeling: Race, Sex, and Science in the Nineteenth Century*, I learned first-hand about the nitty-gritty work of producing rigorous critical scholarship and the many ways in which such a process demands a unique kind of endurance cultivated through learning to *believe* that there is indeed value and worth in one's perspectives, arguments, and words. Kyla taught me much about how to tap into and become accountable to such forms of self-valuation. Bearing witness to Kyla's ongoing, often relentless negotiations with the bodily realities of illness while also undertaking the daily work of endurance and the exertive work of pushing back against the disciplining norms of mainstream, Western bio-medicine has continuously shaped and re-shaped my own vision of what critical work can look like. I am exceedingly grateful for all that Kyla has so generously given both to this project and to me directly in the form of friendship and the opportunity for convivial collaboration. I look forward to so much more.

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In the process, Carlos was one of the first mentors in my graduate experience to “see me” in my full complexity as first-generation college student with working-class roots who wanted to integrate such experiences fully into my critical contributions. Such recognition sanctioned me to speed ahead in ways that shame and fear had often squelched prior to our relationship. I am eternally grateful to have found such recognition and encouragement. Later, as I slogged through the many drafts of these chapters, Carlos continued to remind me to center the vital pleasures of writing and to cultivate a writing practice that honored the spiritual and even erotic dimensions of this work as much as the *labor* of reading and writing. Following such encouragement to turn towards the many pleasures of this process, to revel in the psychic play of crafting argument, and to not drown in doubt and fear is a major part of what sustained this work and I have Carlos to thank for such gifts.

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thinking through the politics and political economy of the clinic. It is a true privilege to know that each of these scholars is taking the time to attend to my work.

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Notes to Acknowledgements

¹ Butler, *Parable of the Talents*, 45.

Dedication

This work is dedicated to the feisty, loving memory of my dad, Chuck Whitmore, who taught me much about the hard work of resisting the many insidious workings of power—state and otherwise. My dad passed away the day after I completed my dissertation research in Summer 2016, and now he is everywhere—guiding this work’s momentary completion and loving me through to its future.

Table of Contents

Abstract	ii
Acknowledgements	iv
Dedication	xiii
Introduction: <i>Challenging Care in the Crucible of the Opioid Crisis</i>	1
Chapter 1: <i>Bodies on the Line: Histories of Pain, Clinical Power, and the Affective Life of Whiteness</i>	67
Chapter 2: <i>Crucibles of Crisis: Ordinary Whiteness, Opioid Biopolitics, and the Racial Mattering of Death</i>	131
Chapter 3: <i>Re-Rooting the Cut: Making and Un-Making Recovery Ecologies in Franklin County, MA</i>	195
Coda: <i>Tapping Ecologies of Care in the Surround</i>	274
Works Cited	285

INTRODUCTION:

Challenging Care in the Crucible of the Opioid Crisis

I. Parables of Pleasure, Parables of Despair

You know the story. “Regular Guy” (RG) wakes up every morning. He makes his coffee. He grabs his lunch. He goes off to work. He does it every day for 30 years. He pours concrete. He operates heavy machinery. He cultivates the land. He mines. He hauls. He lifts. He builds. He carries. He comes home. He eats dinner. He watches TV. He goes to sleep. He wakes up, and he does it all over again. About his work, he is told to be sure that he is contributing to the security and stability of his family, his community, and his nation. He believes every word of it. One day, finally, he sustains an injury. He throws out his back. He tears a rotator cuff. He dislocates a knee. The injury is not, of course, due to his body’s own inherent limits. Rather, it is on account of his showing up for work everyday and not asking questions. Not stirring the pot. Doing what he’s supposed to do. RG ignores the pain—because that’s just what guys do—until it becomes chronic and he can no longer ignore it. RG goes to his doctor to talk about the pain he’s experiencing, and more often than not—at least up until about 2014—RG receives a prescription for a heavy-duty opioid. OxyContin. Percocet. Tramadol. Vicodin. Demerol. Morphine. Fentanyl.

The pain, the doctor tells RG, is the result of his physical injury. It is caused by the sudden emergence of an abnormality in his back, in his knee, in his shoulder. The pain lives inside of his physical structure, and RG knows what the doc is talking about—it hasn’t stopped nagging him, even after 4 months of Advil morning, noon, and night. He lives with it. It causes him to snap at his wife and kids. It causes him to feel inundated

with rage. It causes him to feel out of control and useless. Unproductive. Idle. Lazy. These are new feelings, feelings he's never really had before. Pain relief—misrepresented by the doctor as actual healing—will come from consuming the drug in the manner directed: swallowing the pill, wearing the dermal patch. If he is lucky enough to see the right doctor with the right insurance at the right time of month (i.e., after an office visit from the friendly local pharmaceutical rep) he might even leave the visit with a complementary 10-pack of fentanyl-laced lollipops. These will deliver potent pain relief within 20 minutes—as quickly as an injection—accompanied by a sugar high and a doctor-sanctioned authorization to self-administer this immensely powerful antidote to crisis-inducing pain all the while looking like he's simply having a snack.

RG takes the prescription as directed. Because opioids are indeed a highly addictive class of substances he becomes—at the very least—dependent on them. The pain in his shoulder, his back, his knee, it begins to subside just as his neurobiology is slowly beginning to re-arrange itself—cozying up to a new network flush with pleasure. He kind of likes the feeling. Natural opioid receptors in RG's brain are eagerly shacking up with their synthetic counterparts that live in the pills, the patch, or the lollipop. As connections are sparked, dopamine is released and courses through RG's midbrain, stimulating an internal reward system that very likely hasn't seen activation from an external source in a long time. Workdays are, after all, so slow, and the warm buzz of a six pack during nighttime TV just doesn't cut it anymore. The rest of RG's brain works hard to remember those connections, and the next time he approaches the medicine cabinet, RG's body remembers what it feels like to flush with pleasure. He swallows again.¹ After six months of a game that is increasingly pleasing and also somewhat

concerning, RG begins to really feel like maybe he can't do without his daily bathroom sink regimen. He doesn't like feeling dependent on anything, so he decides to see what happens if he doesn't take his dosage of relief one morning. He's got to have kicked this thing by now, right? Right??? The result is a ravaging return to pain. This time, however, the sensations are not just concentrated in the original source of his injury. They are, rather, setting his entire body on fire. He sweats. He vomits. He shits. He cramps. With this small taste of opioid withdrawal under his belt, RG begins to sense the scope of his situation. The doctor likely never told him that ceasing this prescribed method of pain relief would be as difficult—if not more difficult—than enduring the pain that got him there in the first place. The doctor likely never described to RG that consenting to this mechanism of pain relief would entangle him within a very tempting economy of pleasure that is, it turns out, actually quite hard to kick. The doctor likely never told RG that his brain was wired for this kind of boost and that given the monotonous circumstances of his daily life, RG might really like this kind of sensation. RG didn't know that his life was so painfully devoid of pleasure.

Sooner rather than later, RG faces a juncture: taper down off of the opioids—often with little to no support from the doctor who prescribed the drug in the first place—and lose his newly discovered, albeit private source of gratification. Or, see what else he can work out. He starts posing hypothetical questions: How might that rushing boost that he usually sparks before work feel *during* work? Would that warm, tingling sensation make the day go by faster? Could it tamp out his boss' bad attitude or drown out the mindless chatter of the guy he works next to? Could he alone find a way to increase the

prevalence of this positive feeling in his life—this lightness, this weightlessness, this pure release and coursing of pleasure? Yes. Yes. Yes. Yes.

RG goes back to the doctor to try to secure more pills the legitimate way, but the doctor has recently been disciplined after increased oversight in the practice. His pharmaceutical rep no longer comes by with free samples of the good stuff—the latest in cutting edge opioid research and development. The doctor cuts RG off. Tells him to go back to the extra strength Tylenol and see a therapist. Angry, RG draws on his own sense of self-reliance. When has an authority ever stopped him from getting what he wants? He scores some extra pills from a buddy at work. He finds serenity once again. Quickly, he is spending upwards of \$100 a day to keep his pain in check—the pain in his back, the pain of withdrawal, the pain of returning to a life without access to easy, effortless pleasure. And now, he just really can't afford it anymore and someone gives him a shot of heroin to try instead because it costs \$5 instead of \$65 and then he learns to inject it and that cuts by nearly 20 minutes the wait time for that rush of pleasure and he likes it he likes it he likes it he likes it now he's in it he's in it he's in it he's in it...

II. Regularizing Regular Guy's Regular Pain

Regular Guy is Regular in the way that white and working class have historically been Regular in the United States: Regular as ordinary, Regular as believable, Regular as worthy, Regular as the presumption of integrity, Regular as the beneficiary of the long-unaccounted-for spoils of American Greatness-as-American-Whiteness. RG's *pain* is Regular in that it carries within itself all that we've been taught to know and see as unacceptable about certain kinds of bad feeling today. It is a barrier to his accessing all

that he is *supposed* to have full access to *as* Regular Guy: a good day's work; a loving, supportive wife; continuously appreciating financial assets, kids who respect and care for him; a meaningful role in community. This pain makes RG feel vulnerable to all that he had been impervious to before: the penetrating, inquiring gaze of doctors; the irritation of being dismissed by those who cannot comprehend his hurt; and ultimately, the isolation and loneliness that surfaces when there is no one left to hold his hurt for him. RG's wife works three jobs, now. She can no longer do the work of holding him like he's used to. This pain—taken to its logical end—imperils RG's long-guaranteed access to the Good Life. It imperils his capacity to live, and there is nothing normal or acceptable about that. This pain, it jeopardizes all the truths RG's taken to be self-evident about his body, his self-control, and his integrity. There is nothing comfortable about that. This pain: it threatens RG's right to get better—a claim that has no doubt been quietly nurtured and supported by every single system and structure RG has ever encountered. This pain? It makes RG feel fragile, and it tells him something new about himself: that despite all he's ever been told, he may not actually be—on his own—enough.

As the specter of pain balloons in RG's life, it no doubt upsets RG's hold on “reality” just as it troubles his ostensible right to belong fully to a heroic—albeit no less tangible—story of American Greatness that has always been crafted in his image. RG's own bodily capacity has, up until this point, been something he could depend on—naturally. He is a workingman, after all. Total impairment—the kind that keeps him seeking, seeking, seeking any kind of relief from an increasingly unbearable sense of weakness—has never been something he's expected. To his great dismay, his bootstraps are ripping. Oh shit. Rather than remain invested in the likelihood of a gracious return to

what once was Regular—what RG used to take for granted, even—RG’s despair (along with this torn bootstraps) force him to face the vision of imminent breakdown in his own future, a breakdown that was always for someone else and not for him. In that vision, RG loses his *value* as someone who has “worked” for what he has and has thus “earned it.” This arbitrary injury is different; there is no bouncing back. It has compromised his ability to earn, and what is white, working class life without work, anyways? RG’s pain illuminates the ways in which myriad forms of loss (of work, of capacity, of identity, of productivity, of control) permeate the contemporary animation of whiteness as that which is both in crisis and in desperate need of state protection today. In this project, I refer to the tense aperture of white pain, white loss, and white drug-related harm as *opioid despair*.²

But RG’s perceived losses do not *actually* mean he is alone. Rather, RG’s sense of individual loss will, as this work suggests, be put to good use in guiding and informing an emergent (white) *public* whose collective identity and value rests in the inherent right of (some) bodies to first publicly acknowledge their pain, loss, and despair and then to leverage public and private resources towards the care and remediation of those losses as a special kind of state emergency. As RG’s increasingly familiar parable of opioid despair is offered to us over and over again across media, public health, and law enforcement systems alike, we are collectively invited to be keepers and protectors of the capital and value that RG’s individual losses inherently carry within themselves. We are expected to identify. We are expected to extend sympathy and recognition towards RG’s misery, and we are encouraged to participate first and foremost in a national project of ameliorating and soothing his pain—the pain of his injury, the pain of his alienation, the

pain of his chemical dependence, the pain of his struggles to get “clean” and “back on track,” the pain of recovery. Put another way, the losses that RG has sustained position him within an emergent population of working-class whiteness-in-crisis whose gradual de-capacitation no doubt shows us the kinds of power—clinical, state, military, industrial—that can and will be marshalled when the long-insured agents and icons of (White) American Greatness begins to rust out, overdose, fall apart, or die.

RG’s pain is regular in that it comes to the center of our national consciousness in and through the ongoing disavowal and negation of so many other kinds of pain that hide in plain sight: the sweating, breaking backs of migrant farmworkers who have no health insurance or days off at all; the repetitive, body-stiffening motions performed by a mostly black and mostly disenfranchised prison work force that labors for pennies a day in “compensation” for hand-making products like dentures and Victoria’s Secret lingerie and McDonald’s uniforms and law enforcement equipment.³ In this project, I take up the contemporary landscape of U.S. opioid politics in order to track and account for the visions of crisis that emerge when the presumption of capacity that has always been encoded into formations of U.S. whiteness begins to falter. I argue that the parables and praxes of opioid despair that we are continuously invited to invest in at the height of the opioid crisis ultimately signal a re-capacitation of whiteness-as-we’ve-known-it: whiteness as resilient, whiteness as vital, whiteness as that which can and should be protected and “recovered” *at all costs*. For bodies that have long been presumed expendable and inherently de-capacitated, the frantic onset of the conditions of crisis is instead rather pain-fully ordinary.

Specters and stories of bad feeling no doubt animate the collective will to know more and to do more to relieve the many senses of harm, injury, and discomposure that blossom and die in the crucible of what is being called the opioid crisis today. I use the term “crucible” in this work to denote a kind of container or vessel used to heat and meld together previously distinct elements and substances. I find it useful as a frame because it confirms that what we’ve been taught to call the “opioid crisis” is not, in fact, a distinct or coherent formation that begs distinct or coherent solutions. The crucible of *this* crisis is, rather, a hollow vessel. It is a charged container. It holds unacceptably vulnerable (white) bodies together with a range of vital and deep-rooted cultural assumptions about race, sensation, redemption, valuation, and bodily worth. It holds together the conditions of possibility for the ongoing consolidation of U.S. clinical power and the re-entrenchment of white crisis as a kind of capital. It portends the excavation and re-animation of the site of the factory as the place that will save us as we vision and construct new systems of treatment and recovery in response to that crisis. In their coming together, the contents of this crucible tell us much about where and how and why we care for bodies on the line. As heat is added—via emergent political discourse, growing media and public health attention, increased legislation and funding opportunities, and the daily amplification of “ordinary” voices decrying the ruins of addiction, overdose, and death—we necessarily confront the cogent and formative power of white pain and white despair in forming and stabilizing the landscape of “ordinary” whiteness today.

How does the clinical apprehension of certain kinds of bad feeling make visible some harms at the expense of others? How does pain—and its presumed ability to de-

capacitate good, “productive” citizens—trouble the presumed resiliency of whiteness as a national formation? And how is incapacity always already encoded into bodies of color? What happens when we finally begin to acknowledge that pain—how we understand it, how we treat it, how we recognize its reach—is indeed at the center of a crisis that is as much about opioids as it is about the many ways that we have historically used the tools of clinical power to manage the unspeakable problem of racial difference? And ultimately, what happens when we look towards the generativity of crisis—offered up to us in myriad parables of opioid despair—to tell us something not about breakdowns in individual bodily integrity, but rather about the breakdown of ordinary whiteness as that long-tended invitation into the mythic fold of American Greatness? Where do we go from here?

I pose these questions in order to name the stakes of confronting whiteness as a specific kind of clinical and cultural capital in the contemporary animation of white opioid despair. These questions likewise frame the key intervention this project hopes to make into the structures and praxes of mattering that are both embedded into and concealed within the clinical economies of care that are vested to heal us today. To be clear, the clinical systems and structures of “treatment” and “recovery” that we have at hand to value and respond to opioid-related harms and injuries are steeped in tangible histories of trauma, racism, sensorial disavowal, and the differential management of actual bodily violence. We know this from listening to lived experiences of marginalization in sites of clinical treatment today just as we know it from re-turning to historical accounts of the clinical body and reading for deeply uneven relations of power there. As such, through a critical insistence on revealing narratives and praxes of white

supremacy embedded within sites of clinical power, this project ultimately serves as a call for reparations and for restorative justice in U.S. clinical systems and praxes of care. It asks us to not only name and identify the injurious presence of whiteness in contemporary economies, praxes, and systems of care, but also to account for the historical legacies of those injuries and harms at the level of structure, system, and psyche. It is only through a deep political-economic recognition of and re-distribution of resources, affects, and ethics of care that we might get closer to disarming and re-imagining the racialized ideologies and practices that prop up those systems and validate them to create and then arbitrate the bounds of wellness and unwellness.

The purpose of this work is both theoretical and practical. Ultimately, it invites visions of—and, eventually, strategies for—divestment from deep wells of racial-capital accumulation and the institutional management of bad feeling that prop up and consolidate the boundaries of ordinary whiteness today. Divesting from such structures is necessary if we are to reckon with the fact that contemporary clinical systems—often framed as the most expedient route to facilitating “recovery”—are themselves replenished by the constant demand for replenished populations of harm. Only by coming to terms with—by becoming accountable to—the machinations of violence and extraction that continue to drain those deemed expendable as they seek remediation from harm will we be able to actually generate other systems and praxes of well-being and of care moving forward.⁴ In the next section, I’ll unpack the key frameworks and literatures this project mobilizes to undertake the work of naming and excising racial difference and capital accumulation as key apparatuses of meaning-making and mattering in sites of clinical power today. I’ll likewise point towards the frameworks, praxes, and stories we

must listen to and learn from if we are to move beyond the conditions of valuation and extraction that currently mediate all that we invest with futurity.

III. Contexts and Frames

Developing Critical / Affective Ontologies of Care

A key intervention this project seeks to make is in revealing and dismantling the many consolidations of power (racial, capital, ethical, affective) that structure and vitalize clinical systems of care in the United States, both currently and historically. Attending to consolidations of power in systems of care no doubt reveals the ways in which individual harm and collective crisis function as forms of currency and value that are differentially distributed depending on relations to the state and to key markers of difference—race in particular. As such, in this project, care in the broadest sense names both the sanctioned, systemic clinical management of injury and harm at sites such as hospitals, clinics, and treatment centers, as well as *grassroots* networks, affects, and praxes of attention and response that are mobilized when the sanctioned boundaries of the clinic (or the treatment center, or the school) fail to pull certain bodies into the folds of wellness and, eventually into the folds of futurity. Care here is both technological and material. It is political and embodied. It names the macro-level relations of power that are mobilized in legislative action and public health initiatives, insurance and treatment marketing, and clinical encounters, as well as the micro-level, affectively-driven, and localized relations of attentiveness, orientation, and response that are exchanged in sites of (presumed) vulnerability or liminality.⁵

In attending to the historical legacies and contemporary visions of *clinical* care at work in the crucible of the opioid crisis, we must first make explicit the ways in which care—understood here as the systemic management of injury and harm—operates as a de facto system of valuation, ordering, and mattering that is and always has been forged and protected in the image of ordinary whiteness.⁶ Doing so no doubt shows us that the labor of care is never simply a no-strings-attached relation of tending to harm or injury in a single body. The labor of care in contemporary U.S. clinical medicine is, rather, about messy, feeling-full encounters across multiple delineations of difference. It is likewise about calculated, collective investments in maintaining the structures and safety of whiteness—an (often) “professional” evaluation of a body’s capacity to “measure up” to the norms of embodiment and behavior that signal proximity to and respect for whiteness-as-value. Thinking both whiteness and care in these terms demands a rigorous set of theoretical tools, frames, and practices that can account for and attend to the latent, experiential, and “everyday” dimensions of injury, pain, despair, crisis, and transformation that both exceed and flow through state, public health, scientific, policy, and other institutional accounts of such kinds of bad feeling. Theories of affect and praxes of peer recovery provide such vitalization in this project and thus serve as overarching frames for each chapter and the stories they seek to tell.

The Affectivity of Care

Through an explicit attention to intensity, threshold, and sensation, theories of affect have guided and shaped this project from its seeding to its fruiting. Following a critical divestment from the limits of representational thinking, affectivity tells us we can

and should pay attention to the generativity of emergence, relationality, temporality, network, and encounter as we think and feel the body and its imbrication in relations of power. As such, in theorizing the register of white opioid despair as the elaboration of a kind of opioid bio-politics, affect points us towards different modalities of “evidence” capture and analysis that unfold apart from what’s offered by public health, bio-psycho-social, or “evidence-based” frameworks of “addiction” or “substance use disorder.” “All drugs,” as Deleuze and Guattari remind us in *A Thousand Plateaus*, “fundamentally concern speeds, and modifications of speed...Nothing left but the world of speeds and slowness without form, without subject, without face. Nothing left but the zigzag of a line.”⁷ Here, proto-affect theorists Gilles Deleuze and Felix Guattari offer a compelling invitation into the affectivity of drugs, one that can no doubt tell us much about the embodied shuttle between out-of-time pleasure and stultifying impasse that is the body on opioids—intoxicated, medicated, placated. In white, working class life worlds constituted by the alternately dragging and sped up approach of both the opioid and the economic edge, theories of affect help us unpack why and how self-induced subject-obliteration can be a welcomed *opening* to states of formlessness and disembodiment. This is an insight that no doubt escapes and/or exceeds professional accounts of the white, working class draw to opioid use in the first place; it’s likewise an example of what theories of affect offer attempts to “read” the social, the historical, and the embodied both together and otherwise.

Theories of affect likewise provide much for thinking the generativity of “the ordinary,” another overarching framework on which this project relies. In working through and across the boundaries of body, community, and state, Kathleen Stewart’s

notion of “ordinary affects” remains central to my examination of the structural and political recognition of white harm alongside the intimate, emotional, and embodied dimensions of excision from that recognition. Affect—or, “ordinary affects” for Stewart—function, “not through ‘meanings’ per se, but rather in the way that they pick up density and texture as they move through bodies, dreams, dramas, and social worldings of all kinds. Their significance lies in the intensities they build and in what thoughts and feelings they make possible.”⁸ This project likewise seeks intensities as sites of knowing. The moments, spaces, speeches, spirits, and touches that hold and overflow with vibrations of loss, fear, and fragmented belonging tell us much about the feeling-full machinations of U.S. state opioid response that seek to remediate those tensions. In designating bodily intensities as political but not representational, Stewart furthermore provides a structure of knowing that attends to the ways in which “a reeling present is composed out of heterogenous and noncoherent singularities.”⁹ Heterogeneity and incoherency, although troubling to the structured agendas of clinical “best practices” and behavioralist checklists, ultimately name the messy ways in which bodies of multiplicitous harm navigate through clinical worlds that are anything but reliable.

The register of opioids, then, *is* affective—both in the ways that opioids operate as an affective economy of movement between the poles of pleasure and aversion, as well as in the many ways that the opioid crisis is delivered to us via images and narratives of (white) bodies navigating the affectively charged terrains such as overdose, NARCAN revival, and/or other enmeshments in the emotionality and drama of deep opioid despair.¹⁰ Affect gives us the language and the attentiveness to the *unseen* that is necessary for challenging the presumed “objectivity” of data driven, evidence-based, and

clinical accounts of harm, injury, and recovery. It likewise provides channels of knowing and feeling for the ways in which care is as much about discerning clinical best practices as it is about discerning dynamics of attention, tension, and the feeling of tenable world-making in the wake of myriad kinds of hurt and loss.

Peer Recovery World-Making

If affect helps us theoretically attend to the unseen and the latent in sites of clinical care—the knowledge and power held in body languages, for example—grassroots practices of participatory, peer-to-peer recovery world-making recognize those latent and unseen sources of power and use them to unfold the richness of self- and collective transformation—the richness of recovery—apart from clinical mandates and matterings. The work of U.S.-based peer recovery within which this project is anchored begins with a simple assertion: we must necessarily center the knowledges and experiences of those who have lived experiences with trauma and violence in the systems and structures that respond to such harm.¹¹ It continues with the cultivation of community spaces that encourage us to belong, matter, and contribute to the elaboration of healing—our own and our community’s—in ways that challenge the implicit and explicit hierarchies of clinical medicine.¹² At the heart of such work is a recognition of the inherent disparities in distributions of power, authority, and knowledge in clinical practices that manage and mediate harm. Building upon the “Nothing About Us Without Us” ethos of Mad Pride and disability justice activism of the 1970s and 80s, peer recovery world-making poses an implicit critique of the damages done to marginalized bodies enmeshed in clinical treatment systems that fail to recognize the complexity of

sustaining healing processes within various modes of *ongoing* unsafety, precarity, and explicit violence.

Today, practices of peer recovery unfold by bringing people with wildly different lived experiences together to un-do silos of care while actively pursuing and enacting a participatory ethos of shared vulnerability. Part of that work is simply learning how to talk to other people we might never have encountered in the “real world” with deep respect for one another’s experiences and processes of growth. Another part of the work is creating the conditions for unexpected connectivities to unfold, such that we can explore mechanisms and processes of accountability and transformation honestly and with the support of loving, accountable community as witnesses. Peer recovery work ultimately seeks to create the conditions for a shared vulnerability that is radical in its attentiveness to dynamics of relationality, harm, and difference. People navigating multiple, messy, and often complex pathways to living otherwise are encouraged to use their experiences to undertake the work of community and life (re)-building apart from what clinicians, social workers, or justice systems have deemed prudent. Its focus on the *creative* production of community-driven, truly participatory structures, practices, and ethics of support in the midst of ongoing conditions of insecurity and precarity mark its uniqueness as an alternative site for thinking and doing the work of healing and care otherwise.¹³

My own investment in the radical potential of non-clinical sites and practices of recovery-world-making (also: care) come from over 10 years of work with the RECOVER Project (RP), a peer-to-peer recovery community based in Greenfield, MA. Formed in 2003, the RP emerged as a grassroots response to growing conditions of

disparity in access to formal clinical addiction treatment services and supports in Franklin County, Massachusetts, after a major detox center in Greenfield was closed and publicly-funded social supports were being slashed by increasingly neoliberal state budget cuts. Rather than call for a refortification of traditional clinical models of treatment in responding to the embedded and localized complexities of drug-related harm in Franklin County, RP community elders drew on their own regional and nation-wide work with trauma-informed practices, the mutual support ethos of 12-step programs, and local mental health de-institutionalization activisms to articulate a new model of grassroots care for responding to the many iterations of traumatic despair in this rural, isolated region of northwestern Massachusetts. The RP model centered on building a participatory environment where community members with shared lived experiences would define, design, and implement the ethical and practical dimensions of healing in relationship. Central to that environment would be the resiliency, knowledge, and community-making capacities of those most impacted by experiences with drugs, as well as by the myriad structural realities that subtended drug-related despair in this particular area, including incarceration, housing insecurity, intimate partner violence, child custody issues, and physical isolation.

As a distinctively non-clinical site of recovery world re-making, today the RP cultivates visions and practices of the future that do not wholly rely on the endemic violence of extraction (of profit, of “evidence-based” data, of an always already precarious “recovery” workforce) from bodies of harm or on the false promise of “recovering” one’s tenuous position in local hierarchies of ordinary whiteness. Rather, the work of the RP centers on tending to the fruits of collaboration, or on creating the

conditions for the shared work of building new ways of mattering and belonging to the wider community that do not rely on a “return” to the unattainable demands of normative “recovered” productivity or to the damaging systems of “care” that so many are enmeshed in. Rather than dismissing people as they fail to “measure up” to standardized markers of worth and deservability, the RP holds the most tenuously-rooted members of the community at the center and then works outward from there to build and share new modes of relating and getting on differently. In the process, it offers a viable alternative to what I call the “detox factory” in Chapter 3 in shaping and forging different relations to well-being both in Franklin County and beyond.

Critical engagements with the politics and practices of peer recovery are somewhat thin, and one future goal of this work will be to integrate RP community members’ own complex and critical accounts of their navigation of systems of care and confinement into a rigorous examination of peer recovery as a politics—and a practice—of liberation: as that which can and should guide clinical divestments going forward. For now, I’d like to highlight the work of William White, a prolific and somewhat-DIY theorist and archivist of peer recovery principles and practices based in the U.S. White begins his 2004 piece “Recovery Rising: Radical Recovery in America” by advocating for a wider-than-the-individual lens in recovery world-making, a lens that can account as much for the personal work of recovery as it can for the system-level work for which White’s notion of radical recovery advocates. “In the aggregate,” White argues, “addiction transcends personal tragedy to stand as a symptom of system malfunction—a breakdown in the relationship between individuals, families and communities. An understanding of the ecology of addiction and recovery constitutes the very foundation of

radical recovery.”¹⁴ Here, we get some useful and some not-so-useful insights about the nature and goal of a vision of recovery-as-radical. White is spot on to assert that we must turn our attention to ecologies—to the interactions, exchanges, networks, and relations that will support us in our well-being, particularly as we look to them with reparations rather than extraction in mind. White is likewise right when he asserts that in the contemporary moment, addiction is a symptom of “system malfunction.” However, the breakdowns I am interested in tracking are less between individuals and families or even between families and communities; the breakdowns I seek to articulate are, rather, those schisms between systems and the state, or between marginalized communities, systems of care, and the state. In extending White’s notion of radical peer recovery outward towards more capacious efforts to de-naturalize both the state and existing clinical treatment models in the work of recovery world-making, my work invites visions of peer recovery as anarchic care—or, care forged in the image of non-hierarchical relationality, non-violent communication, and a politics of recognition that takes race, gender, neurodivergence, and other modes of difference as absolutely constitutive to machinations of mattering in the realms of both healing and justice.

Critical Accounts of Care in Women’s and Gender Studies

Looking plainly at the politics of care through the lens of the contemporary opioid crisis no doubt tells us much about who and what we are ready to invest in to “bounce back” from states of injury and harm that are increasingly endemic to modern life. Likewise, it can tell us much about the historical systems and structures that have delivered us to a contemporary moment where the perceived breakdown in the clinical

norms of ordinary whiteness amount to a national crisis. As such, in my specific focus on the contemporary, affective politics of opioid despair, I mobilize four additional theoretical frameworks within the broad field of Women's and Gender studies to clearly elucidate why care as a practice, as an ethics, and as a professional and administrative domain must necessarily confront its own imbrication within long-term public and private systems that leverage and direct bodies of harm towards the end goal of securitized racial-capital accumulation. Making evident the long-term public investments and private partnerships that have fortified and securitized the realm of U.S. clinical power delivered as care over the past 150 years is an absolutely necessary first step in learning how to: 1) divest from those systems and the traumatic baggage embedded within and 2) advance critical praxes of healing justice that will draw that which has been disavowed into emergent ecologies of attention, care, and response built from the bottom up. Below, I briefly outline the four theoretical frameworks that support and advance this work before moving into their elaboration more directly.

The first theoretical framework I draw on comes from critical feminist accounts of care, both in the established subfield of feminist care ethics and from other less "disciplined" sites that tell us where and how care itself operates—and has always operated—as a de-facto system of mattering and managing racial difference. Here, I continue to draw on critiques and praxes that emerged from North American mental health de-institutionalization movements of the 1970s and 80s to connect up critical feminist accounts of care to the grassroots, on-the-ground critiques of treatment, recovery, and trauma praxes posed by survivors and others with lived experience of psychiatric and clinical incarceration. Forging commonalities between academic feminist

critiques of care and grassroots critiques of systems of care generated by those who negotiate disparities and violences “on the ground” is crucial as this work actively seeks to build bridges between a range of sites that have long advocated and worked for similar interventions, albeit using different tools. The second framework I draw on thinks and theorizes care from within larger political-economic histories of neoliberalism—histories that no doubt gesture towards the deep imbrication of the structural and subjective in determining who and what can be marked as worthy of the kinds of re-investments that are demanded by clinical patient-hood under neoliberalism. Here, I also turn briefly to the political-economic landscape of the U.S.’s “War on Drugs” to fully iterate connections between capitalism, care, and the binary state apparatus of confinement/rehabilitation that we’ve used to historically delineate and differentiate state modes of response to drug-related harm. The third framework I draw on is roughly coalesced under queer-of-color, de-colonial strategies to historicize and make contemporary sense of state-level biopolitical imperatives to rehab, treat, incarcerate, and/or dispose of specific bodies of harm at the level of the “life itself.” Here, I delve more directly into the theoretical frameworks of biopolitics and disability/debility/capacity to understand the roots and futures of bodies of whiteness laboring in the presumption of inherent, state sanctioned resiliency. The final framework I draw on is healing justice—a frame that is as spiritual as it is political. In rooting this project within the ongoing, collective, and imaginative work of healing justice, I hope not only to tell some stories about how we’ve gotten to where we are in relation to the deep disparities and violences of clinical power, but also to imagine alongside other future-builders where we’re going once we’ve finally shed the carcass of the state. Here, I articulate a specifically ecological and anarchic framework of

care going forward that centers on rooting into, rather than extracting from, the multiple ecologies—human, natural, political, spiritual—that we labor to be well within.

Feminist Care Ethics

Scholars in the interdisciplinary field of Women's and Gender studies have contributed significantly to the development of a critical politics and ethics of care in the U.S. over the past 35 years. In particular, feminist theorists have examined the ways in which individual and group experiences of injury and harm are mediated and processed through structural relations to bodily difference specifically and state power more broadly. In this work, I seek to push beyond the gender-based critiques of care generated by feminist scholars working in the area of care ethics beginning in the late 1970s and early 1980s.¹⁵ Instead, I seek to account more directly for the operationalization of racial difference more broadly and whiteness more specifically as specific kinds of “mattering” in contemporary and historical political economies of care. However, I here begin with a brief review of relevant frameworks in the subfield of feminist care ethics in order to acknowledge and engage prior efforts to likewise untangle the site of the clinic from the site of the explicitly politicized body. Doing so will no doubt demonstrate why the field of Women's and Gender studies needs theoretical and practical updates in the frameworks we rely on to make sense of our bodies, our communities, and our world.¹⁶

Care emerged as a critical framework for engaging relationality, ethics, morality, and justice as U.S. feminists in the early 1980s attempted to “reclaim” the significance (economic, emotional, juridical, psychological) of care from a long history of masculine (and, I would argue, clinical) devaluation. In these frameworks, care is often discussed in

relation to the differential valuation of women's unpaid emotional and economic labor. However, feminist scholars working on care and care ethics have also worked to leverage critiques of the ethics and praxes of Western biomedicine more broadly and the capitalist bio-medicalized body more specifically.¹⁷ In a succinct summary of the work of feminist care ethics, feminist theorist Alison M. Jaggar suggests that despite the wide theoretical landscape within which feminist care ethics has been deployed, "it is typically described as a moral orientation that not only produces assessments of action different from those provided by traditional Western moralities, especially the ethics associated with the European Enlightenment, but that also arrives at those assessments through an alternative process of moral thinking."¹⁸ Here, Jaggar usefully frames the ways in which the theory and practice of feminist care ethics is in fact about the moral imperative to think and do care "otherwise," or at least to think and do care apart from the white, Eurocentric, masculinist theoretical paradigms and "best practices" that continue to inform the bases of clinical medicine today. As this project charts the systemic imbrication of bodily difference and clinical value in the crucible of the opioid crisis, Jaggar's simple feminist predication that care can and should be theorized—and practiced—apart from the ethical and "moral" baggage of the European Enlightenment is foundational. It no doubt illuminates how and why highly policed norms of white (European) embodiment and behavior continue to serve as the baseline for mattering within frameworks of clinical worthiness today.

One particularly generative framework provided to this project from the field of feminist care ethics is the critical focus on the labor of care as a "moral obligation to otherness." As this project takes up the utility and value of ordinary whiteness in the

contemporary animation of opioid despair, the feminist imperative to “attend to” that which has been excised from dominant frameworks of mattering becomes all the more pressing. It signals an invitation into the work of accounting for the ways in which systems of care shape and produce bodies in the image of whiteness by delineating and consolidating a body’s capacity to matter. Critical disability theorist Eli Clare speaks powerfully to this feminist imperative to attend *intersectionally* to that which has been disavowed by both state and private sectors in the labor of care as, “a will to refigure the world.”¹⁹ However, as we will see, work in feminist care ethics has tended to center *sexual* difference as a key notation of otherness. This effacing of race and other kinds of difference at the expense of gender no doubt tells us something important about the constitutive blind spots in a feminist care ethics that truly aims to capacitate care for “all.” It likewise demonstrates why contemporary engagements with care must necessarily approach the work with a kind of analysis that takes into consideration the many dimensions of difference that constitute contemporary and historical relations to harm and its remediation.

Feminist care ethicists offer us robust frameworks for thinking through why, how, and where we are compelled to care in the face of harm, injury, and other kinds of bad feeling. Carol Gilligan’s 1982 book *In a Different Voice: Psychological Theory and Women’s Development* is often cited as a landmark work in feminist care ethics. Crucially, Gilligan locates the moral imperative to care—the moral imperative to “turn towards” subjects of harm in myriad contexts—as an explicit effect of women’s sexual difference.²⁰ As such, Gilligan ultimately articulates a binary understanding of “morality”—rooted in psychological development theory—where “morality as care” is

“naturally” gendered as feminine and “morality as justice” is “naturally” gendered as masculine. Although Gilligan’s work usefully advocates the necessity of integrating and listening to “a different voice” in psychological and clinical regimes of power, her reliance on the strict value of sexual difference as that which generates and directs the moral imperative to care is increasingly problematic, particularly as the contemporary administration of white liberal feminism takes up the trill of the “opioid crisis” to draw attention to gender-based disparities in access to health care and wellness.²¹ An overreliance on sex and gender as that which defines and outlines the obligation to care largely precludes any engagement with the specific social, economic, and even affective circumstances that may mediate how, why, and with what intention we turn to “the other” in a caring capacity. It likewise obscures the ways in which the specificity of *white women’s* health and wellbeing always already stands in for “women’s health” in dominant accounts of feminist care ethics.

Shortly after the publication of *In a Different Voice*, white feminist scholars in the U.S. began to push the field of feminist care ethics beyond Gilligan’s focus on developmental psychology and into broader feminist accounts of justice, labor, and philosophy. Nel Noddings 1984 book *Caring* is one other such account, where care is situated as an emotional and even affectively oriented action, albeit an action that is still rooted in a framework of obligation. For Noddings, obligation designates the potential for “present relation” and growth—critical orientations to futurity that I find compelling for thinking through systems of care in post-opioid futures.²² However, like Gilligan and other white feminists of her time and place, Noddings ultimately locates the “obligation” to care as an innate or “natural” capacity linked to sexual difference.²³ In this project, I

am interested in generating interventions that explicitly reject binary (gendered, racialized) subject positions as a point of departure for elaborating a critical politics of care. In fact, relying on such models to address contemporary knots of opioid despair no doubt replicates liberal investments in making evident and redressing *certain* kinds of disparity (here, gender-based health disparity) so that other kinds of disparity (i.e., disparity based on race or citizenship status) no doubt remain unacknowledged as constitutive to the current normative ordering of bodies and communities.

Other Critical Feminist Accounts of Care

Two years prior to the publication of Gilligan's seminal text in feminist care ethics and during the growth of U.S. anti-psychiatry and de-institutionalization movements, Audre Lorde had already published *The Cancer Journals*, which poetically and lucidly articulates the nuances of illness, harm, and caretaking from the perspective of a working class, black, lesbian lifeworld.²⁴ Lorde's is only one instance of an analysis of care—and an emergent ethics of care—coming directly from a “different voice” that is not recognized or affirmed by the body of work cohered under feminist care ethics or anti-psychiatry. Oscillating between structural and affective registers of analysis, Lorde produces multiple entry points into the crisis of being unwell—here, the crisis of cancer—by bringing political and bodily harm into intimate contact. Her work juxtaposes critical reflections on identity, nourishment, and healing with snippets of journal entries that reflect her own range of complex emotions during diagnosis and treatment, including rage, despair, bitterness, and fear. The first chapter, “The Transformation of Silence into Language and Action,” denounces the socialization of women towards fear in the face of

illness and speaks against the imperative for silence around cancer experiences as a form of collective care.²⁵ Other chapters reflect on the erotic and affective dimensions of illness and healing and offer insight into the hospital as a site of compulsory whiteness and compulsory heterosexuality through descriptions of straight, white medical-rehabilitation culture. In its attention to the politics of fear and the generativity of crisis, Lorde's reflections offer a critical rejoinder to the contemporary trill of crisis that underpins opioid politics and sheds light on the ways in which crisis is always already a racialized event.

Ultimately, *The Cancer Journals* demonstrates the ongoing generativity of intersectional, personal-is-political style feminist analyses of health care experiences, particularly for those left out of the fold of mainstream care. Lorde frames her experiences with breast cancer directly in relation to her identity as a Black lesbian feminist and generates critiques of medical and scientific culture based directly on the interfacing of that identity with the professional and ethical demands of 'proper' ill subjects and rehabilitative norms. As such, Lorde's work extends past individualized frameworks of care in order to reveal to us some of the long-embedded mechanisms of difference and differentiation that make up contemporary systems and praxes of clinical intervention. Although Lorde's work does not speak to the nuances of navigating opioid despair or addiction treatment and recovery systems explicitly, her cancer narration is no doubt collectivized as an offering to others who seek forms of political critique and affective solidarity that center the particularities of race, queerness, and disability in experiences of illness, injury, and harm. Her voice echoes as a prescient reminder of how

and why we must necessarily listen to lived experiences of difference if we are to re-figure systems of care otherwise.

The critical attention that feminist care ethicists in particular and feminist theorists more generally have generated towards the labor, capital, and power invested in relations of care both echoes and predicates the potent critiques of psychiatric and clinical systems posed by the radical anti-psychiatry, and eventually de-institutionalization movements of the 1970s and 80s in the United States. These movements likewise laid the practical and theoretical groundwork for the peer-to-peer recovery movements in which my own work is rooted. Predicated on revealing and then de-activating the political and clinical utility of the term “mental illness” along with the relations of power that subtend the term, activists and advocates in the arena of anti-psychiatry articulated implicit critiques of the systemic management of bodies of harm in and through the clinical apparatus of the state. Often cited in relation to Judi Chamberlin’s now-classic 1978 text *On Our Own: Patient Controlled Alternatives to the Mental Health System*, grassroots de-institutionalization activists and advocates in the U.S. sought to reveal the many insidious routes through which self-determination and autonomy are drained and vacated by mechanisms of clinical power, particularly in institutional settings. Tracking clinical logics of institutionalization alongside state logics of incarceration no doubt reveals shared investments care as a praxis of confinement that ultimately benefits those who hold the keys. According to Chamberlin, the anti-psychiatry movement envisions, “a system in which this pain would not be labelled as ‘illness’ but would be seen as a natural consequence of a system that puts wealth, property, and power above the basic needs of human beings.”²⁶ Read alongside critical feminist accounts of care, Chamberlin’s

intervention offers a wider critical landscape through which to understand relations of difference and dynamics of harm and their remediation. Working specifically on the consolidation of “professional” power in psychiatric systems, Chamberlin usefully outlines the professionalization of care as that which forges and replicates the consolidation of power at the expense of those who hurt. Here, we get a viable critique of clinical systems in the U.S. as they pertain to both the accumulation of capital and the hoarding of professional authority as value.

Feminist health activists and scholars have likewise posed straightforward, often practice-oriented critiques of U.S. clinical medicine which no doubt lays groundwork for the interventions and critiques this project hopes to make. In feminist health scholar Lisa Diedrich’s account of the movements and organizations that preceded the radical challenges to U.S. biomedicine leveraged by AIDS activists in the late 1980s and early 1990s, she turns to women’s self-help movements to illustrate the ways in which feminists and other radicals were “doing it for ourselves” as a response to the endemic patriarchy of Western biomedicine. Feminist self-help clinics in the U.S., Diedrich reminds us, were operating as early as the 1970s as a, “structural response to the problem of the absolute authority of doctors, the objectification of women’s bodies in health care, and the increasing specialization, technologization, and dehumanization of medicine.”²⁷ Springing up in both institutional and temporary sites, these clinics sought to recognize the inherent trauma and negation that women experienced in relation to the machinations of clinical power and to provide women with the tools to monitor and respond to their own health needs accordingly. “Through group work on their selves and bodies,” Diedrich argues, “women created a critical and clinical method that challenged the

exercise of medical sovereignty.”²⁸ What, I wonder, would an explicit challenge to medical sovereignty look like in the contemporary moment?

Read alongside other ostensibly radical interventions into the ontology of harm and the power dynamics embedded in medical care such as the Black Panthers’ work in creating clinics in the image of health justice²⁹ and Felix Guattari’s radical clinic at La Borde,³⁰ this project is invested challenging the sovereignty of medicine by making an explicit claim about the power, knowledge, and experience held within those seeking care. Only by seeking out and centering alternatives to hegemonic U.S. clinical medicine that have been articulated by those positioned at the margins or out of the fold will we be able to surface and imagine clinical systems otherwise. Attending to and investing with self-determination all that has been excised, de-valued, and drained of power in sites of clinical care is, I want to suggest, a radical act, one that shows us quite clearly what kinds of strategies and alignments we need in order to make divestments accordingly. It is a vital expression of the feminist imperative that the personal is political, and it reminds us of the many ways in which we may call upon (and critique) those who came first in the work of articulating and advancing healing justice.

Neoliberalism & Care

Over the past 20 years, feminist scholarship has likewise generated important political-economic critiques of the intersections of health, capitalism, and the body that help us to track the ways in which the labor of care in U.S. clinical systems is directed and shaped by “market forces” that are no doubt concurrently invested in the long-term goals of capital accumulation and its necessary flipside, dispossession. Feminist (and not-

explicitly feminist) scholars of contemporary neoliberalism such as Cindy Patton, Annemarie Mol, Nikolas Rose, and Michelle Murphy have worked to explicitly name the ways in which the binary ordering of health/illness, disability/ability, and well/unwell are linked to larger structural and political-economic forces and factors that no doubt frame all kinds of bodily difference as that which can and should be institutionally managed and mediated. Furthermore, feminist scholarship in the areas of health, care, and neoliberalism has likewise helped us to track the ways in which contemporary landscapes of care—particularly landscapes of care in the crucible of the opioid crisis—are as much about addressing an individual’s “need” for clinical intervention as they are about policing one’s personal or individual ability to *perform and embody* proper relations to the role of “patient.”³¹ That role is no doubt imbued with specific assumptions about citizenship, worth, and value that guide the generation and distribution of resources accordingly. Scholars such as Nikolas Rose and Robert McRuer have likewise attended to the making (and unmaking) of the category of the proper neoliberal patient in and through multiple relations to difference.³²

In this project, I draw on genealogies of the structural, the affective, and the personal in order to reveal the violent embeddedness of neoliberal economies of care across bodies and communities of harm. I seek to make clear the ways in which such care practices ultimately always already reward and privilege whiteness as a specific kind of value and capital that can be hoarded and relied upon when other markers of “market-based” value are “missing.”³³ I reveal the ways in which contemporary clinical “treatment” systems function as de-facto systems of ordering and mattering by funneling bodies into programming, resources, and networks based either on that body’s perceived

potential “return on investment” or, when the ROI is low, that body’s disposability.

Following Dean Spade, my engagement with care and neoliberalism ultimately, “takes an oppositional approach to key structures of maldistribution rather than seeking recognition by and inclusion into those structures.”³⁴ This point is central, as it explicitly names the ways in which we must reject and de-activate current political-economic structures of healthcare predicated on maldistribution rather than advocate for changes from within those structures. Approaching neoliberalism and care through the lenses of maldistribution rather than inclusion no doubt helps us to understand the ways in which long-standing political-economic practices put into use by neoliberal systems of care serve to reify and securitize the knowable boundaries of “capital” and “value” so that they continue to work in the service of whiteness, rather than in the service of increased vitality and potentiality for all.

What are the relevant genealogies of care as a political-economic relation to whiteness, then? Grace Kyungwon Hong’s review of U.S. neoliberalism provides rich context for understanding the ways in which the contemporary cultural formation of the opioid crisis relies and feeds on long-rooting economic-social relations that are no doubt steeped in the structural and ideological management of racial difference that has long been touted and packaged as “care.” Hong begins with the 1965 policy brief now commonly known as “The Moynihan Report,” authored by then U.S. Assistant Secretary of Labor Daniel Patrick Moynihan. In Hong’s reading, the report, “blames a host of social problems, from poverty to crime to violence, on the ostensible reproductive and domestic failings of poor Black women.”³⁵ Understanding the report as a “distillation of the shifts in technologies of power that mark the past four decades—that era that has been

called neoliberal,”³⁶ Hong suggests that the policy document ultimately gained its strength by mobilizing an emergent, collective sense of threat to the status quo that was no doubt incited by global movements in the 50s and 60s towards de-colonization, desegregation, and self-determination—movements that threatened the sure supremacy of whiteness-as-we’d-known it. Crucially, such threats not only disrupted ideological relations to the “status quo” that made systems like Jim Crow segregation enforcedly possible. They likewise disrupted and/or challenged long-entrenched systems of capital accumulation that relied on extracting surplus value from sites and bodies of color in order to securitize corporate and individual wealth, a system broadly defined as racial capitalism.³⁷ The result of such threats to the status quo, Hong argues, was a national, administrative-level turn towards disarming newly “liberated” populations by marking and sorting racialized bodies and communities into a binary regime of neoliberal power whereby investments in one’s futurity are made according to a body’s or community’s alignment with the strict boundaries of degeneracy or respectability.³⁸ In concisely describing the power of neoliberalism as a, “change in the distribution of respectability in response to the crises in racial capital as marked by the social movements of the mid-twentieth century,”³⁹ Hong’s work helps to name quite explicitly the ways in which systems of care and systems of confinement work hand in hand with contemporary and historical U.S. political economy to leverage racial difference not as a “problem” to be solved, but rather a “solution” to be drawn upon in the creation of new systems and practices of surveillance, sorting, and, ultimately, profiteering.

By reading the respectability politics of contemporary U.S. neoliberalism alongside Trump’s contemporary political imperative to Make America Great Again—an

invective this project engages over and over again to unpack state power and opioid politics—we can begin to track some of the ways in which the explicitly racialized dimensions of contemporary neoliberal political economy no doubt rely on the activation of a crisis-level sense of dispossession for some whites who feel that their sure place within the status quo is once again being “threatened” by political projects that seek to name and reckon with the embeddedness of white power in the arbitration of both capital accumulation and “social belonging” in the U.S. today.⁴⁰ In this frame, the clinical invitation into “treatment and recovery” that is being extended by an expanding array of opioid response mechanisms can be read as an invitation back into the design and fortification of neoliberal systems of care forged in the image of whiteness-as-we’ve-known-it—that which must be protected from co-optation by otherness. Again, Hong is useful here in her analysis of the ways in which neoliberalism works in and through differential invitations into modalities of worth, valuation, and mattering. “...one hallmark of neoliberal power,” Hong argues, “is that it is no longer simply organized around inclusion and exclusion; inclusion itself has differential effects. Put another way, we might understand neoliberal power as the dizzying enfolding of care, regulation, and punishment as simultaneous operations, in which punishment and regulation are not only the consequences of the lack of care, but also, equally terrifyingly, are themselves functions of care.”⁴¹ Here, Hong helps us to unpack the ways in which economic and moral state incentives to respond to white opioid despair come into being in and through concurrent, long-term investments in 1) surveilling, confining, punishing, and demonizing drug-related harms for bodies and communities of color or 2) incorporating those bodies and communities into systems of “treatment” that are actually about

rehabilitating all that is in excess of whiteness back into “proper” or status quo relations of domination.

Drugs, it turns out, have always been crucial to defining and consolidating the conditional boundaries of respectability / deviancy for communities of color through long-term investments in the many arms of what we reductively call the War on Drugs. As such, drugs play a particularly central role in arbitrating the bounds of respectability / disposability in contemporary political economies of care. Curtin Marez’s *Drug Wars: The Political Economy of Narcotics* clearly tracks the ways in which the War on Drugs has served as a de-facto exercise not in “rescuing” those impacted by the infiltration of outside drug-related harm, but rather in constructing new “insider” state apparatuses of power meant to manage and sort bodies of harm that come into being through drug economies. “Thus,” Marez argues, “while official sources often represent the drug problem as a menace that the state is dedicated to eradicating, in recent history drug traffic has just as often served to sustain and reproduce state power.”⁴² In this work, I take Marez’s assertion seriously by asking after the many ways in which state power is explicitly consolidated and fortified through the terrain of opioid politics as a kind of political-economic imperative in restoring the implicit value of whiteness at the national level. I likewise take Marez’s work on the War on Drugs seriously as a departure point for thinking through the differential affective relations to sympathy and identification that seem to be proliferating as we long “forget” and dismiss images of broadscale harm, injury, and despair that have come to us from communities of color for centuries, just as we glue ourselves to television sets seeking out new images of white opioid despair to focus on in the present moment.⁴³

This project seeks to shed new light on the ways in which white opioid despair is being leveraged towards the recuperation of “straying” white bodies (like Regular Guy) back into the fold of respectability, valuation, and worth in and through the clinical apprehension of a specific kind of bad feeling that reads as the emergency of opioid dependency. This is, to be clear, a dimension of the neoliberalization of care that is necessary for understanding the deep imbrication of racial belonging and worth in the workings of clinical power today. Again, Hong’s work on neoliberalism speaks directly to this dynamic. “In this context,” Hong argues, “respectability, increasingly defined by the attainment of monogamous couplehood, normative reproductivity, and consumerist subjectivity, has become indispensable for determining those who are worthy of capital investment and thus protected and those who are not and are thus precarious.”⁴⁴ In neoliberal economies of care, then, the bearers of what I call “ordinary whiteness”—whiteness property contained within the right registers of reproductivity, labor, and bodily comportment—can still access the resources of care (i.e., treatment not jail) without regulation or punishment, as long as specific markers of respectability remain intact. The opioid crisis is one way of reifying and validating that respectability in and through the “humanization” of such despair. If, as the media and public health mechanisms ensure us—opioid despair is a *human* problem, then we can increasingly see that in our contemporary moment, *human* is most clearly aligned with sure markers of *whiteness*.⁴⁵ The flip side to the enthusiastic clinical capture of white bodies of opioid despair in the image of “rehabilitation” is the ongoing incorporation of bodies of color into carceral economies that no doubt continue to extract profit under the self-same guise of rehabilitating that which has strayed.⁴⁶ Attending to the ongoing reality of disparities

in treatment vs. capture is crucial to the labor of understanding and then divesting from the logics and legacies of neoliberalism that produce and discipline landscapes of care today.

States of Care: Debility, Disability, Capacity

If, as much of these interlocutors suggest, our clinical systems and structures of care in the U.S. are indeed invested in the continuous re-fortification and resourcing of bodies and structures of whiteness, we need critical vocabularies that can help us talk plainly about differential distributions of well-ness, of futurity, and of the possibility of what those advocating for post-opioid futures would call “recovery.” Over the past 15 years, the field of Women’s and Gender studies has likewise provided rich frames for thinking through the many bifurcations of worth, value, and capacity that are produced by state imperatives to manage, harness, and extract profit, meaning, and mattering from human life and death. At the center of these imperatives is the state-sanctioned work of policing, monitoring, and actively adjudicating the boundaries of what many have called “life itself.”⁴⁷ Drawing on critical theories of biopower, work in the terrain of “life itself” seeks to make explicit often-concealed state mechanisms that nurture, support, and capacitate whiteness as an exceptional category of state protection, while simultaneously producing populations marked if not for death, than at least for life fully controlled and contained by the centrality of whiteness. Central to those claims is the idea that the U.S. state itself has been built on the predication of whiteness as that which is normal, natural, and always already worthy of life.⁴⁸

When read through the material level of the body, the state imperative to protect and resource formations of whiteness manifests as a kind of differential relation to both

institutional and popular categorizations of injury and harm. Scholars of biopolitics have taught us that the state-managed differentiation of harm quite often unfolds in the language of investment—of delineating who and what state systems and structures can understand as *having been harmed* and, following that, as clearly *deserving of the investment of state resources*.⁴⁹ Disability is one such categorization that some have argued clearly reflects racially and colonially differentiated relationships not only to state resource distribution, but also to larger processes of cultural legibility, popular sympathy and compassion, and the perceived “right” to “cutting edge” systems and praxes of care. In *The Right to Maim*, Jasbir K. Puar argues that in the U.S., the protected category of disability clearly functions as, “a register of biopolitical population control, one that modulates which bodies are hailed by institutions to represent the professed progress made by liberal rights-bearing subjects” (xviii). Although I do not *explicitly* engage with the framework of disability throughout this project, my reading of opioid politics closely follows the modalities of differentiation that Puar outlines here. White opioid despair is, I want to suggest, an overt, crisis-inducing performance of a vision of liberal disability politics that eagerly captures *some* struggling bodies into the fold of the future, while others exist as a pesky matter of endurance, but always with the latent conjugative presence of whiteness standing by to discipline and dispose of that which has been fully taxed. The state’s self-congratulatory “response” to the problematic of opioid despair clearly reflects narratives of liberal “progress” and “potential” that Puar identifies as central to the mechanisms of racially-specific sorting and capture that define U.S. disability politics. Only by making evident the constitutive bifurcations in opioid response—only by asking explicitly after the images and values in which those systems

have been designed—will we begin to account for all that is remaindered by state efforts to construct treatment and recovery options steeped in the self-same practices of racially differentiated clinical apprehension.

Contrasted to the liberal celebration and inclusion of disability in state and “public” health mechanisms of response are the many expressions of what Puar, following medical anthropologist Julie Livingston, has called “debility.” Formulated as a critique of liberal disability rights politics, debility names the biopolitical and affective dimensions of bodily harm that escape or remain unnamed and unattended to by the state—that which even liberal frameworks of disability cannot or will not see as harm. Although Livingston’s methods and fields of analysis depart quite a bit from both Puar’s and my own in this project (Livingston works on debility in community-health care settings in post-Independence Botswana), the questions her work poses about relations between suffering and social change⁵⁰ and the management of debility through both public and private modalities of care⁵¹ are exceedingly important to my own articulation of what’s gone awry in the zeitgeist of the opioid crisis and how we might do futures of care otherwise. In naming debility as a state that, “troubles, mobilizes, and intensifies social relations,”⁵² Livingston’s account of debility not only tells us something about the differential *degree* of harm that may be needed to mark *some* bodies as un-well; it likewise attends to the specific and often-precarious social worlds, ecologies, economies, and historical contexts in which that harm has come to matter. In seeking to understand, “why and how the lack of certain capacities or bodily configurations can trump the possession of others in social life,”⁵³ Livingston’s work on debility seeks to elaborate a

structure to hierarchies of suffering, which no doubt elaborates critical connections between bodily difference, state control, and political economies of care.

If disability is the exceptionality of opioid despair, then debility is what's *painfully* ordinary about the many kinds of dispossession and impairment that demarcate bodies long struggling in the vicissitudes of state-sanctioned harm, drug-related and otherwise. Livingston's attention to debility as a kind of *structure* of suffering portends Puar's claim that debility is indeed a "process rather than an identity or attribute"⁵⁴—one that "foregrounds the slow wearing down of populations instead of the event of becoming disabled."⁵⁵ Debility "comprehends those bodies that are sustained in a perpetual state of debilitation precisely through foreclosing the social, cultural, and political translation to disability."⁵⁶ Here, we get a sense of debility as that which is actively creating—through structural deployment—differential relations to life and death. Relations of debility are, crucially, "endemic rather than exceptional,"⁵⁷ following Puar again. As such, relations of debility tell us much about the imbrication of structures of suffering within "ordinary" life-worlds, and clearly reflect, "a need for rethinking overarching structures of working, schooling, and living rather than relying on rights frames to provide accommodationist solutions."⁵⁸ The many invitations into post-opioid recovery futures that bloom from the crucible of the opioid crisis should necessarily heed this call to look at the endemic and the structural first and foremost. Rather than working to fit the problematic of opioid despair into currently existing systems and structures that guarantee only some bodies the "right" to treatment and recovery, we must attend instead to the many kinds of debility that exist and endure ad finite in sites where extraction has been the state policy par excellence.

Central to the nexus of debility / disability in this work is the charged presence and vitalization of capacity, a frame I mobilize over and over again to understand the effectuating work of white opioid despair. For Puar, capacity names one's well-positioned (or not) relation to the differentiating state work of biopolitics. Capacity indexes value, worth, and, in an always increasingly neoliberal political economy, investability in the conditions of "life itself." Capacity names who and what we're willing to bet on to re-cover the white, American status quo when times are tough. "Biopolitics deployed through its neoliberal guises," Puar continues, "is a capacitation machine: biopolitics seeks capacitation for some as a liberal rationale (in some cases) or foil for the debilitation of many others. It is, in sum, an ableist mechanism that debilitates."⁵⁹ When taken up by the U.S. state—a U.S. state increasingly focused on recuperating mythic (and violent) expressions of "American Greatness"—opioid despair is, then, a capacitation machine, one that clearly motivates, vitalizes, and leverages the resources of "public health" (here, clinical power and federal monies) towards the remediation of one specific kind of bad feeling.

The remainder created by the capacitating movement of resources in the opioid crisis is the same remainder that U.S. clinical power has relied on for centuries—the great pool of "raw material" that feeds scientific experiments and clinical trials but will never truly become the *subject* of care as long as the same conditions continue to delineate capacity. This differential relation to what makes a tenable clinical investment reflects what Puar calls the "liberalization of injury,"⁶⁰ or the active *de-politicization* of the conditions of harm such that harm is not understood as part of the structure of everyday life (as *endemic* to it) but is still rather framed as exceptional (as *crisis*) to contemporary

life. The processes of de-politicization that feed visions of the opioid crisis in the U.S. are no doubt fed themselves by a range of American mythos that seek to evade responsibility for historical and ongoing acts of colonization, labor exploitation, imperialism, and other instances of what Puar calls “working and warring.”⁶¹ By de-politicizing the conditions of opioid despair, I want to suggest that the U.S. state response to such despair reflects what Puar calls a “narrative prosthesis,”—a “habituated emplotment for overcoming tragedy and lack in order to reconsolidate the able body.”⁶² In thinking the opioid crisis as “emplotment,” we get increasingly closer to revealing it for what it is—a story we’ve invested in to tell us where and how to re-cover the many mythic falsities of American Greatness. What, I wonder, might we change at the levels of both system and psyche if we approach currently existing frameworks of recovery more broadly as narrative prostheses—as that which re-capacitates some by incorporating them into clinical systems of management and re-figuration in the image of ordinary whiteness, just as it marks others for incarceration, or at least concealment in underfunded, often exploitative treatment and recovery programming? Frameworks of disability / debility / capacity remain exceedingly critical for answering that question honestly and with reparation in mind.

Listening to Healing Justice

In its commitment to making evident the embeddedness of whiteness as a specific kind of always-replenishing capital in contemporary systems of clinical care, this project is, perhaps most importantly, about the doing the (white-person side of the) work in the broader movement for healing justice. For me, the “white-person side of the work” means

assembling and offering up to other white people the indelible histories of racial negation and disavowal that have propped up the historical power of clinical medicine and then using those histories to become presently accountable—to seek out and do the work of dismantling their contemporary expressions and legacies. It is likewise about naming, making evident, and being accountable to the kinds of entitlements—to care, to being “believed,” to pain *relief*—that whiteness no doubt securitizes and expects in sites and spaces of care. As such, this work is a necessary adjunct to the greater landscape of healing justice movements initiated and led by BIPOC activists and healers who have long carved theories and spaces for the valuation and care of bodies and communities deemed expendable by agents of white clinical power.

Although the genealogy of the term healing justice is no doubt being continuously co-opted by movements eager to put the term to use in the service of many (neoliberal) ends, its clearest contemporary lineage is rooted in the work of Cara Page and the Kindred Southern Healing Collective. A framework of healing justice was developed and shared by Page and Kindred at the 2010 at the US Social Forum in Detroit. Central to that framework is a set of questions about who and what are traditionally pulled in—and excised from—the fold of “wellness,” both today and historically. Page articulates those questions in her “Reflections from Detroit: Transforming Wellness and Wholeness blog post for INCITE!:

“I’ve been asking these questions to the ‘salt eaters’ and the ‘dreamers’ and the ‘shapeshifters’ among us; what is wholeness? Not an ableist notion of wholeness that implies one specific body or blood type, but a shape of wholeness that intrinsically knows what each individual and collective notion of feeling whole and safe and well can look like. Not the bought ‘wholeness’ you can find only in supreme retreat packages at sunset salons but the kind of ‘wholeness’ that calls on whole communities and whole movements to be well, sustainable and

resilient. Who will answer the call to our hurts, our wounds, our double/triple/quadruple pains of oppression and desperation? How will we answer our own calls to wellness and safety?⁶³

Here, Page names explicitly the ways in which intersectional harms accumulate and settle into bodies and communities such that actual demands for wellness and safety by BIPOC and other marginalized folks are not only willfully ignored but also willfully denied by those who gatekeep “traditional” healing resources and knowledges. Crucially, Page reminds us here that “wholeness” *cannot be bought*, but rather must be cultivated through cross-community calls to support and sustain wellness otherwise—wellness outside of the image of whiteness.

As we move through the contents of the crucible of the opioid crisis in this work, Page’s framework reminds us of the ways in which whiteness itself serves as an ever-proliferating invitation into the safety of wholeness, which always already begets the safety of state protection. That kind of invitation has not only been denied to whole swaths of the U.S. population, but it has also been deemed dangerous to the stability and security of whiteness-as-we’ve-known-it. In a final articulation of the political implications of healing justice, Page offers this from her work with Kindred in Detroit:

We are responding to a lack of quality of life and conditions, a pattern of systemic abuse and oppression that reinforces the controlling of our bodies/wellness/systems/cultures and our capacity to remember and transform our conditions. We stand in solidarity as a national collective of grassroots healers, medical practitioners and health justice organizers who seek to create systems of wellness outside of state and corporate models that profit from these conditions.⁶⁴

In centering systemic mechanisms of racialized profit-generation, replenishment of harm, and the labor of extraction in clinical systems, Page and Kindred’s healing justice framework likewise highlights many of the key concerns of this project, including the

necessity for developing, resourcing, and supporting BIPOC-led, non-state, and non-corporate models of care that can in fact transform the structural conditions of wellness in favor of those who sustain ongoing injury and harm in addition to the generational inheritance of the traumas of the U.S. state.

Page and Kindred's framework of healing justice has been taken up and amplified in several key places over the past 8 years, including perhaps most prominently by Black Lives Matter. BLM frames healing justice as, "necessary in a society that criminalizes Blackness, and structurally ensures trauma for Black people while creating no space, time, or resources for healing."⁶⁵ Likewise for BLM, "healing justice also informs our organizing and causes us to hold accountable those institutions like the medical industrial complex, including the mental health apparatus, that promise healing and care, but harm, traumatize and pathologize our people."⁶⁶ Healing justice, BLM continues, "requires that we listen beyond the understandings we've been given of spirit and ancestors and asks us to both recover and create self-determined and effective rituals, processes for the kind of healing we need."⁶⁷ Although this project does not explicitly focus on the vitalization of alternative healing praxes in non-state spaces,⁶⁸ the call for such reconfigurations no doubt informs the visions of care-futures to which this work is in service.

Other vitalizations of healing justice that this project listens to come from efforts to historicize and contextualize the alternative sites and praxes of care that BIPOC and other marginalized communities have relied on for centuries in response to the bodily and psychic excisions performed by the agents of white clinical power. One particularly vivid example is Leah Lakshmi Piepzna-Samarasinha's 2016 essay, "A Not-So-Brief History of the Healing Justice Movement," which offers a wider genealogy for healing justice

that continues to reveal the deep racial faults in praxes and ethics of care and demonstrate how healers and activists of color have labored to address those gaps historically and otherwise: “Healing justice as a movement and a term was created by queer and trans people of color and in particular Black and brown femmes, centering working-class, poor, disabled and Southern/rural healers,”⁶⁹ Piepzna-Samarasinha clarifies. “Before ‘healing justice’ was a phrase, healers have been healing folks at kitchen tables and community clinics for a long time—from the acupuncture clinics run by Black Panthers like Mutulu Shakur in North America in the 1960s and 1970s, to our bone-deep Black, Indigenous, people of color, and pre-Christian European traditions of healing with herbs, acupuncture, touch prayer, and surgery.”⁷⁰ Piepzna-Samarasinha likewise tells of her own experiences using tarot as a radical healing strategy that supports folks in naming and making sense of personal harms that are denied and disavowed by hegemonic sites and systems of care. Through these concrete examples of alternative wellness, healing, and transformation strategies, we can begin to bear witness to the kinds of practices—including ritual, body work, herbs, prayer, and meditation—that are no doubt systematically denied and devalued by Western clinical biomedicine as a strategy for keeping the profit-generating mechanisms of clinical power in place.

Crucially, the frameworks of healing justice that this project listens to are not just directed at the register of the human body or at our collective interventions into its “treatment” and “recovery.” Rather, frameworks of healing justice likewise invite us into the spiritual, ecological, and otherworldly dimensions of wellbeing, care-taking, and healing that circulate underneath, around, and through the concrete landscape of the emergency room or surgical table. In *Emergent Strategy*, activist, writer, and healer

adrienne maree brown works with the concept of emergence to name the networks and connectivities that will re-root us into a concept of healing that does not first require our participation as citizens of a racial-capitalist state. Emergence, brown argues, “is another way of speaking about the connective tissue of all that exists...Emergence emphasizes critical connections over critical mass, building authentic relationships, listening with all the senses of the body and the mind.”⁷¹ In an insistence on critical connections and authentic relationships, brown names here some of the concrete strategies we must begin to develop and deploy in order to deactivate not only historical lineages of clinical power but their contemporary expressions, which remain invested in individualized and isolated experiences of “healing.” As I move towards what I call an “ecology of care” in this work, the concept of emergence is no doubt central to illustrating both the managed intimacies through which clinical medicine retains its power, as well as the emergent, cross-difference connections and supports that are vital for feeding well-being otherwise.

Furthermore, brown’s vitalization of emergence helps us to unpack another key claim of this work—that commitments to the political economy of extraction will only ever produce and replicate lived conditions of crisis which, while we exist there, will never set us free. “With our human gift of reasoning,” brown argues, “we have tried to control or overcome the emergent processes that are our own nature, the processes of the planet we live on, and the universe we call home. The result is crisis at each scale we are aware of, from our deepest inner moral sensibilities to the collective scale of climate and planetary health and beyond, to our species in relation to space and time. The crisis,” brown continues, “is everywhere, massive massive massive. And we are small. But emergence notices the way small actions and connections create complex systems;

patterns that become ecosystems and societies. Emergence is our inheritance as part of this universe; it is how we change. Emergent strategy is how we intentionally change in ways that grow our capacity to embody the just and liberated worlds we long for.”⁷²

Here, brown articulates a powerful and vital re-imagination of the term capacity that I find particularly useful for the work of challenging and dismantling structures of care predicated on the differential and contingent recognition of capacity in all its iterations.

Healing justice helps us name the ways in which systems of care are designed in the image of whiteness so that white discomfort, harm, and injury are always already at the center of the equation in resourcing, valuation, and simple clinical apprehension of what hurts. Opioid politics are only one expression of this deeply insidious reality that precedes and shapes the facts of racial health disparity, eugenics practices, and other expressions of body-centered, state sanctioned violence. In this work, I seek to use opioid politics as an entry for thinking through the potential for broader revolutions in U.S. politics and praxes of care—for how to move systems and structures towards visions of healing justice through collective and rigorous processes of accountability. In the Conclusion, I return to two key words central to the work of healing justice—ecology and emergence—to mobilize the visions contained in frameworks of healing justice towards praxes of clinical reparation.

IV. Methods: Critically Messy Ethnography

The methodology of this project lands somewhere between interdisciplinary critical analysis and what I’ve come to call *messy ethnography*.⁷³ Messy ethnography gestures towards the ongoing work of becoming-with the questions I set out to answer at

the onset of this project. It recognizes the non-linearity of research and knowledge production. It speaks to a recognition of the fact that most often, we cannot know or even feel exactly what is emergent about ourselves and our investigations until we've begun to assemble the "raw data" (here, of lived experience, of interview, of archive) alongside chosen critical and community interlocutors as well as chosen accounts of the future-making practices we most respect. If critical analysis in the field of Women's and Gender studies encourages us to use "traditional" methods of research and evidence-gathering (i.e., reading and writing) to develop "non-traditional" connections between our texts and our objects of analysis, then messy ethnography revels in the fact that sometimes, neither what we understand as "text" nor "object" are nearly enough to make sense of the questions at hand. Sometimes, we need our own bodies—all the versions we've long shed and the ones we live in now; we need our fathers and our grandmothers and all those other ancestors who hang around and bug us with what's unresolved. Sometimes, we need certain landscapes, too—both how they seem now and our desires to know how they seemed some 200 years ago to those both like us and unlike us; we need feelings that have gone unnamed and archives that used to definitively tell us one thing, but now suddenly burst forth with something else that needs to speak its own name, for once.⁷⁴ And, we need some fleeting moments of exchange with strangers to even begin the task.⁷⁵ Sometimes, we need what we don't even *know* we already have. Below, I'll try to account for a bit more of what this project needed in order to tell the story of what it is.

For one, this project needed a space in which to anchor—a fertile site to "root" into that could hold the work of knowledge-making and future-dreaming apart and aside from the protected boundaries of the academy life-world. More specifically, this project

needed a site of *affirmation* in which to root—one that was not directed by the cut of the critic, but by the collaborative work of building something up that might in fact last long after the structures have fallen.⁷⁶ I laid those seeds in community at the RECOVER Project over 10 years of truthfully connecting through bad feeling. I arrived at the RP at 22—fresh from undergraduate work on women’s prison narratives and with a lifetime already behind me of navigating and surviving family chaos “on the edge” and in the face of many kinds of despair—drug-related and otherwise. At the RP, I learned everything I could have ever learned about endurance, persistence, and the collective work of getting on in the face of violent histories and violent systems. I did so by sharing my own often hoarded traumas and by listening to the folks who cross that door every day to make sense of their own. I learned how to be a critical thinker and a critical listener at the RP—critical of the hierarchies that constitute the systems that should make us well and critical of the many ways in which people’s lives are derailed by factors so far out of their control we often can’t even see them. I learned to account for and contextualize the whiteness that is my privilege, especially as I saw others giving the gift of freedom so freely, when they had little else to give. Someone just recently released from prison taught me how to crochet in my first week there. From that exchange, I’ve woven a million blankets, and this is one of them.

If the seeds of this work came from the long time I spent learning, listening, teaching, working, laughing, writing, messing up, and transforming alongside others at the RECOVER Project, the dynamic push of life came from the short period of “officially” ethnographic research I conducted over the summer of 2016. That was the summer I’d finally leave Jersey City and returned “home” to Franklin County with the

goal of making some more explicit connections between the geographic site that had so informed my own growth and the larger critical accounts of care that I was pursuing in my academic work. During that period, my dad's own life hung in the balance. I spent my time running between intense, fulltime days of "research" at the RECOVER Project in Greenfield, brief respites riding my bike along the river in Turners Falls, and the hospital in Northampton, where my dad fought an unknown infection and countless other ailments the entire summer, coming close to death innumerable times. He didn't die in the thick of it all, but he did die on the day just after my summer research ended, the day I returned back to Jersey City to continue on with my "regular life." When he let go, I let go, too. There was so much to hold. His own life was a telling expression of the many ways in which ordinary, working class whiteness can derail into a vivid kind of despair—a "slow death," if you will, that felt as slow as it was emotionally charged. His despair was not necessarily an opioid despair (although he certainly dabbled). Rather, his intensely troubled relationship with alcohol, paired with his own unresolved trauma history and his increasing enmeshment in state systems of surveillance and confinement—including multiple incarcerations—demonstrated a version of despair that was as down and out as it was fired up about all the ways in which he and others were getting *more hurt* by the systems to which they were confined.

My dad was never quite delivered into the dimension of a different world that I dream about co-creating here on this earth, but he certainly taught me over and over and over again how to use your life and your body as method, or how to not be complacent in the face of abuses of power—how to call out systems of oppression and to demand better for all of those who are positioned in the crosshairs of state violence. Sometimes, that call

out looked like the use of his own body to (sometimes grotesquely) protest extreme lapses in care and attention at jails and nursing homes alike. Sometimes, that call out looked like writing letter after letter to jail administrators, outlining exactly why the diet he was fed while incarcerated had directly caused irreversible nerve damage in his feet and legs. “You can’t feed a goddamn diabetic goddamn boiled potatoes every goddamn day and night,” he’d tell me over the scratchy jail phone connection. I listened, and I learned. My dad likewise taught me that the labor of care is never simply about “getting better.” Sometimes, people die and there is no better, or at least no better as we’ve imagined it. The labor of care is, rather, about coming to intimate terms with the systems that hold us and lose us—about knowing thy enemy and proceeding accordingly. It is about the harrowing work of advocacy, of making someone who seems like they shouldn’t or couldn’t matter (“It’s his own fault,” one ER doctor told me) actually matter to the ones *who count*. As I navigated the impending loss of one of my parents—one who had caused me harm and also life!—I also began to recognize and then document patterns (of loss, of excision, of conviviality) between my dad’s life, the lives of so many folks I’ve loved at the RP, and the significant, incisive accounts of structural violence that I had been studying and listening to and learning from in graduate school. This project needed those emergent patterns to become what it is.

Perhaps most important to the trajectory of this work, those patterns also reflected back to me my own whiteness—a kind of capital that capacitates, soothes, and generates potential at every turn. Deep identification with the tenors of ordinary whiteness in Western Massachusetts facilitated a bodily and social experience for my own dad that contributed significantly to the kinds of protections he had been able to afford in this

life—protections such as access to federal disability insurance, access to some limited family resources, and a hard-to-land spot in the small public housing complex in Hadley, the town I grew up in. At every turn, my dad’s own precarity clashed with the privileges of his and my own ordinary whiteness, forcing me to reckon with the confusing and often uneven ways in which racial difference distributes and mitigates both harm and the kinds of care we rely on to ease the sting. As it unfurled itself, this project demanded an accounting of the ways in which our shared whiteness—the whiteness he gave me—limned the blow of structural inequity faced by so many others (RP-based and more broadly) who didn’t or couldn’t mobilize their inherent claim to the “ordinary” as a kind of capital, even as the boundaries between ordinary and other had been crossed over and over again. As such, I began to realize that I couldn’t tell the story of an ecology of care in this place without coming to terms with the invasive species that has colonized and sucked this land dry.

The centralizing turn to whiteness became increasingly clear as I listened to my RP interlocutors express and frame their own lived experiences of harm, both now and in the past, in such explicitly racialized terms. One friend, a black, gay man now in his late 60s, spelled out for me quite succinctly what it was like for him to grow up as a kid in this region without the protections of what some today call the Tofu Curtain.⁷⁷ “By 5, I knew I could get killed for being black. By 14, I knew that if you were gay, you moved to San Francisco and killed yourself,” he told me once. His was only one such flash of insight that packed decades of lived experience with racially differentiated dimensions of care into two short sentences. “I don’t want to block the blessings,” he told me, but his trauma was certainly intersectional, and I’d need to listen to that fact closely if I was to

make sense of the bigger picture. Another friend, a black man in his 50s who has spent over half his life in state and federal prisons, recounted the story of being an elementary-level student at one of the first public schools to racially de-segregate in Springfield, MA in the early 1960s. As his school bus traveled from his predominantly black neighborhood into the white neighborhoods where his new classmates lived, neighbors gathered and fiercely shook the bus, trying to flip it over while expressing rage at having their children schooled with black children so ostensibly different. Those sensations of terror, of feeling the bus shaking with the anger of whiteness gone challenged, my friend told me, never really left. Today, those loops of trauma—those loops of fear and their many insidious hiding places in the body—are the focus of his own work with mindfulness and meditation, reminding of us the many containers we can root into otherwise to make sense of what we’ve been given.

As I rode my bike through the fields and over the rivers of Turners Falls during the summer of 2016, and as I listened to RP community giving me so much, I was acutely aware of what it felt like to be away from the familiar hub of Jersey City, a city that lived in difference unapologetically and without the “choice” of such upstream advantage. Speeding through a landscape that looked at the surface to be quite idyllic, I felt the knowledge of displacement and dispossession alongside the knowledge of emergence in a way that told me that this “raw material” (of bird, of tree-cathedral, of burned out factory threaded with vines and lined with sleeping bags and beer cans) was as relevant to the work I wanted to do as was the “raw material” of my IRB-approved participant observation notes. Contrasting the increasing specter and hum of opioid-related harm over in Greenfield was a natural silence that buzzed with life, just as it held the roots of a

whole lot of violence that has never fully been named. Drawing uncomfortable connections between histories of dispossession that gave this land to murderous white settlers under the pretense of having earned it, a present moment concentrated on searing white the pain of opioid despair, and futures that are yet to be determined became central to the form this work has taken today. The work of drawing and producing uncomfortable connections is, I came to see, part of the affective work of a method focused first and foremost on relating to that which is both familiar and different, changing both in the process.

The unfolding “opioid crisis” was an unavoidable lens through which to describe and engage these tensions. In fact, critical consumption of opioid-related material was as much as method for this work as anything else. As I pursued my research and thinking, articles, books, and news items on the many dimensions of the “opioid crisis” proliferated. Operating as a quite clear “incitement to discourse” both here and in sites across the U.S., the problematic of opioid despair was continuously, from my perspective, pulling attention away from the stories of loss and harm that never get told on the front page of the *Greenfield Reorder*, or get told only in terms of their correlation with or departure from existing norms, policies, and institutions. Where was there room in this narrative for the fact that local police had long harassed and surveilled under-housed or un-housed people in this town, pushing folks without secure housing or folks who experienced extreme states into communities alongside railroad tracks or into unsafe, slum-lord housing conditions? Where was there room for talking about the ways in which “treatment” and “recovery” often demanded folks line up with the quite local norms and values of whiteness in order to be seen as a viable investment in the future?

Over the past 5 years, Greenfield had become an easily identifiable emblem of “small town,” post-industrial, opioid despair.⁷⁸ In the process, it has begun to accumulate national attention in unexpected ways. Anthony Bourdain travelled to the region in 2015, meeting with my RECOVER Project family and filming an episode of *Parts Unknown* that addressed the story of his own addiction to and recovery from heroin alongside the community members’ stories and an exploration of the food and history of the region.⁷⁹ As the camera pans Franklin County’s white steepled churches and rolling hills in the episode’s opening, Bourdain frames Greenfield as a kind of modern-day Normal Rockwell painting, a perspective that replicates the fantasy of unassuming, vulnerable whiteness being taken to the grave by opioids. The television star’s own untimely death at his own hand over the past year tells us much about the ways in which some kinds of pain never actually go away, even as we attempt to turn attention elsewhere. Turning towards the work of debunking, complicating, and re-framing the problematic of opioid despair in this region quickly became part of the larger work of unpacking an ecology of care, ultimately pushing me towards engagement with a range of historical and critical accounts of the racialized dimensions of pain, loss, and other kinds of bad feeling here and elsewhere.

And even with all of this, this project needed more, still. For one, it needed the ongoing encouragement of critical readers and critical mentors that would continuously push me both into and away from the theory-heavy brain that I so relished developing throughout graduate school. It needed the vital reminder—over and over again—to, as my advisor Carlos Decena has endlessly encouraged me, put the theory that I love so much *into service of the stories I want to tell*. I’m not sure I’ve gotten that part down just

yet. This work is still focused so largely on the critical / theoretical threads that tell us why and how we must re-think the boundaries of pain, sensation, and belonging in sites of clinical power otherwise if we want to do futures of care otherwise. As this work has unwound itself slowly, taking the long way home, I've come to realize that these three chapters are only the beginning—the frame, the stage, the set up for a deeper and more rigorous engagement with the stories that show us, rather than tell us, what exercises of clinical power look like in the lives and on the bodies of those positioned on myriad edges. Ultimately, the vital life of this work is a turn towards the future—the cracks where new seeds are rooting and blooming, willing to choke out the old structures and let new ones grow up in and around the crumbled mess of the past.

V. How it Unfolds:

This work is broadly organized around three keywords: Pain, Crisis, and Recovery. Each keyword gives shape, weight, and context to the arguments of each of the three chapters. Together, they build a story about the movement of histories, resources, affects, and praxes of care in U.S. clinical systems towards the well-resourced protection of ordinary whiteness and towards the state-directed remediation of white opioid despair. Ultimately, these three keywords direct the momentum of this project towards the on-the-ground work of what I call post-opioid future-building—a world beyond recovery—in the Coda.

Chapter 1 correlates with the keyword Pain. Here, I contextualize and problematize what we talk about when we talk about pain and its relief. More specifically, I explore the historical apprehension of pain as a privileged, clinically

validated category of bad feeling that belongs to (and has always belonged to) bodies of whiteness in the U.S. I do so in order to track some of the ways in which *contemporary* clinical systems meant to respond to broadscale expressions of harm and injury have been built quite literally on the *historical* negation of the feeling capacities of bodies of color. Turning out the false, racially motivated mythos of American Medical Greatness is central to this chapter's work. Seeking to make historic sense of racially differentiated access to the clinical category of pain tells us much about the ways in which pain today is increasingly mobilized as a resource and as a kind of capital in systems of care predicated on the accumulation of profit. I develop the term *clinical power* in this chapter to name more explicitly the ways in which the presumed authority of U.S. clinical systems has historically served—and continues to serve—as a machination of mattering, working in and through circuits of racial capitalism to consolidate the boundaries of whiteness as that which belongs and should be protected at all costs. Ultimately, Chapter 1 allows us to bring critical historical elaborations of pain into the present moment, suggesting that pain is indeed a key *affective* register of contemporary whiteness-in-crisis—a specific kind of bad feeling that carries within itself both fear of loss and the embodied experiences of despair that subtend it.

Chapter 2 correlates to the keyword Crisis. In this chapter, I bring the historical, racially differentiated, and clinical construction of pain to bear on the present moment's amplification of white opioid despair as a specific kind of state emergency—the birth of crisis. In asking what political work the contemporary formation of the U.S. “opioid crisis” achieves, I track some of the ways in which the ostensible emergency of white pain, overdose, and death is driving an explosion of new mechanisms for seeing,

counting, and responding to white harm. In the process, I identify the emergence of new ways of building and binding white publics, thereby justifying the flow of resources accordingly. This chapter likewise turns out the fantasy of American Military Greatness by probing connections between nationalist, military-driven narratives of state protection from harm and the seemingly crisis-level problem of opioid despair. I develop the term *ordinary whiteness* in this chapter to contextualize some of the ways in which Trumpian rhetorics of white loss, white entitlement to capacity, and fractured white belonging at the national level no doubt shape both individual and collective claims to the narrow protections offered by state opioid response mechanisms.

Chapter 3 focuses on the keyword Recovery. Here, I look more explicitly at the construction and resourcing of opioid *treatment* systems that presume to respond to the problematic of opioid despair by re-mobilizing investments in both clinical power and the ongoing fantasy of endless (white) re-capacitation. Here, I move beyond the wide-lens analysis taken in the first two chapters in order to root into one specific locale—Franklin County, Massachusetts. By looking directly at the history and the present moment of Franklin County’s long-term investments in the norms of ordinary whiteness, I show how recovery systems that are directed by the logics and values of the factory will never deliver us into recovery futures that look like anything other than a revolving door run on replenished populations of harm. Here, I problematize the figuration of American Industrial Greatness, illustrating why and how a “detox factory” built in the image of ordinary whiteness is no better than a silver factory for re-figuring right relations to collective care and personal transformation.

In the Coda, I return again to Franklin County, rooting even more intentionally into the site and space of the RECOVER Project and the natural landscape of Franklin County to articulate visions of post-opioid future-making that unfold as ecologies of care. Harney and Moten's concept of the surround provides a structure and a vision for what such care might look like. The Coda is an opening to the practical and theoretical implication of this work. It is an invitation into a clearer and more direct engagement with the work of peer recovery as a praxis of liberation and of structural transformation in both the aftermath of the opioid crisis and the in the many futures of care to come.

Notes to Introduction

¹ See Kosten and George, "The Neurobiology of Opioid Dependence" for a more descriptive engagement with circuits of opioid dependence, withdrawal, and addiction.

² Cultural discourses on the term "despair" in relation to the "opioid crisis" continue to proliferate. Jeff Guo's March 2017 *Washington Post* article, "The disease killing white Americans goes way deeper than opioids," is only one example of an attempt by mainstream media to frame the harms of the opioid crisis directly in relation to the perceived losses—material and spiritual—faced by white Americans in the current moment. Guo writes, "So the theory comes back to despair. Case and Deaton believe that white Americans may be suffering from a lack of hope. The pain in their bodies might reflect a 'spiritual' pain caused by 'cumulative distress, and the failure of life to turn out as expected.' If they're right, then the problem will be much harder to solve. Politicians can pass laws to keep opioids out of people's hands or require insurers to cover mental health costs, but they can't turn back the clock to 1955." Here, we can begin to see some of the ways in which the term despair is charged by its popular circulation and even virality as it continues to infiltrate news spaces as a harbinger of a particular kind of ostensibly "new" bad (white) feeling. Guo connects up that "bad feeling" to mid-20th-century values and ideals made increasingly unstable and irrelevant as they are applied and (and increasingly dismissed) in the current moment. I address contemporary opioid politics' relation to mid-century U.S. politics and political/industrial economies more specifically in Chapter 1 and Chapter 3.

³ McGauley, "13 Items You Never Knew Were Made By Prisoners."

⁴ Here, I am reminded of Stefano Harney and Fred Moten's lyrical frame for thinking and enacting accountability in their work in *The Undercommons*: "We say, rightly, if our critical eyes are sharp enough, that it's evil and uncool to have a place in the sun in the dirty thinness of this atmosphere; that house the sheriff was building is in the heart of a fallout zone. And if our eyes carry sharpness farther out we trail the police so we can put them on trial. Having looked for politics in order to avoid it, we move next to each other, so we can be beside ourselves, because we like the nightlight which ain't no good life" (19). Accountability can and should look many ways, and this vision is gracefully capacious enough to hold parts of what this work envisions, too. I return to Harney and Moten's work in *The Undercommons* in the Coda to articulate an ecology of care mobilized by what they call "the surround" (19).

⁵ This definition of care is inspired by Julie Livingston's concept of "microprocesses of care" as she develops it in *Debility and the Moral Imagination in Botswana*. Framed as a protracted period of time before death, the concept of debility evokes, according to Livingston, particular 'microprocesses of care' (18), which unfold as intimate relations played out at the level of the living, feeling body. I find the term 'microprocesses of care' especially useful for an affective engagement with care, as it evokes the contingent circulations of force and attenuation that play out on and in particular bodies in particular milieus, both institutional and otherwise. I return to Livingston and the genealogy of the term debility more explicitly later in the Introduction.

⁶ I develop the term *ordinary whiteness* more explicitly in Chapter 2.

⁷ Deleuze and Guattari, *A Thousand Plateaus*, 283.

⁸ Stewart, *Ordinary Affects*, 3.

⁹ Stewart, *Ordinary Affects*, 4.

¹⁰ A relevant example of the contemporary affective charge of opioid despair is an image released in 2016 by the East Liverpool, Ohio police department that depicted two people passed out in the front seat of a car, purportedly overdosing on heroin, with a toddler in the backseat. The image circulated online as a particularly evocative example of growing opioid-related harm, particularly in "small town, middle America." In its virality, it both evoked visions and fears of white vulnerability while also consolidating linkages between local white police forces and the many savior narratives that continue to proliferate as more institutional attention and resources are directed towards the problem. See Park, "The Story Behind the Viral Photo of an Opioid Overdose" for a more pointed analysis of the image and the politics it achieves.

¹¹ I am eternally grateful to my wise mentor Rene Andersen who has worked at the grassroots level in Western Massachusetts for over forty years with survivors and others with lived experiences of trauma to develop and implement trauma-informed, participatory, community- and peer-driven supports. Rene's visions and practices are directly informed by her own lived experiences as a poor person and a psychiatric and sexual assault survivor, as well as by her own navigation of interpersonal violence, addiction, and recovery. Although her work on trauma and peer recovery reaches a national audience today, some of her earlier grassroots efforts included working with communities in Western Massachusetts to develop new webs of care upon the move towards de-institutionalization at the Northampton State Hospital, a major psychiatric institution that operated in the area from 1856 until its official closure in 1993. Part of what emerged from that work on de-institutionalization was the creation of the Western

Massachusetts Training Consortium, an agency based in Holyoke, MA that hosts a range of peer-driven supports, including the RECOVER Project and the Western Mass Recovery Learning Community. When I joined the Western Massachusetts Training Consortium in 2008, Rene was no longer in her role as Executive Director of that organization, but her values and visions continued to permeate the work. Rene's assertion that tremendous "competency and wisdom reside in those with lived experience" quickly became a refrain for my own emergent ideas about the power of non-institutional sites of care, as well as the harms embedded in clinical systems that dismiss lived experience in favor of professional hierarchies of knowing and practicing.

¹² The RECOVER Project—a key interlocutor for this project, which I introduce in the next section—is based on a peer participatory model that centers on this basic assumption. In 2013, I had the opportunity to co-author, along with Linda Sarage and Jacob Powers, the manual *From the Ground Up: How to Start Your Own Peer-to-Peer Recovery Center*, where we outline some of the key principles of peer recovery, particularly in relation to challenging institutional and organizational hierarchies: "Many traditional service programs operate within a model that resembles a traditional triangle. Instead of recognizing and valuing people's wisdom, knowledge, and experience, traditional programs often focus on what is "wrong" with an individual and attempt to "fix it". A traditional hierarchical model ensures: 1) That the power and authority to craft and carry out programs, policies, and procedures affecting the whole community are concentrated in a few decision makers at the "top" of the pyramid. 2) The rest of the community—those most affected and impacted by these "top down" decisions—are located at the bottom. The Peer Participatory Process literally "flips" this model upside down so that the community determines and maintains the programs, policies, and the "vibe" of a recovery space. This model requires that the entire community really and truly values the wisdom, knowledge, and expertise that inherently resides in the many folks that make up any given community. The Peer Participatory Process ensures that: 1) Expertise is recognized as residing within the community. 2) Those affected by programs, policies, and procedures are an integral part of the work being done. 3) Community members are involved at all levels of the organization." Sarage, Powers, and Whitmore, *From the Ground Up*, 16.

¹³ Another relevant model of this kind of community-making-as-radical-care is offered by science fiction visionary Octavia Butler in her Earthseed novels, *The Parable of the Sower* and *The Parable of the Talents*.

¹⁴ White, "Recovery Rising," 3.

¹⁵ Key scholars in the realm of feminist care ethics include Joan Tronto, Carol Gilligan, Nel Noddings, Virginia Held, Fiona Robinson, and Eve Feder Kittay.

¹⁶ An emerging research consortium organized around critical care ethics and called the Care Ethics Research Consortium (CERC) is housed at Portland State University. I was invited to present at CERC's first annual conference organized around the theme of Care Ethics and Precarity in October 2018, but I was unable to attend. For more information see Care Ethics Research Consortium at their website, <https://care-ethics.org>.

¹⁷ See especially Clarke, et al., *Biomedicalization*; Cooper, *Life as Surplus*; and Mol, *The Body Multiple*.

¹⁸ Jaggar, "Caring as a Feminist Practice," 179.

¹⁹ Clare, "Stolen Bodies," 363.

²⁰ Gilligan, *In a Different Voice*, 19.

²¹ See in particular Elaine McMillion's Netflix short documentary *Heroin(e)*, as well as Ivana Rihter's March 2018 *Vogue* article, "It's Time to Talk About the Opioid Crisis as a Women's Health Issue."

²² Noddings, *Caring*, 86.

²³ Noddings, *Caring*, 83.

²⁴ Lorde, *The Cancer Journals*.

²⁶ Chamberlin, *On Our Own*, 7.

²⁷ Diedrich, "Que(e)rying the Clinic Before AIDS," 128.

²⁸ Diedrich, "Que(e)rying the Clinic Before AIDS," 129.

²⁹ See Alondra Nelson's *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* for a comprehensive engagement with Black Panther work on non-state health and social justice initiatives.

³⁰ In "Que(e)ring the Clinic," Diedrich likewise discusses La Borde as an example of a pre-HIV/AIDS activism alternative health movement. Guattari's concept and practice of "transversality" is one that I would like to explore more in-depth as a potentially potent strategy for this working going forward. A seemingly fascinating account of daily life at La Borde is provided in the book *I, Little Asylum*, which was published by Felix Guattari's daughter Emmanuelle Guattari in 2014 and recounts her childhood at the clinic.

³¹ Annemarie Mol's *The Logic of Care* is a particularly useful account of such patient-making practices, which she explores through ethnographic work at a diabetes clinic. Mol's critical focus on clinical frameworks of patient "choice" vs. patient "care" is one way to identify the neoliberal logics that remain unarticulated in the structuring of every day experiences of bodily precarity in the clinic. Although Mol does not explicitly engage neoliberalism as a contemporary mediating structure in (diabetes) care, her turn to classical liberalism and Western Enlightenment ideals as a lens for understanding choice locates these contemporary trends in a larger political/economic trajectory that currently rests in the pervasiveness of neoliberalism. In re-thinking the primary distinction between those who are "able" to choose particular schemas of care and those who are not, Mol suggests we dig deeper into the messy practices of care that meet bodies where they're at, outside of the ideal of presumed liberal autonomy. This breaking down of a "capable" and "rational" subject as the ideal subject of illness makes room for the so many different in-between states that bodies find themselves in.

³² See Rose, *The Politics of Life Itself* and McRuer, *Crip Theory*. McRuer posits "crip theory" as a mode of re-theorizing, re-embodying, and re-signifying the flexibility demanded by global neoliberalism. He seeks forms of subjectivity and embodiment that challenge the basic assumptions of rehabilitation, "it gets better," and the clean recovery of some idyllic pre-disabled past (and future). Crip theory is about re-negotiating the terms of having and living in a body that is in excess of medical/social/economic dictates of 'normal' in our current globalized/neoliberal moment. Although McRuer is interested in material culture, embodiment, AND global movements of capital, he does not take up race as an explicit element in the construction and deployment of crip theory, which is significant. Much of that focus is displaced by thinking through global capitalism's work within and on the disabled body, reifying the race-neutral concept of disability that

permeated much of the critical theory in this area. Although McRuer's angle is important in terms of opening disability studies up beyond Euro-American frameworks, I felt the absence of race in crip theory as a marked loss. His section on Crip communities in LA is a small exception, but ultimately, this project wonders how ideas of pathology and alternative community-building can and should be expanded through a vision of "crip theory" that is infused with critical studies of race (and whiteness in particular), as well as the more insidious workings of settler colonialism as they manifest in contemporary systems and institutions of care.

³³ An interesting historically-situated interlocutor around race and the production of bio-value going forward is Neel Ahuja's *Bioinsecurities*. Kaushik Sunder Rajan's *Pharmocracy* may also contribute to a more globally situated analysis of such dynamics going forward.

³⁴ Spade, "Intersectional Resistance and Law Reform," 1042.

³⁵ Hong, "Neoliberalism," 56.

³⁶ Hong, "Neoliberalism," 56.

³⁷ I take up the core theme of racial capitalism as it has been articulated by Jodi Melamed in Chapter 2 and by Cedric Robinson in Chapter 3.

³⁸ Critical black feminist accounts of respectability politics—both historical and contemporary—have been generated by Evelyn Brooks Higginbotham in *Righteous Discontent* and by Deborah Gray White in *Too Heavy a Load: Black Women in Defense of Themselves, 1894-1994*, among many others. For a more recent critical engagement with the political work of black respectability politics, see Brittney Cooper's *Beyond Respectability*.

³⁹ Hong, "Neoliberalism," 57.

⁴⁰ Those movements include, for example, the Movement for Black Lives, Standing Rock, and, to some extent, #MeToo.

⁴¹ Hong, "Neoliberalism," 61.

⁴² Marez, *Drug Wars*, 2

⁴³ See Vann R. Newkirk II's July 2017 article in the *The Atlantic*, "What the 'Crack Baby' Panic Reveals About the Opioid Epidemic," for a critical take on the visual politics of sympathy and policy response to drug-related harm in two different eras.

⁴⁴ Hong, "Neoliberalism," 60.

⁴⁵ These lines of thought are indebted to Sylvia Wynter's rigorous work on the category of the human, as well as to Alexander Weheliye's interpretations of Wynter's work. See Wynter, "Unsettling the Coloniality of Being/Power/Truth/Freedom" and Weheliye, *Habeas Viscus*.

⁴⁶ See the recent publication "The Opioid Crisis in Black Communities" by Keturah James and Ayana Jordan for a clear analysis of the racial disparities in media and clinical attention to black opioid deaths.

⁴⁷ The genealogy of the term "life itself" originates with Foucault's early articulation of biopower at the end of *History of Sexuality, Volume I*. Here, Foucault begins to outline the 18th century movement in Europe from disciplinary and sovereign modes of power to emergent mechanisms of biopower, where "methods of power and knowledge assumed responsibility for the life processes and undertook to control and modify them...Power would no longer be dealing simply with legal subjects over whom the ultimate dominion was death, but with living beings, and *the mastery it would be able to exercise over them*

would have to be applied at the level of life itself; it was the taking charge of life, more than the threat of death, that gave power its access even to the body” (143). I explore Foucault’s articulation of biopower more pointedly in Chapter 2. Nikolas Rose also usefully unpacks the concept of “life itself” in relation to modern clinical subjectivities in *The Politics of Life Itself*.

⁴⁸ See Reddy, *Freedom with Violence* for a rigorous argument about the constitutive roles of racial and sexual difference in building and fortifying the power of the U.S. state.

⁴⁹ In *The Right to Maim*, Jasbir K. Puar clearly outlines the differentiating work of biopolitics in the language of investment: “Neoliberal investments in the body as portfolio, as site of entrepreneurship, entail transition of *some* disabled bodies from the disciplinary institutions of containment, quarantine, and expulsion into forms of incorporative biopolitical control” (76).

⁵⁰ Livingston, *Debility and the Moral Imagination*, 1

⁵¹ Livingston, *Debility and the Moral Imagination*, 11

⁵² Livingston, *Debility and the Moral Imagination*, 3.

⁵³ Livingston, *Debility and the Moral Imagination*, 8.

⁵⁴ Puar, *The Right to Maim*, 73.

⁵⁵ Puar, *The Right to Maim*, xiv.

⁵⁶ Puar, *The Right to Maim*, xiv.

⁵⁷ Puar, *The Right to Maim*, xvii

⁵⁸ Puar, *The Right to Maim*, xvii

⁵⁹ Puar, *The Right to Maim*, xviii.

⁶⁰ Puar, *The Right to Maim*, 66.

⁶¹ Puar, *The Right to Maim*, 63.

⁶² Puar, *The Right to Maim*, 85.

⁶³ Page, “Reflections from Detroit.”

⁶⁴ Page, “Reflections from Detroit.”

⁶⁵ Black Lives Matter, “Healing Justice.”

⁶⁶ Black Lives Matter, “Healing Justice.”

⁶⁷ Black Lives Matter, “Healing Justice.”

⁶⁸ One version of the project once aspired to this end!

⁶⁹ Piepzna-Samarasinha, “A Not-So-Brief Personal History.”

⁷⁰ Piepzna-Samarasinha, “A Not-So-Brief Personal History.”

⁷¹ brown, *Emergent Strategy*, 3.

⁷² brown, *Emergent Strategy*, 3.

⁷³ The term “messy ethnography” has recently been used by Alexandra Plows in the edited volume *Messy Ethnographies in Action*, although I came to the use of the term on my own.

⁷⁴ For me, this experience drove my own desire to engage increasingly with local history archives in Massachusetts as I approached the “recovery” chapter of this work and began to think through the settler colonial legacies that preceded the factory in Franklin County. As a kid growing up in Western Massachusetts, my mother’s own fascination with the “colonial history” of the area brought me in close contact with many of the stories and figures that populate this work (i.e., the Turners Falls massacre in Chapter 3). However, they emerge quite differently here than they did when I was a kid as I take the time to unpack and apply critical lenses to the archives and stories I’ve long been drawn to

imaginatively and otherwise. A methodology of intervention into the archives of “local history” is a major element that I take away from this work—one that also drives my emergent draw to write critical historical fiction based on “local” figures and spaces of settler colonial occupation and resistance in the aftermath of my dissertation.

⁷⁵ Consider my mind blown when I met a woman at the RP that summer who came in, sat down as some of us ate lunch together, and began unpacking exactly how and why the word “recovery” simply did not fit the path to transformation she was pursuing. “I’ve started to think that *ecology* tells the story so much better,” she told me, unprompted, as she described the ways in which her time spent alone in nature beside the Green River attuned her to all that natural processes of communion, tension, resolution, and emergence could teach about living otherwise. I stuttered, trying to figure out how to tell her that my own work was likewise coalescing around the concept of ecology to name what was happening in that instance—an ecology of care. Somehow, I did find the words, although the uncomfortable yet wholly necessary demand for translation has always been a troubling part of this experience. We remain connected on social media today, exchanging brief flashes of same-vision that always remind me of the ways in which our most important interlocutors are the ones we least expect.

⁷⁶ I am inspired here by Harney and Moten’s take in *The Undercommons* on critique and sociality in the revolutionary context: “Critique endangers the sociality it is supposed to defend, not because it might turn inward to damage politics but because it would turn to politics and then outward, from the fort to the surround, were it not for preservation, which is given in celebration of what we defend, the sociopoetic force we wrap tightly round us, since we are poor. Taking down our critique, our own positions, our fortifications, is self-defense alloyed with self-preservation” (19).

⁷⁷ This term indexes not only racial but also class divides in the region of Western Massachusetts, which are often delineated by the boundary between Northampton / the “Pioneer Valley” (home of the Five Colleges: Smith College, Mt. Holyoke College, Amherst College, Hampshire College, and the University of Massachusetts – Amherst) and Holyoke/Springfield to the south.

⁷⁸ Greenfield’s current population is 17,442 according to 2010 Census data. U.S. Census Bureau, “Quick Facts: Greenfield, MA.”

⁷⁹ *Parts Unknown*, “Massachusetts.”

CHAPTER 1:

Bodies on the Line: Histories of Pain, Clinical Power, and the Affective Life of Whiteness

I. Troubling Clinical Greatness, Troubling Clinical Power

In 1952, the Detroit-based pharmaceutical company Parke-Davis commissioned an oil portrait of “pioneering” gynecologist J. Marion Sims for their new series *Great Moments in Medicine: A History of Medicine in Pictures*.¹ Currently a subsidiary of the mega pharmaceutical conglomerate Pfizer, Parke-Davis was, in 1952, its own company, one that faced major industry and public backlash as one of their key compounds—an antibiotic called chloromycetin—was increasingly generating reports of toxic anemia in those to whom it was administered.² Sales plummeted for the company who was, up until then, at the pinnacle of a burgeoning pharmaceutical research and manufacturing industry in the post-war U.S. In an effort to recoup their concerning decline in industry control—and its attendant toll on public morale—Parke-Davis began investing in an advertising editorial campaign comprised of professional art portraits of so-called “Great Moments” in medical history. The goal was, it seems, to re-bolster an *image* of U.S. clinical medicine that was fully capable and commanding in practice at a moment when that post-war capability was undoubtedly jeopardized by increased breakdowns in the efficiency, surety, and safety of U.S. pharmaceutical manufacturing.³ The Sims portrait would find its home within this collection, serving to highlight the nineteenth century surgeon’s supposedly groundbreaking work in women’s reproductive health and gynecological surgical procedures. “Without realizing it,” suggested the public relations material that accompanied prints from the series as they were distributed to doctors’ offices throughout the U.S., “viewers will be impressed with Medicine’s rich heritage of dedicated service

and its continuing efforts to improve the health and well-being of mankind.”⁴ Despite the grand intentions spelled out by the Parke-Davis PR department, the *Great Moments* series was—perhaps more realistically—born out of a period of industrial vulnerability motivated by corporate negligence.⁵ In other words, it was business as usual.

Whiteness has always been endemic to many forms of Greatness, demonstrated in and through the kinds of visions and scenes that Parke-Davis commissioned for its series. Although not all of the 45 commissioned portraits contain representations of *American* “medical greatness” specifically, the images generally present examples of clinical achievements being developed and performed by Very Important White Men.⁶ The portraits show white European and American male doctors acting on the bodies of desperately ill and otherwise defenselessly vulnerable patients. The doctors are rendered heroically for their labor as they examine, treat, and cure with confidence. The majority of the bodies treated in the portraits appear to be young white children and white mothers. A short narrative that illuminates the clinical achievements of each scene accompanies the portraits.⁷ There is John Hunter, an “untutored Scottish country boy,” depicted in London in the mid-1700s as he develops the “revolutionary” practice of scientific surgery using his decades-long comparative studies of anatomy. Thanks to Hunter’s prodigious work gathering (or, stealing) and preserving (or, hoarding) the almost 14,000 specimens that comprised his infamous collection, as the narrative suggests, we now have permanent access to the pristinely preserved skeletons of the extinct Great Auk (a bird) and the Irish Giant (a human).⁸ And there is Dr. Benjamin Rush, a “founding father” (or, early colonizer) who would eventually come to be known as the “first great physician in the United States of America,” according to Parke-Davis’ narrative.⁹ Here, however, Rush is

pictured in the early days of his career, displaying “professional, moral, and physical courage” as he labors to (supposedly) treat and cure victims of the yellow fever epidemic that ravaged the early U.S. population in the late 18th century.¹⁰ Despite the fact that his treatments were often “severely criticized” for their seemingly detrimental effects on patients,¹¹ the narrative assures us Rush was “unswerving” in his commitment to his patients and to his profession. And there are 250 early American physicians (or, 250 white men, 250 upper crust, Civil War-era physicians) convening among excavated mastodon bones (or, plundered artifacts) in the hall of the Academy of Natural Sciences in Philadelphia in 1847 to form the first delegation of the American Medical Association. Sealed with the portrayal of handshake between key players in the Association’s formation, one of the world’s “largest and greatest medical bodies” was established in “service both to the public and to the profession.”¹²

Parke-Davis’ *Great Moments* series naturally culminates with a final portrait titled “Medicine Today and Tomorrow.” This image depicts a sick child presumably in her bed at home as a capable doctor attends to her. Worrying parents watch from the doorway. Thanks to the work of, “countless thousands of dedicated medical men throughout fifty centuries,” the narrative concludes, doctors of today can continue to make the necessary “discoveries and advances” to advance a “better world.”¹³ It should come as no surprise that Parke-Davis’ narrative pinnacle of progress climaxes with an image of a professional (white) clinician protecting the precious (white) “future” for an ordinary (white) nuclear family.

Although the specific details of Greatness vary from portrait to portrait in Parke-Davis’ *Great Moments* series, it soon becomes clear that the grander story being

produced, packaged, and distributed by the largest pharmaceutical manufacturer of its era was as much about celebrating the supposed “progress” of Western clinical medicine as it was about soliciting sentimental investments in a particular vision of clinical power. That vision was, it turns out, unquestioningly benevolent, assuredly capable, and—perhaps most crucially—indelibly white. For whom was this image of medical Greatness manufactured? And how might we understand the presence of these scenes in doctors’ waiting rooms across the U.S. as a kind of subliminal message about the scope and attention of clinical power? I develop the term *clinical power* throughout this work to chart the various collusions and co-operations that link up ever-extractive methods of accumulating corporate capital and individual wealth to the expedient authority and presumed expertise of clinical knowledges and clinical practices in the U.S. Clinical power names the various circuits—affective, economic, racial, historical—through which some bodies have come to matter as worthy (and lucrative) sites of investment for clinical practitioners in the U.S., just as others have been marked for mining, extraction, and eventual disposability. Clinical power names the strategies, systems, and stories that work to grant clinical legibility and assign clinical worthiness according to the prevailing logics of racial capitalism.¹⁴ Pain, as this chapter will show, is one key circuit through which clinical power has gained coherence as a mechanism of racial sorting in the U.S.

Pain arbitrates the boundaries of social belonging. Pain shows us how we matter (or don’t) as fleshy, sensing bodies circling through clinical economies and seeking respite. A collective historical-clinical consciousness in the U.S. can and should contend with the vital role that embodied markers of difference (i.e., race, sexuality, gender, class) have played in consolidating clinical power in and through the bodily register of pain

specifically and sensory experience more broadly. And yet, we consistently fail to recognize those markers of difference as relevant to all that is activated in the contemporary formation of the U.S. “opioid crisis,” where whiteness, pain, and the imperatives of pharmaceutically manufactured relief have converged as a kind of trifecta, always already mediating where and how individual bodies come to matter in clinical sites and spaces. The collective “us” that animates the opioid crisis is, no doubt, a contemporary formation that gains its vital power in and through the ongoing activation of histories of white racial formation that privilege the clinical apprehension of white pain, just as it disavows the sensory experiences of un-whiteness. This is no mistake, nor is it a fluke of history. Pain is, as Sara Ahmed suggests, a contingency;¹⁵ access to its categorical weight depends quite often on one’s ability to make sense as a subject-in-pain to the clinical powers that direct and administer economies of intervention. As such, in order to more fully articulate the limits and boundaries of pain as a kind of clinical mattering—and as a kind of belonging (to nation, to self, to futurity)—we must necessarily think through the clinical construction of pain *today* alongside the *historical* construction of sensation as racially differentiated. This will, no doubt, tell us something about the ways in which clinical power has operated as a mechanism of conversion, whereby vulnerable whiteness manifests as capital, which then feeds back into the work of securitizing the corporate bodies that underwrite clinical power.

Parke-Davis’ *Great Moments* series is an especially fruitful site from which to begin unearthing the long-productive links between race, sensation, and clinical power in the U.S. because it presents a series of cautionary, albeit implicit messages about the specific nature of harm and injury in a collective vision of American Clinical Greatness:

your harm and your suffering are important, just as long as “you” are white, just as long as “you” are part of a nuclear family, just as long as “you” remain dedicated to the normative boundaries of American embodiment and American respectability. David Theo Goldberg suggests that the excision of certain bodies from the “foundational code” of liberal concern and attention is, in fact, a constitutive part of U.S. political economy as it has evolved in and through the racialized labor of capitalist extraction. “Thus the labor of race,” Goldberg argues, is the work for which the category and its assumptions are employed to effect and rationalize social arrangements of power and exploitation, violence and expropriation.”¹⁶ Here, we get a sense of the labor of meaning-making involved in positing whiteness as a kind of supremacy in clinical sites and spaces. Each portrait clearly articulates the message that “we” (white people, the expected consumers of these images) will only be saved from impending threats of harm by placing “our” deepest and most vulnerable trust in the sanctioned stewards of Medical Greatness. Only in “their” capable hands will “our” pain be adjudicated and “our” vulnerable bodies nourished back to life. Through the development and deployment of their specific visions of Greatness, Parke-Davis effectively demonstrates that some key mechanisms for establishing, consolidating, and maintaining the hegemony of clinical power in the U.S have concurrently functioned as key mechanisms for establishing, consolidating, and maintaining the hegemony of whiteness in the U.S.

In the midst of all of the carefully curated history offered up to us in the *Great Moments* series, what, we must ask, remains *unarticulated* in Parke-Davis’ corporate translation of the history of medicine? What political work has been achieved by suturing the presumed (and, it turns out, false) efficacy and benevolence of “dedicated medical

men” to the promise of a safe and protected future? Who is invited into “healthy” futures and who is excised from possibilities of futurity? And finally, what can an attention to the specifics of a mid-20th century pharmaceutical advertising campaign tell us about the very current miasma of the “opioid crisis,” where bodies of clinical power, aggressive practices of corporate marketing, and the industrial management of vulnerability converge once again? Plenty, it turns out—especially if we start by looking for what’s been missing—historically *and* contemporarily—in this specific vision of Greatness.

In order to do this work, we need critical genealogies of sensation that can attest to pain as a vital metric of the white body. And we need critical genealogies of pain that can reveal something about the limits of U.S. clinical knowledges that have been forged in and through the hegemony of white sensation. In a moment where the long-concealed mechanisms of white supremacy are increasingly being turned over and out by movements like Black Lives Matter and Standing Rock, Parke-Davis’ *Great Moments* series—and the Sims portrait that opens this chapter more specifically—offer vital opportunities to reckon with the constitutive role of whiteness in the formation and consolidation of myriad contemporary systems of power.

Clinical power is only one facet of a long-nurtured social monster that thrives on the productivity of whiteness as it is embedded in multiple formations of power: the state, the police, the corporation. Attending to the adjudicating work of pain and sensation alongside an analysis of the role of whiteness in securitizing clinical power specifically gets us even closer to revealing the conditions of possibility that permitted Parke-Davis to feature J. Marion Sims as an easy, nostalgic emblem of Greatness, even as his practice was no doubt built on the paradoxical mining of black women’s reproductive pain in

order to relieve the reproductive pain of white women. This paradox, which is built on the differential clinical meanings ascribed to black and white women's pain—indexes much of the work that race and gender achieve in formations of clinical power.

By culling together critical histories and genealogies of race, sensation, and clinical power, this chapter seeks to challenge the very fact of (white) pain as an implicit, objective, or self-contained organic bodily state that demands clear modes of intervention and management. Instead, I work to develop Sara Ahmed's claim in *The Cultural Politics of Emotion* that, "stories of pain involve complex relations of power."¹⁷ Unpacking pain as a function of power rather than a stable organic referent demands acute attention to the role that pain specifically and sensation more broadly have historically played in processes of U.S. racial formation. I use the term racial formation here following the foundational work of Omi and Winant, who suggest that race as a concept, "signifies and symbolizes social conflicts and interests by referring to different types of human bodies."¹⁸ Racial formation, according to Omi and Winant, names a "process of historically situated projects in which human bodies and social structures are represented and organized."¹⁹ How, then, has pain historically functioned as a specific project of the body, and what does this have to do with the story of whiteness-as-we-currently-know-it?

In answering this question, I look to three key historical moments in the U.S.—the mid-19th century emergence of gynecological surgery driven by the controversial figure J. Marion Sims; the mid-20th century development of industrial pharmaceutical public relations and marketing by the proto-Big Pharma firm Parke-Davis; and the late 1990s/early-2000s explosion in opioid manufacturing and distribution driven by global pharmaceutical conglomerates—to develop one of this chapter's key claims: pain is

indeed a key affective register of whiteness today. In the chapter that follows this one, I take up the threat of crisis that underpins contemporary opioid politics—its affectivity, its political utility, its branding and manufacturing—in order to explore the ways in which the cultural formation of the opioid crisis more specifically re-entrenches contemporary practices of *biopower* at the level of population. I track the ways in which many of the public health apparatuses vitalized by the opioid crisis “count” and “bind” white, working class communities into a white “public,” which 1) sanctions the large-scale mobilization of resources and infrastructure in the service of whiteness itself and 2) further supports the biopolitical work of differentiating populations based on race. First, however, we must come to a clearer understanding of the affective and racial animation of pain at the *individual* level in order to trace the ways in which current clinical-cultural models for apprehending sensation and “bad feeling” (and, ultimately, for apprehending racial difference) feed the emergence of racially differentiated populations-in-pain. In other words, we must first make explicit the ways in which individual white bodies have been historically constructed as implicitly sensitive, vulnerable, and primed to feel pain by clinical praxes of seeing, and then, following the clinical presumption of pain-as-vulnerability, as *worthy* of receiving clinical care directed towards that pain through myriad exercises of clinical power. In thoroughly articulating race as productive of individual corporeal figures, this chapter seeks to reveal the ways in which clinical systems and practices of care that are being marshaled around the fact of pain today are, in fact, actually reifying historically differentiated relations not only to life and death, but also to whiteness itself, as a specific kind of life-ness. In the process, I argue that pain continues to function as a vital landscape for processes of U.S. white racial formation,

just as it works to secure and consolidate a bodily terrain of clinical power that operates in the service of racial capitalism.

Looking to where, how, and why pain has typically registered across clinical systems, social bodies, and individual corporealities in the U.S. reveals that the fact of pain and the surety of its treatment (and resolution) have traditionally functioned as affirmations of the presumed resiliency of vulnerable whiteness: whiteness in pain, whiteness in loss, whiteness in fear. As such, I begin with the section “En-visioning Medical Greatness, Un-visioning Medical Apartheid,” in order to track the formation of sensitive, resilient whiteness in the three key moments framed above: the mid-19th century surgical world of J. Marion Sims; the mid-20th century world of industrial pharmaceutical manufacturing; and the early 21st century world of mass market opioid production and distribution. Across these three moments, I show how the collective work of seeing and investing in a manufactured image of “American Medical Greatness” has historically relied on un-seeing the affective remainders of racialized clinical power: psychic terror, bodily subjugation, and the large-scale disavowal of non-white economies of sensation. I attend to the visual register specifically in this section to show how clinical practices of seeing (seeing pain, seeing individual bodies, seeing clinical “breakthroughs”) that emerge coeval with the securitization of whiteness are likewise always already clinical practices of *unseeing* that establish their own capacitation in and through the disavowal of non-white economies of sensation. Although this chapter as a whole does not claim to make any totalizing historical argument about processes of racial formation or the productive role of sensation throughout U.S. history, it will, I hope, allow us to put into conversation a handful of particular historical-political-economic

moments in which processes of racial formation and the productive power of pain have cooperated in the service of both professionalizing and standardizing bodies of U.S. clinical power across the last two centuries.

Unpacking pain as a function of power rather than a stable organic referent in the animation of clinical power likewise demands deep listening to black feminist and queer of color histories and theorizations of the intersections of race, sensation, and clinical power to learn pointedly what's gone so drastically wrong, both historically and contemporarily, in our clinical systems of meaning-making. As such, scholarship on nineteenth-century U.S. sensory economies and practices of medical knowledge production provide useful interpretive frameworks for thinking through the ways in which race, sex, and gender have cooperated to secure the presumed vulnerability, sensitivity, and eventual resiliency of whiteness. These histories and frameworks provide a critical platform that allows us to listen to and excavate some of what's been buried in what Washington calls the "mass grave" of "medical apartheid." As such, in the next section I bring the political work that is achieved by the historical negation of the feeling capacities of bodies of color up to the present moment by thinking through some of the more contemporary political effects of the ongoing disavowal of non-white sensory capacities, including the charged fact of racial health disparity. Utilizing the work of Dorothy Roberts, I show more clearly the ways in which present forms of national belonging and rubrics of citizenship emerge from racist histories of managing and responding to white pain at the expense of other kinds of bad feeling.

By listening deeply to historical legacies of racial health disparity born from the ongoing clinical disavowal of non-white pain, the urgency of tending to "archives of

feeling,” or what Christina Sharpe calls “wake work,” becomes all the more pressing as they counter what’s been lost to the ongoing erasures that comprise “professional” clinical archives. As such, I put Washington, Sharpe, and the performance artist Geo Wyeth into conversation in order to articulate some myriad ways in which psychic and bodily violences have quite conventionally subtended the clinical capture and (mis)-management of bodies of color. Taken together, the interlocutors in this section move us towards a recognition of the ways in which pain specifically and sensation more broadly might be more generatively understood as a tense clinical aperture where affective, fleshy bodies; state/clinical power; and apparatuses of meaning-making gain a particular kind of focus in historical and ongoing acts of clinical apprehension.

In more fully exploring historically encoded—and racially differentiated—parameters of sensation, this chapter concludes by locating and centering other possible frameworks of pain that are de-naturalized and re-socialized. José Esteban Muñoz, Frantz Fanon, and Sara Ahmed come together to offer further insight into some of the ways in which we might feel for myriad kinds of “bad feeling,” including pain, otherwise. I draw on this active and vital archive of un-white knowing (and feeling) to glean some possible interventions into what’s currently available for attending to non-white pain from sites of clinical power. This deep dive into the historical and racial life of pain will, no doubt, open up the conditions of possibility for thinking through the multiple effects of the opioid crisis differently in Chapter 2.

What is pain? And where does it live? Does it sink down heavy around the ruptured muscles and tissues and bones of your worn out, working body? Is it sharp? Do you talk about it? Is it the secret, hidden thing that the doctor's sterile hand grazes over in your examination attire? Or is it the thing you rub and attend to at home, when no one is watching? Do you wish it away? Or is it the thing you shout from the rooftops? Do you hoard it and shelter it from the light of day? Is it dull? Is it carried forward in the weight of history that breathes down your neck in the present? Is it hot? Is it stoked and amplified in daily encounters of micro—and not so micro—aggression? Is it your grief: what you've lost? Does it make you tired? Is it cold? Is it the crush of a fist? Is it icy knives in your back? Is it your growling, hungry stomach? Is it utter lack of feeling? Is it your loneliness? Is it the slippery thing that screams at you, demanding that you protect it? Does it protect you? Is it a refrain? A refusal? Is it a sanctuary into which you retreat? Is it security? Or is it the loss of security? Does it nag at you? Does it bind you to yourself, reminding you that you are a living, sensing human? Or does it cleave you from yourself, reminding you that you are first and foremost alone, forgotten? Is it crazy? Are you?

II. En-visioning Medical Greatness, Un-visioning Medical Apartheid

Parke-Davis' vision of Medical Greatness was, no doubt, powerful and convincing in its time. It was especially so for those doctor-going, health insurance-having, post-war consumers who could easily see themselves reflected—either as rescuer or as rescued—in the calculus of historical accounting undertaken by the *Great Moments* series. That calculus goes something like this: the (typically white) professional

storytellers of (typically white) industrial PR give us a record of (typically white) medical history that is chock full of robust reminders of (typically white) American fortitude and resiliency in the face of the melodrama of crisis. Those (typically white) patients who gazed upon the portraits of Sims, Hunter, Rush, and others in the waiting rooms of (typically white) doctor's offices across mid-century America were invited to act as first-hand witnesses to the nascent advent of exciting and lifesaving treatments and technologies. They saw courageous (typically white) physicians making technical and scientific breakthroughs that apparently saved the lives of thousands of (typically white) people held in the jaws of unforgiving epidemics. They bore witness to the many kinds of (typically white) growth and progress that presumably come from steadfast exercises of efficiency, efficacy, and expertise. They saw powerful (typically white) arbiters of care rush forth to the rescue in so many different times and places, always with the sure result of conquering the evils of natural illness and biologic contamination. And, they felt like they were in good (typically white) hands because of what they saw: white hands delivering white bodies into a white future.

The productive power of whiteness to assess and arbitrate the many faces of vulnerability is, no doubt, both constitutive and obscured in Parke-Davis' telling visual account of the history of medicine. The series is constructed so that viewers—particularly white viewers— categorically cannot “see” the many kinds of harm that have been unconditionally leveraged against bodies of color (and, often, bodies of difference more broadly) that have sought treatment or care in myriad clinical settings and were instead met with neglect, erasure, and even direct injury. The series naturally conceals the ways in which bodies of clinical power in the U.S. have been consolidated and securitized

through a process that ties their value to the presumed supremacy of whiteness. And, it fervently suppresses the decaying undersides of these visions of Greatness—their conditions of possibility—which no doubt affects where and how we make investments in bodies of clinical power that manage and direct our vulnerabilities today. To be clear, there is no room in Parke-Davis’s vision of Greatness for an image of Dr. John Hunter as he steals, boils, drains, preserves, and eventually exhibits the dead body of Charles the “Irish Giant” Byrne against his will in the late 1700s.²⁰ There is no room here to talk about—never mind witness—Dr. Benjamin Rush’s many attempts to cure “Negritude”—his diagnosis of black skin pigmentation as a mild form of leprosy—once and for all.²¹ And there is certainly no room here to talk about the many desecrations of ecosystem, environment, and livelihood that surely subtended the excavation of all of those mastodon bones that surrounded the early conveners of the AMA in Philadelphia in the years just after the Civil War. What remains unarticulated though clearly palpable in each of these commissioned images is the political work achieved by aligning the collective work of “envisioning” medical Greatness with illusory and often erroneous images of emboldened, capable white men acting responsibly and ethically to eradicate bodily harm. That political work ultimately comes to look like the story of white, professional capacity told in and through the abjuration of bodies of color.

The portrait of J. Marion Sims that opens this chapter is no different. Rendered by the commercial artist Robert Thom, who also designed commissioned artwork for other corporate sponsors like General Motors and Chevrolet, the portrait features a forceful and aloof Sims surrounded by several other white medical colleagues. They all stand anticipatorily before an operating table. The title of the portrait, “J. Marion Sims,

Gynecological Surgeon,” communicates some of what we know about this scene: Sims is preparing to perform an experimental gynecological procedure on his black slave, Betsey. The goal of these surgical experiments was to develop a cure for vesicovaginal fistula, an immensely painful childbirth complication in which a hole develops between the bladder and vagina, leading to uncontrollable urinary incontinence.²² We know that Sims’ earliest “patients”—who were also, crucially, his de facto research material—were mostly enslaved black women; many of them Sims likely purchased for the explicit purpose of clinical experimentation.²³ We know that the enslaved women Sims worked on early in his career largely endured his “experiments” without the aid of anesthesia, even as it was increasingly available to surgeons of his time.²⁴ And we know that the bodies and experiences of the enslaved women Sims worked on rarely surface in clinical histories (or anywhere else) to complicate and challenge the conditions of his legacy of Greatness. Surfacing those conditions is, as it turns out, imperative to re-negotiating systems and practices of care in the U.S. that have been built—quite literally—on the institutionalized disavowal of black women’s pain.

Clinical histories that continue to celebrate Sims’ contributions to reproductive and gynecological medicine (he was elected President of the American Medical Association in 1875) often assume that even though his “groundbreaking” techniques were largely developed on the bodies of un-anaesthetized and enslaved black women, the eventual relief of pain that those techniques made possible first for the enslaved women and eventually for “all women” does in fact justify the pain-full conditions of that research.²⁵ These clinical legacies continue to center the efficacy and surety of the white clinical gaze—a vision of American Greatness—directed beneficently towards suffering

bodies of color at the direct expense of that gaze's material conditions.²⁶ Physician and medical historian Vanessa Northington Gamble's work on Sims—and his enslaved patients—tells some of that story. “These women were property,” Gamble reminds us in an interview with Shankar Vedantam on NPR's *Hidden Brain*. “These women could not consent. These women also had value to the slaveholders for production and reproduction—how much work they could do in the field, how many enslaved children they could produce. And by having these fistulas, they could not continue with childbirth and also have difficulty working.”²⁷ Here, Gamble contextualizes the specific ways in which the political economy of American chattel slavery, which operated largely through the non-consensual reproductive labor of black women, provided Sims with an unending pool of vulnerable and in-pain bodies upon which to labor in securing his own image of Greatness. The ongoing vulnerability and incapacity of Sims' enslaved patients was, indeed, a prerequisite condition for his own capacity building. According to Gamble, one woman, Anarcha, underwent 30 surgeries before Sims' technique to repair the fistula was perfected.²⁸ That Sims increasingly invited other physicians to witness these surgeries confirms the production of a spectacular visual register that directed the labor of black women's reproductive pain towards bolstering and consolidating white clinical power in the mid-19th century.

The visual register tapped by Sims himself centers the spectacularity of white clinical performance. This same register is alive and well in Thom's rendering of this specific scene of American Medical Greatness. In the portrait, Betsey faces Sims directly; she is kneeling on the table, deferential and still clothed. Her left hand rests on her chest. Behind her, Sims' colleagues appear with their shirtsleeves rolled up, as if waiting for a

sign from the man clearly in charge to dive in to all that this display has to offer. Sims' own authority within the scene is visually confirmed by the fact that he is the *most fully dressed* of all the figures portrayed. A deeper reading of the scene's sartorial politics, for example the far less "showy" clothing of the other doctors present, reveals a potentially latent class divide flowing throughout the portrait, hinting at the multiple sources of capital Sims drew on to strengthen his own legacy. From behind a white sheet, two other black women's faces peer out, ostensibly next in line on the table. The cool, detached Sims evaluates Betsey's body. His pointed gaze, animated by furrowed brow and crossed arms, evokes countless other scenes of belabored racial evaluation—from the blocks of urban slave markets, as memorialized in paintings such as Eyre Crowe's 1856 "Slave Auction at Richmond, Virginia (1856)"²⁹ to the infamous French oil painting "Les Curieux en extase, ou les cordons de souliers,"³⁰ which features "Hottentot Venus" Saartjie Baartman being examined by the penetrative gazes of other white men who appraise an ostensibly sub-human "other" in the service of their nation: French soldiers. In this particular exhibition of spectacular clinical viewership and performance, Betsey's ready and willing body offers Sims something he desires: a canvas for his own unfolding life's work which, as time tells us, will catapult him into clinical notoriety. Betsey's tremendous reproductive pain—the result of forced and ongoing pregnancy in chattel slavery—makes possible Sims' legacy. Spectacle begat Speculum.³¹

Thom's wholly celebratory portrait of this burgeoning moment in Sims' medical prowess was produced almost a century after Sims executed the bulk of these experimental gynecological surgeries on un-anesthetized, de-facto non-consenting enslaved black women like Betsey and the other two women portrayed in the portrait. In

that 100 years, Sims' legacy as the "father" of women's reproductive medicine was, quite literally, fortified: there are at least three statues of his capable, professional body installed across the U.S., including one bronzed installation that currently lives on a stone wall bordering Central Park just across the street from the New York Academy of Medicine. And yet, in the 70+ years since Thom's portrait was produced, we've only just begun to grapple with the gross and violent dissonance that lies at the center of his supposedly pioneering work: in his search to secure techniques that would remediate the unacceptable pain of childbirth for some (white, middle and upper-class) women, Sims relied on his ability to secure the bodies of other (black, poor, enslaved) women as raw material. In the process, Sims fortified clinical assumptions about the expendability and lack of sensitivity of black and poor women's bodies in the service of remediating the pain and sensitivity of white women.

To be clear, as Sims' work trained a supposedly compassionate clinical eye on the gendered pain of childbirth in "dedicated service" to all of "mankind" (at least according to Parke-Davis' narrative), it likewise trained the burgeoning formation of U.S. clinical power to recognize and work from the assumed insensitivity of the laboring, racialized body. Laura Briggs' critical work on Sims attends directly to this constitutive contradiction in our available clinical histories of women's pain and its treatment: a simultaneous reliance on *and* disavowal of the ways in which race and gender historically cooperated to secure and stabilize myriad constellations of power. Constellations of power that are invigorated by the doubling work of race and gender range from the clinical capacity to define and police rubrics of "pathology" and "health" to more abstract formations like modernity and nationalism, which likewise harness gendered forms of

difference toward the securitization and stability of whiteness. “At least one consequence of this bifurcation,” Briggs argues, “was the production of a class of patients immune to pain that provided the clinical material for often risky attempts to improve surgical techniques.”³² Briggs calls this maneuver in which the specificities of racialized embodiment for black women are sublated to the specificities of gendered embodiment for “all women” a “rough coherence”³³ because of the unaccounted for contradictions in applying clinical practices based inherently on *difference* to *all* women’s bodies. I call it a feat of white capacitation, or the historically entrenched process through which “women’s pain” comes to naturally to mean “white women’s pain,” just as we’re taught to not recognize the work of race that has been critically eliminated in that category. In a sense, Briggs’ reference to the historically co-constitutive nature of gender and race helps us to more fully understand the ways in which feminist politics—as the political demand for equality for “all women”—in fact precipitates a kind of white capacitation that we still haven’t begun to fully grapple with in our current feminist political landscape today.³⁴

First securing and then disavowing all that remains *outside of gender* (i.e., the fleshy, insistent ways that race registers on the body) in our visioning of American Medical Greatness no doubt bolsters historical *and* contemporary processes of racial formation that work through the production of individual corporeal figures. The generativity of pain is central to this work. Betsey’s body is central to this work. By disavowing race and its fleshy history in clinical settings, we can more clearly suture the vulnerability of *certain kinds of bodies* who labor under *certain kinds of conditions* to the deservedness of clinical protection. The visual capacities of Thom the artist and Parke-Davis the industrial manufacturer are each protected—as individual body and as

industrial body—by the supreme whiteness of a post-War period that is, at least in the U.S., not yet quite awoken to the disruptions soon to be posed by the de-colonial and civil rights movements of the 1960s. Shrouded in protection, we can at least attempt to trace the ways in which inherently contradictory images and ideals of labor (i.e., the forced labor enslaved childbirth vs. the Great Labor of medical experimentation) and freedom (i.e., the inability to exercise agency in the treatment of one's own body-in-pain vs. the freedom to direct and capitalize from medical experimentation on enslaved bodies-in-pain) from the 19th century contribute and appeal to the ascendancy of a white sensory economy in the mid 20th century. Labor and feeling co-emerge as Sims' painful manipulation of black sensoriality is sublimated and put to work in the service of bolstering white clinical capacitation in the mid-1800s and, later, in bolstering white industrial capacitation in the 1950s.

As such, the “vision” of “Greatness” that we are offered by the commissioning pharmaceutical company Parke-Davis in its own moment of vulnerability cannot—by definition—capture the affective remainders of very different kinds of vulnerability that made such a vision not only possible but productive for over 100 years: the institutionalization and professionalization of racial terror, the national coercion of sexual reproduction in chattel slavery, the personal agony of nowhere else to turn when one's body has literally broken as it labors with no choice otherwise. Medical historian Harriet Washington powerfully qualifies the ways in which Parke-Davis' construction of the *perception* of clinical capacitation for white waiting room visitors who consume Thom's scenes relies inherently on the excision of what is held though never fully seen in the

scenes that deck the doctor's halls. In her critical explication of Thom's portrait for the Parke-Davis series, Washington offers this:

This innocuous tableau could hardly differ more from the gruesome reality in which each surgical scene was a violent struggle between the slaves and physicians and each women's body was a bloodied battleground. Each naked, un-aestheticized slave woman had to be forcibly restrained by other physicians through her shrieks of agony as Sims determinedly sliced, then sutured her genitalia. The other doctors, who could, fled when they could bear the horrific scenes no longer. It then fell to the women to restrain one another."³⁵

Gone is the insistent presence of restraint and blood in Thom's account of Sims' experimental Greatness. Gone are the shrieks, gone are the slices and sutures, and gone are the fleeing physicians who felt they could not morally serve as accomplice to Sims work. Gone is Betsey's own sensory capacity and the sensory capacities of the two other black faces that peer from behind the curtain, literally "un-seen" until it's their turn. These women are, for all intents and purposes, broken machines. Their presumed need to be fixed—their desperation to be fixed—is the only affectivity afforded to them in the dominant narratives that survive. These affective remainders (shrieks, straining muscles) are the languages of pain that exceed white clinical capacities for apprehension, recognition, and remembrance. And yet, the insistent presence of these remainders speaks directly to the *ongoing labor of feeling* for bodies of color within clinical and cultural frameworks that insistently privilege white sensation as capacitation.

If we heed what the *Great Moments* series can show us about pain, power, and the racial politics of clinical seeing, the individual body of Betsey—her broken corporeality, her presumed (in)sensitivity, her machinification—serves as a enlivened channel or conduit for better understanding the story of white racial formation in sites of clinical power, both as we have inherited it and as we put it to use today. Sensation, affect, and

feeling have, as Kyla Schuller shows in *The Biopolitics of Feeling*, historically operated as technologies of racial formation that work in and through the registers of material body and population to cohere hierarchies of difference. Schuller's work in excavating a framework of sentimental biopolitics³⁶ in the nineteenth century reveals more specifically the ways in which, "political claims to life" in the U.S. have historically hinged on a living body's, "relative impressibility, or the energetic accumulation of sensory impressions and its capacity to regulate its engagement with the world outside the self."³⁷ *Relative* is a key term in Schuller's examination of sensation and political life; it indexes the differential ways in which bodily differences have been distributed and designated through economies of feeling. Pain has and continues to be a fundamental economy of feeling that is produced, distributed, and affirmed through the bodily (and psychic, and social) difference of whiteness.

The vital capacity for movement—between, for example, the poles of vulnerability and resiliency—is consolidated and capacitated in whiteness, just as stagnancy, immobility, and insentience consolidates and de-capacitates the racial remainder that exists outside of whiteness. *Regulation* is likewise key to what Schuller's work offers this project, as it indexes the ways in which processes of racial formation are largely about harnessing, channeling, and forging meaning from the body's affective capacities. The vital capacity for movement that underpins sensation is only useful in maintaining the hegemony of whiteness if the imperative to engage and regulate it towards the re-entrenchment of difference is also a central component of its productivity. The differential management of sensation is, then, a key project of racialization. Schuller's historical genealogy of sensation and biopower in the nineteenth century

provides a clear outline of how whiteness comes quite literally to matter as a kind of sensory relation in today's discourses around chronic pain and opioid despair. The capacity to accumulate sensation, to receive impression, to claim pain, as Schuller's work shows, has historically constituted claims to whiteness. It comes as no surprise, then, that sensation—and the clinical engagement and management of sensation—surfaces as a central site of intervention for clinical systems that are indelibly invested in maintaining established hierarchies of difference. In today's context, opioid despair is *white* opioid despair because historically, white bodies have been ontologically primed to surface and hold the pain that despair thrives on. Crucially, this insight offers a way of thinking race that can speak to the tense interfacing of bodily difference and sensation that is at the heart of our current clinical imperative to remediate myriad kinds of “bad feeling,” including pain, through available clinical modalities which are always already technologies of racialization.

Pain itself has always been at the center the clinical capacity to grasp and make meaning from a body's organic state. And pain itself has always been a racialized sensation, one that is differentially accessible to people based not only on how individual clinicians perceive their patients, but also on how discrete clinical specialties have produced, practiced, and legitimated those perceptions in medical education and clinical training programs. Sims' foundational work in gynecological surgery attests directly to the ways in which the foundation of an entire clinical specialty can indeed be built on the production and mobilization of violent, racially motivated theories about who can and cannot feel pain, which are then put into practice by those who hold the power to define such rubrics. Foucault has something to say about the political work achieved by the

construction of this kind of praxis of clinical seeing, too. He begins his incisive genealogical critique of the entirety of Western clinical medicine in *The Birth of the Clinic* by enlivening this very same insight about the dense variability of clinical perceptions of pain.³⁸ The subtitle for the text, “An Archaeology of Medical Perception” speaks directly to a clinician-led politics of looking that invests clinicians with the authority to first perceive a subject as a *clinical* subject and then construct an always already racialized clinical schematic for the patient that is based not so much on the affective particularity of an individually complex body, but rather on the accumulation and mobilization of what Frantz Fanon calls “a thousand details, anecdotes, stories...”³⁹ that are no doubt infused with fantasies about the Other. The “objectivity” of clinical medicine is, according to Foucault, a kind of fantasy in itself. Pain is also a kind of fantasy that has worked—both historically and contemporarily—to justify some medical subjectivities as worthwhile of investment and others as pathologically beyond repair.

The supposed “fact” of objective and organic body states that can be viewed and assessed with a clinical “distance” is crucially at the core of this fantasy, according to Foucault, whereby clinicians mistake their own perceptions of a patient’s body state for an organic, bio-logic truth:

Far from being broken, the fantasy link between knowledge and pain is reinforced by a more complex means than the mere permeability of the imagination; the presence of disease in the body, with its tensions and its burnings, the silent world of the entrails, the whole dark underside of the body lined with endless unseeing dreams, are challenged as to their objectivity by the reductive discourse of the doctor, as well as established as multiple objects meeting his positive gaze. The figures of pain are not conjured away by means of a body of neutralized knowledge; they have been redistributed in a space in which bodies and eyes meet.⁴⁰

In attending to “figures of pain” that shift from “unseeing dreams” to the “silent world of the entrails,” Foucault makes a convincing case for opening up the tools of clinical perception at hand to other planes of feeling and apprehension—spiritual, psychic, social, imaginative—that are decidedly less “objective.” These modes of discerning otherwise may in fact be far more capable of capturing the complexities of “bad feeling” as they are circulated through the social fabric precisely despite their lack of “objectivity.” Although Foucault was no affect theorist, his work substantiates the ways in which clinical power is consolidated in and through the ongoing refusal of sensing, racialized bodies.

Sensory regimes are, then, regimes of power. They are, following Foucault again, regimes of truth.⁴¹ Betsey’s relegation to the footnotes of history and Sims’ to a statue in Central Park confirms as much. As such, in thinking race and sex as, “calculations of relational capacity,”⁴² Schuller provides vital historical context for the ways in which race has come into being as a vector of power in and through the deployment of racially differentiated sensory regimes. Foucault adds to this a keen jab at the presumed objectivity of clinical viewing practices. Both help to think through sensory regimes—of which pain is only one—as an example of what Alexander Weheliye calls “racializing assemblages,” following the work of black feminist theorists Hortense Spillers and Sylvia Wynter.⁴³ Here, racializing assemblage names an affective modality for theorizing physical domination and political violence against bodies of color that works through the differential movement of bodies in and out of the category of the human. “Overall,” Weheliye argues, “I construe race, racialization, and racial identities as ongoing sets of political relations that require, through constant perpetuation via institutions, discourses, practices, desires, infrastructures, languages, technologies, sciences, economies, dreams,

and cultural artifacts, the barring of nonwhite subjects from the category of the human as it is performed in the modern west.”⁴⁴ Here, Weheliye offers a sense of the range of tools that work in the service of maintaining hegemonic sensory regimes. As such, we can more clearly identify some of the spaces, practices, institutions, and materials that need to be tapped and primed in order to keep those dominant sensory regimes invigorated.

In evading discourses of agency and resistance, which presumably require a unified, stable, and recognizable subject, Weheliye’s framework of racializing assemblage instead establishes a materialist approach to parsing ways in which multiple forms of living and existing are rendered *inhuman*, depending on the relational context in which they are situated. Sensation is, as Schuller’s work establishes, constitutive of a body’s capacity for this kind of rendering. Sensation is, as Foucault’s work establishes, a clinical map of the bounds of a normative body. As such, pain may operate exactly as a kind of racializing assemblage within the context of opioid despair today, just as it operated as a kind of racializing assemblage in the time of Sims’ surgeries and in the era of Parke-Davis’ pharmaceutical-industrial uncertainty. We must necessarily consider the primacy of whiteness across these temporal sites in mediating access to the kinds of bodily attention that pain demands at the level of the clinic, the body, and the population.

Mobilizing the political work of whiteness-as-impressibility and pain-as-racializing assemblage ultimately enriches an analysis of Parke-Davis’ own role in securing white racial formation to increasingly unstable bodies of U.S. clinical power in and through the national dissemination of (false) images of white clinical capacitation and knowledge production. This way of thinking race is both historic and affective. Rather than pulling from the tired binary of biological determinism versus social

constructivism that has largely plagued critical academic engagements with race over the past three quarters of a century, Schuller, Foucault, and Weheliye help us to see that sensory regimes—including pain—are politically productive of processes of racial formation that provide for us the ontological boundaries of *what we can know* about bodily difference. In other words, by paying attention to where feeling and sensation register as historically important or relevant, we can likewise begin to “see” the development of tools and practices of knowledge production (i.e., established technologies of clinical knowing) that rely on processes of racial formation for legibility and strength.

In their calls to “impress” viewers with American medicine’s “rich heritage,” the optics that Parke-Davis’ deployed to remediate their faltering public image and nose-diving profits ultimately functions quite effectively as this kind of tool of knowledge production. In the process, Parke-Davis’ *Great Moments* series further attests to the ways in which bodies of U.S. clinical power—even in moments of de-stabilizing liability and exposure—can successfully detach from problematic histories and practices by developing tools that re-train the “public eye” back towards steadfast investment in the ideal or *impression* of clinical Greatness. The implicit fact that “public” ultimately always already indexes whiteness within hegemonic U.S. systems and institutions remains concealed in Parke-Davis’ grand narrative. Instead, this particular industrial body harnesses technologies of seeing such that emotional investments in clinical authority and industrial resiliency are directed back towards images of clinical competency that un-tell the racialized history of how we’ve gotten to know and see pain. We need acts of counter-analysis that can show how clinical histories and economies of feeling work together to

make possible the perpetuation of specific practices of racial refusal that comprise bodies of clinical power today.

J. Marion Sims, Robert Thom and Parke-Davis, and late 20th century Big Pharma ultimately work together across the divides of time to re-affirm that when things go bad, some of us—namely, those of us who have been always already well positioned to “see” and “be seen” in ways that center our vulnerability *and* our resiliency—may very well access and draw strength from a seemingly endless font of possibility and capacitation. That font crucially works to reflect and affirm our “Greatness” in and through the manufacturing and marketing of a particular politic of seeing that is actually more realistically a politic of un-seeing. Tracking the utility of differential economies of sensation within an excavation of the racial life of pain means paying close attention to the specific mechanisms that have taught us how to actively see the presence of pain across bodies of whiteness and how to un-see the presence of pain across bodies of un-whiteness. Paying that kind of attention will, no doubt, orient us to the differential ways in which access to capacities for feeling (good, bad, nothing) have always already been encoded into processes of racial formation in the United States. They will continue to be so until we actively work otherwise.

III. Naming the Un-nameable Chasm: Racial Health Disparity and the Mass Grave of Medical Apartheid

The deployment of a politic of *unseeing* in our historical narratives of pain and clinical medicine’s supposedly powerful triumph over that pain very much constitutes the current paradoxical reliance on and disavowal of bodies of color in generating clinical

breakthroughs, justifying experimental outcomes, and re-entrenching the unchallenged efficacy of American Clinical Greatness. Harriet Washington pointedly calls this something else: medical apartheid. In the introduction to *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Time to Present*, Washington defines the term in a way that's useful for understanding current racial health disparities as the present day remainders (and reminders) of what's been historically disavowed in the project of consolidating U.S. clinical power: "The much bewailed racial health gap is not a gap, but a chasm wider and deeper than a mass grave. This gulf has riven our nation so dramatically that it appears as if we were considering the health profiles of people in two different countries – a medical apartheid"⁴⁵ In naming the fact of racial health disparity today as a "chasm" that is "wider and deeper than a mass grave," Washington locates a site—a literal "mass grave"—where we might begin to excavate the affective remainders of all that's been disavowed in our available clinical histories of sensation and pain. This excavation is, I think, only a first step in extricating racially differentiated sensory economies from the theory and practice of clinical care.

We need new language that can likewise teach us to see differently. The term "medical apartheid" quite effectively captures the ongoing effects of the disavowal of the affective remainders that have been forged in the image of whiteness as a kind of clinical power: psychic terror, bodily subjugation, and, yes, death, even though death is not always the most useful framework for counting and refracting the lived effects of medical apartheid. The specific sites that Washington's research focuses on provide further substance to what's been concealed in a "mass grave" that only continues to widen and deepen the longer we ignore it. The book's interventions vary in temporal and historical

scope from the 18th to the 21st centuries, including 19th century studies such as “Circus Africanus: The Popular Display of Black Bodies” and “Southern Discomfort: Medical Exploitation on the Plantation”; 20th century studies, including “Nuclear Winter: Radiation Experiments on African Americans” and “A Notoriously Syphilis-Soaked Race’: What *Really* Happened at Tuskegee?”; and 21st century studies, including “Genetic Perdition: The Rise of Molecular Bias” and “Aberrant Wars: American Bioterrorism Targets Blacks.” I include this partial list of Washington’s archive here as further context for the kinds of disavowals that I do not have the capacity to integrate fully into this argument but nonetheless want to be sure remain at the forefront of our minds as we consider the ongoing supremacy of whiteness in recognizing and responding to certain kinds of bodies in pain at the direct expense of others. Washington’s voice is clear on this matter: “The experimentation of African Americans is not an issue of the last decade or even the past few decades. Dangerous, involuntary, and nontherapeutic experimentation upon African Americans has been practiced widely and documented extensively at least since the eighteenth century”⁴⁶ In stating clearly the ways in which these abuses have been both *practiced and documented*, Washington confirms the prolific power that the work of un-seeing un-white sensation continues to hold over popular and clinical U.S. imaginaries.

Excess Death and Machineries of Belonging: Locating a Critical Framework of Harm

The ongoing project of “feeling” for what’s been left unseen and unfelt for centuries by clinical exercises that emerge together with processes of white racial formation confirms that sensorial illegibility (and its attendant, clinical mistreatment) is

not, for many if not most people of color, relegated to the bad, old past. In fact, attending to the *ongoing* effects of sensorial illegibility and clinical mistreatment tells us something significant about the ways in which racialized legacies of sensoriality operate as contemporary machineries of citizenship by moving bodies in and out of the invisible yet entirely palpable sphere of “national belonging” that is forged in the image of clinical power. Dorothy Roberts’ contemporary work on race and medicine at the intersections of science and capital further contextualizes the ways in which the political work of health and medicine has always operated—and continues to operate—through racialized systems of meaning making and the demarcation and extraction of value from racialized bodies.⁴⁷ The possibility for national belonging—the possibility of inhabiting a body that matters—is, no doubt, bound up tightly with these processes. In the opening anecdote to a chapter on medical stereotyping in her book *Fatal Invention*, Roberts offers a quick, yet impactful portrait of what race-based medical disparities look like in contemporary U.S. society as a kind of index of political mattering:

Imagine that every single day a jumbo jet loaded with 230 African American passengers took off into the sky, reaching a cruising altitude, then crashed to the ground, killing all aboard. According to former Surgeon General David Satcher, this is exactly the impact caused by racial health disparities in the United States. In a 2005 article, he and several other health experts reported that there had been 83,570 ‘excess’ black deaths in 2002. That represents the number of African Americans who would still have been alive that year if their life expectancy were the same as that of whites. The number of excess deaths is closer to 100,000 today. In one generation, between 1940 and 1999, more than 4 million African Americans died prematurely relative to whites. Overall life expectancy is actually declining in some counties where there is a high proportion of African Americans.⁴⁸

What does an “excess death” look like? And how have we arrived at a moment where that “excess” constitutes a kind of normal for non-whites people in the U.S.? In locating and centering this stark statistical rendering of racial disparities in life expectancy and overall possibilities for surviving and thriving as a person of color in the U.S., we can begin to develop a critical framework of harm that recognizes and accounts for the political and ethical value of whiteness in the context of opioid despair. This kind of critical framework of harm will, no doubt, also shed light on the ways in which clinical systems continue to be deeply implicated in the replication of both racial health disparity and racially differentiated clinical populations in medicine through the deployment and fortification of the praxes of seeing we have at hand today.

The clinical power to *define* praxes of seeing necessarily subtends the clinical power to *create and deploy* rubrics of worth as weapons against people of color with the same impact as a daily jumbo jet crash. Roberts begins her work with definitions, too, suggesting once again that the power to define the terms of the game may very well affect the power one has in playing the game in the first place. Race is, Roberts suggests, a kind of political taxonomy, one that, “governs people by sorting them into social groupings based on invented biological demarcations.”⁴⁹ Articulating race as a kind of “invented” governance confirms the ways in which sorting mechanisms that rely on projects of categorization in order to confer visibility and worth actually solidify and replicate the kinds of sorting work that are already being performed by processes of racial formation throughout the United States. Although Roberts crucially focuses on the ways in which blackness is taken up in the political taxonomy of race, her definition of race as political taxonomy is useful for likewise tracking the binding capacities of whiteness in the

context of opioid politics. In conflating the *social processes* of categorization in the opioid crisis (i.e., the processes that allow a medical practitioner to say with authority: *this* is what a true victim of the opioid crisis looks like) with the “invented biological demarcation” of whiteness as both receptive and vulnerable to a specific kind of harm (i.e. your white body is in pain because *pain looks like* being unable to work, or being unable to care for your children), opioid politics further reveal the ways in which both political claims to worthiness and clinical processes of identification and diagnosis are channeled through an index of race in landscapes of clinical power.

Bodies of research on racial disparities in the management and treatment of pain only reflect and substantiate this claim. Roberts excavates numerable examples of the ways in which pain has operated explicitly as a metric for racial mattering. She shores up a 2008 nationwide study of Medicare claims to show that even in the states with the highest rates of leg amputation in the country (Louisiana and Mississippi), the rate for leg amputation in black patients is five times higher than for white patients.⁵⁰ Black patients are also far less likely to be referred for organ transplants, and when they are, they die more often while waiting for a transplant.⁵¹ The two surgeries that black patients were recommended for at rates much higher than whites included the amputation of a lower limb and the removal of testicles to treat prostate cancer. When we consider the body of Betsey as a broken machine that necessitates repair by the white doctors in power, the present-day deployment of this same perspective is chilling: taking the whole leg of a black patient in pain is more justifiable if the role that person is to play is always already one of incapacitation. What use is investment if there will be no return? This contrast is drawn out by the fact that doctors were also less likely to refer black patients to basic

curative therapies like in-patient treatment for heart disease, coronary bypass surgery, and the repair of hip fractures than white patients.⁵² In a critical framework of resiliency, this statistic violently affirms the presumed disposability of non-white patients just as its flip side—the ushering of white patients towards curative practices—confirms clinical investment in white re-capacitation.

The means for securing and advancing this specific kind of disparity can no longer conceal its ends. The institutionalization of capacity is, no doubt, the institutionalization of whiteness, just as it always has been. And whiteness, as Jasbir Puar reminds us in an on-point analysis of race and biopolitics, is always already a capacitation machine.⁵³ Roberts usefully highlights this through a discussion of the research of Dr. Knox Todd, who started tracking racial disparities in treating pain at the UCLA Emergency Center in the 1990s. By focusing on a single injury over a two-year period—fractures of the long bone in either the leg or the arm—Todd found that Latinos were twice as likely as whites to receive no pain medication in the ER. He then replicated the study in Atlanta and found that 43% of black patients received no pain medication for the same painful injury, whereas only 26% of whites patients received the same lack of medication: “By carefully looking at notations in medical files, he found that black patients were about as likely as whites to complain of pain. Black patients thus received pain medication half as often as whites because doctors did not order it for them, not because blacks do not feel pain or do not want pain relief.”⁵⁴ At the same time, Roberts excavates studies that show the over-prescription of psychiatric medications for populations of color, particularly a 2009 federally-funded study that found that doctors are, “four times as likely to prescribe powerful antipsychotic drugs to children covered by

Medicaid as they are to children whose parents have private insurance”⁵⁵ These facts help illuminate the kinds of political ends that are achieved through the maintenance of these disparities at the level of the body. Further, they demonstrate the utility of racialized pain as a metric of clinical—and national—worthiness.

In its ability to confer and sanction the forms of belonging that matter, the political utility of race is, then, resonant with the political utility of citizenship in the ongoing work of maintaining states of medical apartheid forged in white supremacy. Following Omi and Winant’s work on racial formation, Roberts suggests that we can grasp the political governance of race as a technology of belonging only because it is so unstable.⁵⁶ Utilizing historical analyses of the ways in which racial categories in the U.S. Census have shifted with the demands of the political projects of any particular era, Roberts debunks the idea that demographic categories (including race) have any stable ties to our material—and historical—understandings of harm. Instead, we can increasingly see how race—under the pretense of a biologically based category—has functioned as a social and political justification for the centering of some types of harm and the evacuation of other types of harm from public and institutional points of views. Race and citizenship work together to index a body’s specific relationship to the state that is, no doubt, integral to practices of clinically seeing and responding (or not) to emergent crises that come to matter on a national level (i.e., the crisis of opioids). “Citizenship,” Roberts reminds us, “doesn’t describe a person’s intrinsic characteristics; it defines her relationship to a nation’s government, to the other people who are citizens, and to noncitizens.”⁵⁷ In refusing to acknowledge race as a kind of active, politicized *relation*—to the state to history, to other people, to the law, to the currents of daily existence—

rather than as a supposedly stable index of demography, bodies of clinical power silently sanction the unacknowledged practice of medical apartheid. This is largely because clinical power continues to attribute to racialized bodily capacity the same kinds of un-belonging that constitute non-white citizenship. We need not look very far for examples of the constitutive un-belonging of non-whiteness in the U.S.: rates of black felon disenfranchisement and the many other subtle machineries of fraud in U.S. voting systems continue to remind us that there are, indeed, many ways to be a “second class citizen” in the U.S. and that that way is indelibly paved with the remainders of that which is not white.⁵⁸

In centering the *instability* of racial formation in a discussion of the racializing effects of clinical power, the need to critically interrogate whiteness as a seemingly stable category of analysis (and identification) in this crucible of crisis becomes all the more evident. What political project(s) are we investing in as we invest in the (unstable) category of whiteness of the opioid crisis? What are the remainders—economic, social, material—of these investments? In attempting to answer these questions, it becomes clear that race very presently operates as a function of citizenship, *always already* mediating forms of belonging within the normative social structures that validate and confer status to particular kinds of harm. In utilizing this framework, it likewise becomes evident that the robust public health machine that so keenly measures the impact of opioids in largely white demographic areas cannot—by definition—also account for the *immeasurable* ways in which drug-related harms have also impacted POC communities, usually without any activation of health-focused interventions.⁵⁹ The tools do not exist. Proper relations to the state do not exist. And legibility in the available frameworks for interpreting and

making sense of harm—particularly the harm of pain—do not exist. The pain that matters—the pain that is seen and captured and attended to—is always already white because whiteness indexes belonging and belonging necessitates the protection conferred in and through consolidated clinical power. Medical apartheid feeds on the pain that matters.

IV. Defending the Dead: Wake Work and Excavating Archives of Feeling

The chasm of medical apartheid holds so much: bodies, visions, screams, dreams, limbs, tools, jets, and organs that were never transplanted. In that dense amalgamation of what's been remaindered, who does the work of peering into the chasm—that wide, mass grave—carved by the vigorous exercise of medical apartheid? Who attends to the absent bodies and stories? Who carries the remainders of history into the present? Who evokes disavowed sensory material into life once more? As we face increasing breakdowns in the surety and resiliency of whiteness, we need mediums that shuttle past and present in order to teach us how the past is deeply chiseled in the contemporary. Christina Sharpe poses some version of the questions I pose above with lyricism and force in the introduction to *In the Wake: On Blackness and Being*. The framework for Sharpe's questions arises from a consideration of her many family members lost in succession to various exercises of institutional violence: the Philadelphia police who murdered her cousin Robert, a young man with schizophrenia; the undiagnosed mesothelioma that killed her uncle Stephen, due most likely to a summer's work installing home insulation 45 years prior. In each of these instances, and more, Sharpe seeks clarity about the

present work that is demanded by what's been lost to the chasm of medical apartheid specifically and Blackness in America more broadly:

What does it mean to defend the dead? To tend to the Black dead and dying: to tend to the Black person, to Black people, always living in the push toward our death? It means work. It is work: hard emotional, physical, and intellectual work that demands vigilant attendance to the needs of the dying, to ease their way, and also to the needs of the living. Vigilance, too, because any- and everywhere we are, medical and other professionals treat Black patients differently: often they don't listen to the concerns of patients and their families; they ration palliative medicine, or deny them access to it altogether.⁶⁰

In a consideration of the many forms of Blackness that live always in the push towards death, Sharpe extends the specificity of familial suffering—of intimate pain and intimate illegibility—towards the collective chasm. The labor of tending and defending—of honoring what's already been lost and of laboring for what's still suspended in our midst—becomes not just about advocating for the innumerable black bodies that are currently held (just barely, if at all) in the web of clinical power. It's also about the spirit work—what Sharpe calls “wake work”⁶¹—of naming and cherishing what's been disavowed *as* valued, vital life that continues to give and to teach. Sharpe is, “trying to articulate a method of encountering a past that is not past. A method along the lines of sitting with, a gathering, and a tracking of phenomena that disproportionately and devastatingly affect Black peoples any and everywhere we are.”⁶² As such, the work of counter-seeing emerges as a viable, creative, and productive process that can, no doubt, re-shape the ways we see and implement histories of clinical violence.

Chasm-peering can look many ways. And looking doesn't always mean you'll see. Saidiya Hartman's *Lose Your Mother: A Journey Along the Atlantic Slave Trade* begins with a proverb delivered by a housekeeper at the Marcus Garvey Guest House in

Accra, Ghana as Hartman was beginning her own journey back, back, back towards the continent from which she was lost. “No matter how big a stranger’s eyes,” the housekeeper tells Hartman, “they cannot see.”⁶³ In highlighting the “proverbial blindness of Westerners”⁶⁴ the proverb tells us something about the inability to rely on vision—especially the vision of those forged in the disordered chaos of Western modernity—to “see” what’s been lost. This warning is resonant with the *feeling* work of another such chasm peer-er, the interdisciplinary visual and performance artist Geo Wyeth. Wyeth’s own history and identity are complex; they are trans and biracial, Jersey-born with southern roots. They are also the great-great-great grandchild of J. Marion Sims himself via a complex ancestral lineage that speaks to the intimate and bodily registers of domination and desire. In an act of re-membering and re-encountering the affective vicissitudes of their own tensional familial legacy, Geo Wyeth produced the 30-minute experimental film *Quartered* in 2014. A multi-genre video installation, *Quartered* documents the artist’s return to Heath Springs, South Carolina with the intention of feeling for the lingering presence of Sims and the violence he did in both individual and collective consciousnesses that remain in that area. The result is a disjointed yet sensorially-charged landscape framed by Wyeth’s external narration of characters and places they’ve encountered, as well as the spectral movements of another of the film’s creatures, the “Golden Shard of Light” who represents a cross-temporal spirit/force who is maybe partly Sims’ patient, partly his lover, and partly his child.

The narration in *Quartered* begins almost fairy-tale-like, suggesting the ephemeral and sometimes un-trackable movements of medical trauma across body-scapes, time-scapes, and land-scapes:

Once upon a time there was a creature who was so afraid of the world that she turned herself into a pure golden shard of light that cut through the air and the earth. She was afraid because someone had hurt her and she was angry and the anger hasn't ever left her and it ruled it every action. She was damn pissed and it was for a good reason and she could never forget any of it. She could only do what she could, and she tried her hardest, it wasn't easy. There were so many parts and she looked and looked and often moved quickly and blindly through the town. Where the hell is that noise coming from she wondered as she cried and cried to herself at the Waffle House near her home...⁶⁵

Wyeth's *Quartered* offers a kind of recuperation of the figures that populate J. Marion Sims' own personal "mass grave" that doesn't actually privilege concretely *seeing* anything or anyone at all. Rather, the film's power lays in its excavation and recharging of the disavowed power of feeling and sensation, particularly women's feeling and women's sensation. There are scenes where the Golden Shard of Light collects, arranges, destroys, and re-configures objects ranging from beer cans and fast food containers to antique medical equipment on an abandoned piece of land where Sims' clinic once existed. And there are narrated encounters with several women "seers" who live in the physical and psychic midst of Sims' legacy. These women communicate and illuminate extra-sensory experiences, messages, and forces that continue to exert their palpable presence in the town. In centering the affectivity of objects and by taking women's (extra)sensory experiences seriously—including the capacity to "see" in and through other registers of the body and environment—Wyeth's work no doubt critiques the dominant modes of seeing (and unseeing) that made Sims' work so esteemed and so violent. In the process, it makes evident the many other kinds of embodied loss that rarely surface when we talk about the production and replication of women's pain.

A final scene in the film eerily and effectively evokes the palpable presence and power of normative whiteness in shaping practices of seeing in this particular geography

of loss, too. The Golden Shard of Light leads the camera to an outdoor concert held in the town and trains the lens on an unfolding scene: an all-white, all-male band performs jazzy, blues-driven rock n' roll in cut off tank tops and blue jeans, set off by a huge American flag in the stage's background. A large crowd—mostly middle aged and elderly white people—surrounds the stage. A few older couples mechanically square dance in the foreground. Nothing specific or out of the ordinary is happening, if you try to look to see. Kids run around. The wind blows. The dominant affective charge, rather, comes from the easy sense of belonging, cohesion, and entitlement that seems to comprise the crowd's occupation of the public space that the Golden Shard of Light approaches with trepidation. That subtly communicated sense of belonging—the affectivity of fitting into “the ordinary”—can be subtly felt, too, by any viewer of the film who somehow doesn't match up to matrix of “normal” set up in the scene. It's felt as a tense blockade: a reminder of what it feels like to be a shard, to be on the edge, rather than whole and in the middle of it all. You can, however, see Regular Guy everywhere if you look right. He is on the stage, performing songs that he can only know by the cultural appropriation of black artistic survival strategies. He forgets this, or he never knew it. It doesn't matter. He is in the audience, visibly and unabashedly swilling beer even though open containers in public are technically illegal in this town. He won't get fined or even approached about it because he went to elementary school with the police chief and he knows how to take up his mantle as rightful occupant of this kind of ordinary. In juxtaposing an image of easy, public whiteness with the confusing, scrambled temporality of trauma left in Sims' wake, Wyeth's work attests to the vital ways in which affective legacies of apartheid driven by specific praxes of clinical seeing continue to

remain unseen, even as they exert pressure in daily life. In the process, we get a clearer sense of the ways in which sensoriality operates in daily life as a mechanism of cohering and making sense of whiteness.

Feeling for, facing, and attending to what's in the archive of medical apartheid is, no doubt, a critical praxis that can teach us other ways to talk about, see, and feel for connections between overtly racist historical legacies of clinical power and the more concealed or coercive mechanisms by which we accomplish the ongoing clinical work of racial refusal across U.S. sites today. Ann Cvetkovich's use of the term "archives of feeling" provides some map for what this process may look like. Much like Wyeth, who excavates and punctures Sims' legacy not through the narratives of medical textbook or clinical history but rather through myriad ordinary objects to which Sims' legacy "sticks" (i.e., beer cans, speculums), Cvetkovich's feeling-archives remind us that "the memory of trauma is embedded not just in narrative but in material artifacts"⁶⁶ In her insistence on the affective generativity of objects and other material residues, Cvetkovich's project delves into the folds of everyday experience in order to draw out different ways of encountering nuanced forms of violence that leave impressions and traces that have not yet had the permission to be theorized, and, in many cases, even felt.⁶⁷ Her work establishes that present day affects and sensations are a vital register through which to re-encounter and re-connect with what's been buried in the wide chasm of medical apartheid.

This critical praxis—feeling for archives in order to remold the present in other images— might also be excavated from the political and psychic work undertaken by the exhibition "When the Stars Begin to Fall: Imagination and the American South" at

Boston's Institute for Contemporary Art.⁶⁸ The exhibition, which included Wyeth's *Quartered*, along with works by Kara Walker, Carrie May Weems, and "lesser known" artists, some of whom were incarcerated during the period when the works were produced, attests to the ongoing emergence of other praxes of seeing and feeling that explicitly account for—and counter—white cultural formations and exercises of white sensory domination that keep concealed and buried the disavowed sensory material that constitutes so much of this nation's trauma. As the exhibition's title suggests, non-white exercises of imagination, movement, and vitalization can and will unfold in the liminal period opened up "when the stars begin to fall." Indicative of the ongoing possibilities that emerge in the midst of all sorts of "falling stars," J. Marion Sims own statue in Central Park is, per an order in January 2018, finally going to be moved out of its location of visual dominance per the recommendation of Mayor DeBlasio's commission. The statue will not be destroyed, but rather moved to Brooklyn's Greenwood Cemetery.⁶⁹ This decision speaks to the ways in which even as stars fall, their legacy cannot be erased entirely. Instead, it will be taken to its own grave: buried but not forgotten.

V. Sensations of Un-Whiteness: Affective Genealogies of Race and Bad Feeling

These inherited legacies of race, pain, and sensation reverberate as we peer into the wide chasms carved and abandoned by Sims, by Parke-Davis, by Pfizer, and by the daily jumbo jet crash of racial health disparity in the U.S. These legacies tell us—loudly and without hesitation—that pain is a contingency; that pain is an effect of white racial formation; and that pain is a metric of racial mattering which functions as a kind of power-in-feeling. These legacies tell us—precisely and without reservation—that we're

far past the time to think pain differently and that we're far past the time to think race differently. If we want to do the work of thinking clinical power otherwise in the crucible of the opioid crisis, we need different critical vocabularies of race and sensation through which to work. We need different tools of discernment and evaluation. We need different praxes of seeing harm and of visioning hurt. And we need different accounts of bad feeling within myriad formations of power. Parsing pain as an effect of racialization—and as the byproduct of white racial formation more specifically—means, too, that we need models of whiteness that no longer proclaim to be neutral, and thus, “unmarked.”⁷⁰ We need models of whiteness that are attentive to these racially differentiated histories of sensation and feeling, rather than to the hardened and often individual-body-based assumptions of identity politics. We need models of whiteness that ask what whiteness *does*, rather than what whiteness *is*. And we need models of whiteness that help us see that whiteness is not something that we *are*, but is, rather, made in and through the things that we *do*.

Pain in non-white sensory economies is, no doubt, something that exceeds the registers of representation and the mechanics of visioning that reign supreme in exercises of U.S. clinical power. I want to suggest that pain might be more usefully rendered as a kind of subtly molded body language that tells stories in pitches and tones that clinical power hasn't been trained to hear. Maybe these are stories that are not, as we've been so surely taught, audible. Maybe our pain is not visible. How, then, might we render vital (or at least useful) frameworks and epistemologies of pain in the wake of the ongoing machination of clinical power? Where can we look to for other models of sensoriality and sense-making that can (at the very least) begin to dismantle and re-figure available

clinical praxes? And how might the field of affect—as it has been taken up and theorized by critical race scholars and queer of color critique—already contain some vital possibilities? In its attention to intensities, vibrations, and circuits of transmission rather than to linear narrativity and the surety of representation, the conceptual work of affect offers much for tuning into this kind of nuance. As such, this final section will explore the fruitful supposition that in listening to non-white, or what I call un-white, sites of knowing and affecting “bad feeling,” we can glean other means of meeting and working with the presence of pain both in clinical sites and otherwise.⁷¹

Theorizations of the affectivity of race from black studies and queer of color critique offer rich material for thinking and feeling pain otherwise. These are frameworks that recognize and work from the assumption that racialization and sensation are deeply, affectively, and historically intertwined. These are frameworks that move the objects of this analysis—race, pain—out of the falsely constructed stratum of biologic/organic and into affective fields that unfurl in tandem with the many other kinds of “bad feelings” that churn inside and outside of us. These are frameworks we desperately need (especially the “we” of whiteness, the “we” of clinical and direct service workers) in order to account for and respond to various modes of pain, hurt, and harm apart from what’s been developed and maintained in the consolidation of U.S. clinical power. Re-framing pain as affectively charged and even, perhaps non-personal *social* process, rather than a stable or measurable fact of individual human *biological* existence largely means abandoning the ways in which we’ve been taught to see race as productive of corporeality. Moving pain out of the over-coded field of bio-logics and re-positioning it within the intensified field of affect demands a re-thinking of what processes of racialization *do* to affected bodies

that encounter and face myriad “bad feelings.” More specifically, this shift demands that we look for articulations of pain not only in the audible voices of self-contained, white body-subjects that can easily connect to and find solace in the “bad feeling” of a seemingly “organic” harm or hurt,⁷² but also to the many destabilizing ways in which inhabiting life-worlds made in the image of whiteness can *feel* bad, or wrong, or out of step, without ever being recognized as pain-full.⁷³

The pain that underwrites, and in many ways sanctions, the proliferation of opioid despair in the very current moment serves as a marker of one kind of “bad feeling” that has been coded again and again in the national majoritarian imaginary as white and, thus, as desperately *important*, uncomplicatedly *defined*, and decidedly *bad*. José Esteban Muñoz offers a critical vocabulary that may be useful for beginning to de-activate these powerfully productive assumptions. Crucially, Muñoz reveals that the political ends achieved by these kinds of designations (important, definable, bad) are not by any means neutral. Instead, they contribute to a broader understanding of the ways in which white pain—as an affirmation of uncomplicated whiteness—ultimately functions as a kind of “doing” rather than a kind of “being.” More pointedly, for Muñoz, whiteness serves as a kind of “political doing” that arises from the various possibilities that “racial belonging, coherence, and divergence present in the world.”⁷⁴ This definition of whiteness indexes a very specific kind of racialized “political doing” that operates through a “cultural logic that prescribes and regulates national feelings and comportment.”⁷⁵ Here, whiteness is, “thus an affective gauge that helps us understand some modes of emotional countenance and comportment as good or bad.”⁷⁶ The kinds of comprehension or recognition that we may (or may not) access from the powers of clinical diagnosis depend largely on our

ability to “do” pain right at the level of emotional display and bodily comportment. As such, “doing” pain “right” means, for all intents and purposes, effectively “doing” whiteness right. These are fruitful vocabularies to probe, as they bring the contemporary animation of white opioid despair into direct conversation with the affective legacies of negation and repudiation that traditionally structure the presumed feeling-capacities of non-white bodies.

There are, no doubt, countless modes of feeling that escape or exceed the boundaries of whiteness’ affective gauge. Although pain is, as I want to suggest, a particularly useful way of “feeling white,” Muñoz offers a somatic language for accessing and making sense of all the various “bad feelings” that inevitably fall outside of or exceed that framework. “Feeling brown” is one affective modality Muñoz develops to describe, “the ways in which minoritarian affect is always, no matter what its register, partially illegible in relation to the normative affect performed by normative citizen subjects.”⁷⁷ In centering the “illegibility” of minoritarian affect, Muñoz reminds us once again of the ways in which practices of discernment and sorting are central to entrenching racializing hierarchies in a range of environments including clinics, schools, and other sites of surveillance. “Feeling brown,” for Muñoz, gestures towards an, “ethics of the self that is utilized and deployed by people of color and other minoritarian subjects who don’t feel quite right within the protocols of normative affect and comportment.”⁷⁸ “Feeling brown” thus evokes a method of feeling more broadly that cannot and will not register on the normative rubrics of whiteness; it is a method of communicating the somatic dimensions of the un-nameable.

These methods of feeling otherwise—these un-white affective modalities and un-white sensory economies—can no doubt be tracked across both aesthetic and political registers. Sometimes, there is no difference. Muñoz tracks the specific affective generativity of “feeling brown” in Nao Bustamante’s 2003 video installation *Neapolitan*. The video features an 11-minute loop of various close-up shots of Bustamante, a Chicana multimedia and performance artist, sobbing at the end of a film. Through an engagement with Bustamante’s emotive installation, Muñoz extracts a technique of identification, a praxis of somatic affiliation, for subjects who are expunged from the affective contours of normative “bad feeling.” Crucially, the utility of affect is multidimensional in Muñoz’s rendering; affect functions not only as a “ruler” of one’s capacity to “measure up” to the normative sensory and emotive contours of whiteness, but also as a somatic-political mode of receptivity that indexes a capacity to recognize and make sense of “bad feelings” differently. Affect, for Muñoz, “is not meant to be a placeholder for identity...it is, instead, supposed to be descriptive of the receptors we use to hear each other and the frequencies on which certain subalterns speak and are heard or, more importantly, felt.”⁷⁹ As such, affect offers up a framework of receptivity or a way of *knowing* feeling that does not necessarily operate through dominant channels of visual discernment and recognition utilized so willingly by bodies of clinical power. Rather, Muñoz’s conceptualization of affect gestures towards a mode of attention that lets us access questions *and* feeling states that are categorically impossible when we stay inside dominant ontologies of sensation: “How does the subaltern feel? How might subalterns feel each other?”⁸⁰ In formulating this line of questioning, Muñoz demonstrates the urgent need to develop non-disciplining tools of listening, discernment, and co-

connection in clinical settings, such that economies of sensation, including pain, are no longer contingent on the same old processes of racialized “doing.”

If pain is a mode of “bad feeling” that indexes the affective capacities of whiteness, then we must also look towards theories of sensation that are generated apart from, or in spite of, the whiteness that is entrenched within dominant social and cultural logics of embodiment. Muñoz’s “feeling brown” is, as we’ve seen, one such method that centers the generativity and receptivity of non-white affective states. And yet, the stability and surety of determining and interpreting one’s *own* bodily sensations is never, as Frantz Fanon reminds us, fully accessible to those who live outside of the structuring paradigm of whiteness. “In the white world,” Fanon writes in *Black Skin, White Masks*, “the man of color encounters difficulties in the development of his bodily schema. Consciousness of the body is solely a negating activity. It is a third-person consciousness. The body is surrounded by an atmosphere of certain uncertainty.”⁸¹ In re-training the analytic eye inward, Fanon articulates a fractured personal consciousness that subtends sensations of non-white embodiment. Inhabiting a non-white body in a world constructed through whiteness is inherently an uncertainty; everyday existence is wrapped up in the work of suspicion, negation, processing, and reflection such that one’s sensations are never truly one’s own. Rather, body consciousness, Fanon tells us, is something assembled in and through a non-white body’s interfacing with other bodies, logics, and practices of whiteness. In this reading, Fanon demonstrates the very embodied ways that racial difference channels and shapes our understandings of the sensation—and construction—of pain.

Attending to pain's productivity—how it's made, what it holds, where it circulates—becomes increasingly important to the work of tracking the differential direction and efficacy of pain across racialized bodies and communities. As a physician, psychiatrist, and critical theorist, Fanon's work ultimately shapes a multi-faceted understanding of the "burden of that corporeal malediction,"⁸² bodies read as un-white experience and negotiate incessantly, both in clinical settings and alongside the very trying, daily work of getting on. His work brings together multiple registers of existence—bodily, psychic, social, spiritual—that are still largely understood as discrete in current clinical frameworks. As such, the phrase "corporeal malediction" is, in fact, an immensely generative term for identifying the kinds of pain that cannot ontologically register in clinical settings because they cross the presumably impermeable boundaries of body / social / psyche. There is, as Fanon demonstrates, a categorical chasm in the interpretation and processing of a body's corporeal malediction—of a body's "badness." This clearly echoes Muñoz's attentive play on "feeling brown, feeling down." Rather than being able to self-determine and fully inhabit one's own body and its sensations (good or bad or neither), Fanon shows that black and brown corporeal schemas—these senses of "*self* as a body in the middle of a spatial and temporal world"⁸³—are forged in and through strained relations to otherness, to whiteness. The elements Fanon uses to construct his own bodily schema, "had been provided for me not by 'residual sensations, kinesthetic, and visual character,' but by the other, a white man, who had woven me out of a thousand details, anecdotes, stories."⁸⁴ The sensation of being "woven" by another is, no doubt, a specific kind of "bad feeling" that the clinical consolidation of whiteness cannot and will not comprehend and respond to.

Fragmentation is a palpable effect of explicitly racialized states of existence, particularly the state of existence marked by living life in the U.S. in a state of unwhiteness. In Fanon's theoretical narrative, the bodily schema he has access to as a black man de-privileges any sensorial or affective relationship to his own unique body, replacing it instead with a triply fragmented body that is responsible at once to his own corporeality, as well as to the bodies of his race and his ancestors.⁸⁵ This tripled responsibility—to self, to race, to ancestors—illuminates some of the ways in which inherited legacies of racial violence, of gender violence, and of state violence manifest and bear down on bodies that are presumed to only hold what's in the very current moment. Fanon's work thus makes a clear case for attending to hurting bodies not as coherent units that simply exist within the specific pressures of this-time, but also as archival beings that carry both what is in-time and all that is out-of-time. Doing so requires clinical recognition of the ruptured relationship between biological materiality, psychic consciousness, and temporality that Fanon suggests arises out of lived experiences of blackness. The bodily ruptures that result from competing schemas also signals what Fanon later acknowledges as a more collective cleavage from a unified (non-Othered) human species: "Black magic, primitive mentality, animism, animal eroticism. All of it is typical of peoples that have *not kept pace with the evolution of the human race* [emphasis mine]. Or, if one prefers, this is humanity at its lowest."⁸⁶ Not only is Fanon's own body an unstable or incoherent material entity, but that body once again is linked up with a broader racial/cultural body that is concurrently un-paced and un-made along various political, intellectual, temporal, and biological lines of difference. Here we get a sense of some of what's held in the crucial moments where clinical power

meets and evaluates non-white sensoriality. Fragmentation, malediction, and self-doubt rise up but cannot register.

There are, crucially, so many examples of the ways in which Fanon's clear articulation of un-white schematic composition structures and composes mechanisms of clinical mattering. Pain in affective sites of un-whiteness, as Fanon and Muñoz suggest, is an undoubtedly slippery terrain. As a kind of identification, pain sticks easily to some bodies that effectively perform the affectivity of whiteness, just as it slides off of others who cannot or will not invest in the norms of white comportment. Pain is, as Sara Ahmed reminds us again and again, a contingency. In returning to Ahmed's work on pain, we get closer to a kind of framework that might hold the many dimensions of pain explored above. Ahmed herself works from a definition of pain adopted by the International Association for the Study of Pain (IASP), a professional forum that guides research, practice, and education in the broad field of pain management and diagnosis. IASP's definition posits that pain: 1) is subjective; 2) is more than a simple sensory event; 3) involves forging associations between negative sensory experience and "bad" feelings; and 4) involves the attribution of meaning to those associations.⁸⁷ Ahmed's interpretation of this definition departs with the assumption that:

...pain, as an unpleasant or negative sensation, is not simply reducible to sensation: how we experience pain involves the attribution of meaning through experience, as well as associations between different kinds of negative or aversive feelings. So pain is not simply the feeling that corresponds to bodily damage. Whilst pain might seem self-evident...the experience and indeed recognition of pain as pain involves complex forms of association between sensations and other kinds of 'feeling states.'⁸⁸

What, this definition of pain begs us to ask, has got you feeling bad? And how, as a result of identifying that badness, can your alignment with a clinical index of pain offer some

kind of respite? Ultimately, Ahmed's definition points us to the ways in which pain is more about the ways we generate local, situated kernels of meaning from the sites of our individual, affected bodies than it is about naming stable and universal bodily truths that arise independent of our own manufacturing of it. Some of us can, it seems, shuttle our "bad feelings"—including the "bad feelings" of a ruined back or knee or marriage or nest egg—into a kind of clinical mattering that demands the mobilizing and leveraging of clinical and emotional resources. Pain, according to this affective logic, names the *work* that we (and our clinical interlocutors) have done to suture a set of internal, often negative bodily sensations to a clearly defined framework of interpretation that clinical powers would have us understand as etiology. This slippage between objective evaluation (*you are in pain*) and the actual historical work of racialized sensoriality pressing on the current moment constitutes the constitutive—and, ultimately, quite profitable blindspot in U.S. clinical power.

When we consider the ways in which the mechanics of racialization proliferate across economic, political, and psychic landscapes, frameworks of loss are potent in this alternative framework of pain. Ahmed's argument about the meaning-making capacities of pain gesture towards the complex ways that we are invested—both individually and clinically—in producing pain as an answer (or, perhaps, lamentation?) to the many losses we've accrued and still feel inside of us: pain as injury, pain as vocalization of lived experiences of struggle, pain as a call to the arms of attention. The affective life of pain is robust as it makes and unmakes what we've learned to *do* with the losses that, it turns out, may be constitutive of the neoliberal political economy we live within. Pain is, I suspect, about the surfacing of those losses as negative sensory experience; as it

emergences, we come to know and feel the boundaries of our own bodies more palpably, and we are reminded of the many faces of our precarity. Issues arise, of course, when the most popular and most profit-generating solution (opioids) is expected to “treat” a racializing assemblage of sensation, sociality, and sentiment that is far more slippery than organic etiology would have us believe.

The racial life of pain, is, then, deeply implicated in the social life of pain. Ahmed’s turn to the sociality of pain further enriches an inquiry into the efficacy of pain by asking specifically after what pain *does*. This attention to the “doing” of pain resonates clearly with Muñoz’s affective frameworks of race explored above. “Pain,” Ahmed reminds us, “is hence bound up with how we inhabit the world, how we live in relationship to the surfaces, bodies, and objects that make up our dwelling places. Our question becomes not so much what is pain, but what does pain do.”⁸⁹ Ahmed challenges articulations of pain that project a kind of harm that is private and self-contained, suggesting instead that pain might actually function as a binding mechanism in social worlds, particularly through the demand for *witnessing* that pain states evoke:

The sociality of pain—the ‘contingent attachment’ of being with others—requires an ethics that begins with your pain, and moves towards you, getting close enough to touch you, perhaps even close enough to feel the sweat that may be the trace of your pain on the surface of your body. Insofar as an ethics of pain begins here, with how you come to surface, then the ethical demand is that I must act about that which I cannot know, rather than act insofar as I know. I am moved by what does not belong to me....it is the very assumption that we know how the other feels, which would allow us to transform their pain into our sadness.”⁹⁰

In articulating an ethics of pain that centers sociality—one’s sense of belonging to shared communities of harm—we can begin to trace the ways in which pain also works to secure and consolidate sympathetic attachments within particular groups. We must be able to

connect—even contingently—with a body in pain in order to act ethically in response to that pain. That connection requires a kind of intimacy that is, no doubt, a chilling, yet necessary part of the affective life of white supremacy: we are more likely to *look at* the trace of sweat on another’s body and understand it *as* pain if that person looks like us, or if we share some ideas about what it means—culturally, politically, psychically—to be in pain.

As we consider the racialization of pain states (i.e., pain as the key affective register of whiteness) in sites of clinical power, it becomes clear that the work of “turning towards” those who look and feel like “we” do generates a mechanics of identification, which instigates a process of witnessing, which facilitates ethical action towards another human being in their pain. Pain is, then, a pre-condition for witnessing and for identification. The sociality of pain is potent; its ability to cleave social worlds—including the social world of medicine—into sectors of identification and non-identification means that action and attention towards what *feels* bad is greatly impeded or entirely impossible for some, just as it is expedited and institutionally supported for others. Ahmed’s attention to the affectivity and sociality of pain renders this bodily state a compelling weapon in the scramble to identify whose pain matters.

VI. Turning Towards: Clinical Praxis, Racial Belonging and the Re-birth of Biopolitics

Understanding pain as a key affective register of whiteness today ultimately indexes the subtle ways in which feelings of white belonging (to nation, to community, to self, to Greatness) no longer cohere through a calculus of resiliency, but rather

increasingly come to matter through a calculus of vulnerability. In this chapter, the racialized histories of pain that I've begun to unpack make evident some of the ways in which an emergent shift from whiteness-as-resiliency towards whiteness-as-vulnerability begins to justify the presence of chronic pain as a national emergency for some individuals, just as it continues to affirm the expendability of others. But what happens when we begin to think more critically (and more whitely) about the *large-scale* failure of systems of care to respond to the bodily remainders of capitalist labor extraction? Where do we allow *individual* stories of hurt and loss to stand in for those systemic failures? And how might we better understand those systemic failures not as failures at all, but as clear signals that our capitalist machine is in fine working order? In the following chapter, I take up the assumption that the structural conditions of late stage capitalism render even the most robust and well supported of bodies to ruin in order to ensure that extraction is replicable and consistent. Understanding the cultural formation of the opioid crisis in these terms reveals that there is, in fact, nothing at all in "crisis." The opioid epidemic is, rather, a ubiquitous response to crises in whiteness that works in and through the fear of white death. The opioid epidemic is, rather, yet another opportunity for state power to marshal resources and tools towards the eradication of white vulnerability, so as to continue mining and extracting from the bodies that do not matter.

Notes to Chapter 1

¹ I first encountered this image of Sims in Harriet Washington's introduction to *Medical Apartheid*. She opens the book by telling the story of how she wanted to use Robert Thom's image of Sims on the cover of her book. Upon seeking permissions from the current copyright holder, Pfizer, she was asked to submit the entire manuscript to the corporation for review. Upon reading what Washington submitted—material that largely exposed past and ongoing medical experimentation on black bodies—they, according to Washington, “refused to grant my permission to reproduce this telling image or even respond to my query after I supplied the requested chapter and outline. This act of censorship exemplifies the barriers some choose to erect in order to veil the history of unconscionable medical research with blacks” (2). I am grateful to Washington for calling out an institution's contemporary policies and practices in order to reveal latent connections to the historical practices that her work exposes.

² Hoefle, “The Early History of Parke-Davis and Company,” 33.

³ The Thalidomide birth defect catastrophe was beginning to unfold around the same time. See Lenz, “A short history of thalidomide embryopathy” for a clinical / historical account of the intersections of pharmaceutical marketing and clinical trials in this specific event.

⁴ Quoted in Duffin and Li, “Great Moments,” 16.

⁵ Parke-Davis' early history is heavily enmeshed with the violences of colonial knowledge production. According to Hoefle, “In order to gain both publicity and new products, Davis [the 19th-century iteration of Parke-Davis] began sending expeditions to far-off corners of the world to collect various plants used by the native peoples. Starting in 1871 expeditions were sent into the wilds of Central and South America, Mexico, the Pacific Northwest, the West Indies, and the Fiji Islands. Over a twenty-year period, Parke-Davis introduced 50 new drugs, and most of these proved to be of sufficient value to be recognized in the United States Pharmacopoeia.” Hoefle, “A Short History,” 29.

⁶ An exception are the first four portraits in the series, which feature “native” and indigenous healing practitioners contributing to early medical advancements. The fact that no non-white people appear as practitioners after the first century A.D. speaks volumes to a clinical telos—and its narrative history—that is all white, almost all the way down. See Metzel and Howell, “Great Moments” for an in-depth analysis of the mid-century politics of clinical medical authority and the nascent industry of pharmaceutical advertising as they were expressed and communicated in Thom's paintings. Unfortunately, I did not encounter Metzel and Howell's critical contribution on Thom and Parke-Davis until I'd finished writing, but upon review, it is clear that the authors do not attend specifically to the racial politics of these paintings. My own analysis supplements and enriches their work by accounting for the work of white racial formation more directly within the realms of clinical authority and pharmaceutical advertising. Moving forward, I plan to incorporate and articulate critiques of Metzel and Howell's arguments about the consolidation of medical authority and pharmaceutical advertising in these images more directly.

⁷ The original images are now housed at the University of Michigan's Museum of Art, made as a gift to the institution by Pfizer when their Ann Arbor industrial campus was sold to the University in 2009 as part of the re-development of their medical school. In addition to circulating as advertorial posters sent to doctor's offices across the U.S., the original images were also published by Parke-Davis in 1966 in the now out-of-print book *Great moments in medicine; the stories and paintings in the series, A history of medicine in pictures* with text by George A. Bender. See Bender, "Great moments." Although the archival images are restricted to UMich personnel, the images now also appear along with excerpts from the accompanying text at Imgur. See Dtouch, "History Of Medicine: All 45 Paintings By Robert Thom."

⁸ Quoted at Dtouch, "History of Medicine."

⁹ Quoted at Dtouch, "History of Medicine."

¹⁰ Quoted at Dtouch, "History of Medicine."

¹¹ Rush's curative therapies for yellow fever apparently included bloodletting and forced vomiting, treatments that may in fact have caused as much toxicity as the yellow fever itself. See Historical Society of Pennsylvania, "What the Doctor Ordered."

¹² Quoted at Dtouch, "History of Medicine."

¹³ Quoted in Dtouch, "History of Medicine."

¹⁴ I take up Melamed's work on racial capitalism directly in Chapter 2. For now, I provide a brief introduction to Melamed's arguments about the intersections of race and capital. According Melamed, "capitalism is racial capitalism. Capital can only be capital when it is accumulating, and it can only accumulate by producing and moving through relations of severe inequality among human groups—capitalists with the means of production/workers without the means of subsistence, creditors/debtors, conquerors of land made property/the dispossessed and removed. These antimonies of accumulation require loss, disposability, and the unequal differentiation of human value, and racism enshrines the inequalities that capitalism requires. Most obviously, it does this by displacing the uneven life chances that are inescapably part of capitalist social relations onto fictions of differing human capacities, historically race." Melamed, *Racial Capitalism*, 77.

¹⁵ Ahmed's first chapter in *The Cultural Politics of Emotion* is titled "The Contingency of Pain" and begins with the following relevant statement: "How does pain enter politics?" (20).

¹⁶ Goldberg, *The Threat of Race*, 4.

¹⁷ Ahmed, *Cultural Politics of Emotion*, 22.

¹⁸ Omi and Winant, *Racial Formation*, 55.

¹⁹ Omi and Winant, *Racial Formation*, 56.

²⁰ Byrne lived his short 22 years with an untreated tumor on his pituitary gland, which caused his unique height (seven feet, seven inches) just as it delivered him into a life of excruciating pain and marked him as a social outcast who could earn income only by exhibiting himself in London as a "eloquent and elegantly dressed giant above a cane shop near Trafalgar Square." Despite many unsuccessful attempts at convincing Byrne while he was still alive to bequeath his body to Hunter's surgical inquisitiveness upon his death, Byrne died without ever consenting. In fact, he purportedly convinced his friends to bury his body at sea in a lead coffin to protect himself from the many physicians who wanted access to his post-mortem anatomy. Despite these clear directives against

research, Hunter hired a henchman—one of Byrne’s former associates—to open Byrne’s coffin, steal his body, and replace it with heavy rocks. Byrne’s body was then brought back to Hunter in London, who spent years preparing it for its eventual display in the Hunterian Museum of the Royal College of Surgeons in London. This scheme was not uncommon for Hunter, who apparently maintained a payroll of “Ressurrectionists” comprised of undertakers, cops, coroners, and grave robbers who alerted him to the arrival of corpses of interest—usually bodies that were excessively large or otherwise “deformed.” Details from this account provided by Connelly, “Should giant Charles Byrne be left to rest in peace?”

²¹ See Szasz’s chapter “The New Manufacturer: Benjamin Rush, the Father of American Psychiatry” (pp. 137-159) in *The Manufacture of Madness* for an in-depth account of Rush’s clinical practices aimed at the intersections of “negritude” and leprosy.

²² L.L. Wall provides a somewhat problematic interpretation of the ethics of Sims’ medical practices in, “The Medical Ethics of J. Marion Sims: A Fresh Look at the Historical Record,” (see Note 24), while also providing useful background information on the figure and his techniques.

²³ The question of Sims’ purchasing enslaved black women in order to operate on them as patients is still officially a point of contention. According to Durrenda Ojanuga’s 1993 article, “The medical ethics of the ‘father of gynaecology,’” Sims “used a total of seven enslaved women as experimental subjects; permission was obtained from their masters” (29). In Terri Kapsalis’ 1997 book *Public Privates*, however, the author draws on materials from Sims’ biography, suggesting that he did indeed purchase one enslaved woman “expressly for the purpose of experimentation when her master resisted Sims’ solicitations” (35).

²⁴ There is likewise scholarly debate over whether Sims’ lack of use of anesthesia on his enslaved patients was due to his own belief in the inability of those women to feel pain in the same ways as his white patients, or whether he was simply ignorant to the availability of anesthesia, which was only recently being used in surgical environments. Wall argues that Sims simply did not know about or have access to new anesthesia compounds like chloroform when he was initiating surgeries with enslaved women, and that by the time he did know about the pain-numbing substances, he had already moved on to performing the surgery with white women in New York after leaving the south due to health issues. Wall’s article is, it seems, a *politicized* attempt at refuting a body of feminist historical scholarship that questions the racist medical ethics and practices of Sims. Wall, “The Medical Ethics of J. Marion Sims.” For critical feminist historical accounts of Sims see especially Ojanuga, “The medical ethics of the ‘father of gynaecology’” and Kapsalis, *Public Privates*. In this work, I both acknowledge Wall’s challenge to some historical renderings of Sims’ work, and also assert that the “ethics” of the situation matter less than the fact that enslaved women did in fact undergo numerous immensely painful surgeries, seemingly without clinical acknowledgement of the affectively charged weight of those experiences. Keith Wailoo’s 2018 “Viewpoint” piece for *JAMA* critically unpacks popular and academic analyses of Sims’ medical ethics, asserting the following argument about the differential valuations of reality at work: “Often framed as a stark choice between medical pioneer and notorious villain, Sims’ story is more complex. At its heart sits a tension: which reality should be valued? Should the focus be on the innovative

medical discovery, the experiences of research subjects and patients, or the awful circumstances that led to Sims' innovation?" Wailoo, "Historical Aspects of Race and Medicine," 1529.

²⁵ See Spettel and White, "The Portrayal of J. Marion Sims' Controversial Surgical Legacy" for a clinical discipline-specific engagement with the historical question of Sims and the ethical controversies his work continues to provoke. Researchers and clinicians in the field of urology, Spettel and White conclude that, "While historians, ethicists and the popular press have debated Dr. Sims' legacy, medical sources have continued to portray him unquestionably as a great figure in medical history. This division keeps the medical profession uninformed and detached from the public debate on his legacy and, thus, the larger issues of ethical treatment of surgical patients" (2424).

²⁶ A comically clear example of the *ongoing* consolidation of white clinical power in and through a present-day investment in false narratives of American Medical Greatness can be found in two blog posts on the website TriageMD: Wealth Planning and Education for Physicians. The first post from June 2015 claims its unnamed author just "stumbled" across a "wonderful gallery of 45 medical paintings by Robert Thom" online and encourages other clinicians to seek these images out. The MD includes a link to purchase art prints of Thom's work. A second post from August 2015 notes that the author was on a walk in his neighborhood and came across a pile of trash on the curb that included large portfolios of Thom's images. The author "rescued" them from the pile and hopes to share them with a physician in the Philadelphia area. The literal impulse to resurrect these images from a trash heap as someone either intentionally or otherwise figured the time for these images has passed is indicative of the psychic depth of these narratives. That the post appeared on a website providing wealth advising for physicians only reiterates the ways in which the consolidation of clinical power at the system level is always already also about the consolidation of racial, gender, and class power at the individual level. See TriageMD, "Paintings Capture 'Great Moments in Medicine'" and TriageMD, "'Great Moments in Medicine' Part 2."

²⁷ Gamble, "Remembering Anarcha, Lucy, and Betsey: The Mothers of Modern Gynecology."

²⁸ Gamble, "Remembering Anarcha, Lucy, and Betsey: The Mothers of Modern Gynecology."

²⁹ Eyre Crowe, *Slave Auction at Richmond, Virginia (1856)*.

³⁰ Unknown, *Les Curieux en extase, ou les cordons de souliers*.

³¹ According to Rose Eveleth writing for *The Atlantic*, "The idea for the speculum came to Sims while treating a white patient who had been thrown from a horse. After he helped her 'reposition her uterus,' he had an idea. He fetched a slave, had her lay on her back with her legs up, and inserted the bent handle of a silver gravy spoon into her vagina. That's right, the very first modern speculum was made out of a bent gravy spoon." Eveleth, "Why No One Can Design a Better Speculum."

³² Briggs, "The Race of Hysteria," 265.

³³ Briggs, "The Race of Hysteria," 266.

³⁴ Thanks to Kyla Schuller for helping me to relocate the work of "gender" in this "gender studies" project, and for clearly naming and framing feminism as a kind of white capacitation in an early processing conversation.

³⁵ Washington, *Medical Apartheid*, 2.

³⁶ I take up Schuller's genealogy of biopower in the nineteenth century more pointedly in Chapter 2 as I explore the opioid crisis' role in re-entrenching these same principles.

³⁷ Schuller, *The Biopolitics of Feeling*, 3.

³⁸ Foucault, *The Birth of the Clinic*, x.

³⁹ Fanon, *Black Skin, White Masks*, 111.

⁴⁰ Foucault, *The Birth of the Clinic*, xi.

⁴¹ Foucault articulates the concept of "regimes of truth" in a 1977 interview "Truth and Power": Each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true" (131). Here, Foucault assents to the production of truth not through narrativized, subjectivizing acts of confession, but through disciplinary and institutional practices, modes of constraint, mechanisms, techniques, and procedures that sanction *statements* about the world (and its bodies) as either true or false. I find this framework useful in relation to the power held by clinical medicine to evoke truths about vulnerability and pain in and through racial taxonomies of the sensing body.

⁴² Schuller, *The Biopolitics of Feeling*, 33.

⁴³ Weheliye, *Habeas Viscus*, 13. See also, Spillers, *Black, White, and in Color* and Wynter, "Unsettling the Coloniality of Being/Power/Truth/Freedom."

⁴⁴ Weheliye, *Habeas Viscus*, 3.

⁴⁵ Washington, *Medical Apartheid*, 2.

⁴⁶ Washington, *Medical Apartheid*, 7.

⁴⁷ Washington's work on non-consensual medical experimentation on bodies of color resonates especially within arguments about the limited value and capital of blackness in medical contexts.

⁴⁸ Roberts, *Fatal Intervention*, 81.

⁴⁹ Roberts, *Fatal Intervention*, 4.

⁵⁰ Roberts, *Fatal Invention*, 102.

⁵¹ Roberts, *Fatal Invention*, 102.

⁵² Roberts, *Fatal Invention*, 102.

⁵³ Puar, *The Right to Maim*, xviii.

⁵⁴ Roberts, *Fatal Invention*, 93.

⁵⁵ Roberts, *Fatal Invention*, 94.

⁵⁶ Roberts, *Fatal Invention*, 20.

⁵⁷ Roberts, *Fatal Invention*, 4.

⁵⁸ Just ask former Republican Presidential candidate and Arkansas Governor Mike Huckabee, who definitely said in a 2015 radio interview that the 1857 Dred Scott decision, which stated free blacks could never be U.S. citizens, was "still the law of the land." Clearly, this major-party political player, among others, "acts as if" black humans were not in fact given the right to citizenship in the Citizenship Clause of the 14th Amendment in 1868. Mathis-Lilley, "Huckabee Claims Black People Aren't Technically Citizens During Critique of Unjust Laws."

⁵⁹ I take up the data-fication of white death in Chapter 2.

⁶⁰ Sharpe, *In the Wake*, 10.

⁶¹ Sharpe, *In the Wake*, 13.

⁶² Sharpe, *In the Wake*, 13.

⁶³ Hartman, *Lose Your Mother*, 19

⁶⁴ Hartman, *Lose Your Mother*, 19

⁶⁵ Transcribed text from Geo Wyeth, *Quartered*.

⁶⁶ Cvetkovich, *An Archive of Feelings*, 10.

⁶⁷ Cvetkovich's method here is resonant with my work in Chapter 3 on residual histories of settler colonial silver and the resurrected site of the factory in Franklin County, MA.

⁶⁸ Institute of Contemporary Art: Boston, "When the Stars Begin to Fall."

⁶⁹ Neuman, "City Orders Sims Statue Removed From Central Park."

⁷⁰ George Lipsitz crucially articulates whiteness as the "unmarked category against which difference is constructed." I take up this concept more directly in Chapter 2 in my elaboration of the term *ordinary whiteness*. "The Possessive Investment in Whiteness," 369.

⁷¹ My use of the term "un-whiteness" attempts to recognize the totalizing binary of whiteness—that which is both itself and not-itself. I'm not sure it works usefully, however, in communicating the specificities of racial difference, particularly in relation to BIPOC.

⁷² Given the weight of clinical authority and expertise that has historically been attached to organic models of pain, I likewise want to acknowledge the ways in which successful claims to pain's bio-logic roots might work as a kind of negotiated bargain within systems that have always already been designed out of the favor of many of its "charges." For those who can find it, the solace and recognition that comes from being comprehended as a subject-in-pain with a clear, physical etiology can be immensely forgiving. For a feminist-ethnographic account of the politics of clinical recognition, particularly around categories of contested illness, see Kristin K. Barker's *The Fibromyalgia Story*.

⁷³ An ongoing tension in the scholarly field of affect studies lays in how we distinguish between affect, emotion, and feeling. I work here with Sianne Ngai's supposition in *Ugly Feelings* that, "affects are *less* formed and structured than emotions, but not lacking form or structure altogether; *less* 'sociolinguistically fixed,' but by no means code-free or meaningless; *less* 'organized in response to our interpretations of situations,' but by no means entirely devoid of organization or diagnostic powers" (27).

⁷⁴ Muñoz, "Feeling Brown, Feeling Down," 679.

⁷⁵ Muñoz, "Feeling Brown, Feeling Down," 680.

⁷⁶ Muñoz, "Feeling Brown, Feeling Down," 680.

⁷⁷ Muñoz, "Feeling Brown, Feeling Down," 679.

⁷⁸ Muñoz, "Feeling Brown, Feeling Down," 676

⁷⁹ Muñoz, "Feeling Brown, Feeling Down," 677.

⁸⁰ Muñoz, "Feeling Brown, Feeling Down," 677

⁸¹ Fanon, *Black Skin*, 110.

⁸² Fanon, *Black Skin*, 111.

⁸³ Fanon, *Black Skin*, 111.

⁸⁴ Fanon, *Black Skin*, 111.

⁸⁵ Fanon, *Black Skin*, 112.

⁸⁶ Fanon, *Black Skin*, 126.

⁸⁷ Ahmed, *The Cultural Politics of Emotion*, 23.

⁸⁸ Ahmed, *The Cultural Politics of Emotion*, 23.

⁸⁹ Ahmed, *The Cultural Politics of Emotion*, 27.

⁹⁰ Ahmed, *The Cultural Politics of Emotion*, 31.

CHAPTER 2:

Crucibles of Crisis: Ordinary Whiteness, Opioid Biopolitics, and the Racial Mattering of Death

I. Trump's Opioid Politics on the Border

In August 2017, *The Washington Post* obtained and released transcripts of a phone call that took place between U.S. President Donald Trump and Mexican President Enrique Peña Nieto. The call was just seven days after Trump's controversial inauguration and just two days after Trump signed an executive order to begin construction on a southern portion of his proposed border wall. The contentious topic of the border wall—and, more specifically, the question of who will pay for it—dominates the leaked 50-minute phone call. In addition to repeatedly renouncing fiscal responsibility for the construction, Trump continuously rebukes Nieto's proposed solution of a “virtual wall,” which might, according to the Mexican president, promote the possibility of equitable economic development on *both sides* of the border.¹ Instead, Trump returns to an argument he drew on time and again during his presidential campaign: a physical wall is absolutely necessary precisely because U.S. citizens are *at risk* and *need protection* from the many threats of harm being trafficked into this Great Nation by undocumented Mexican immigrants.

The alleged sources of that harm are not the “rapists” and “criminals” that Trump infamously—and quite cavalierly—associated with Mexico's migrant population during his presidential announcement speech in 2015.² This time, it is “drugs” and “drug dealers” that top Trump's list of frenzied—albeit non-specific—justifications for building a wall that will ostensibly secure a one-sided vision of protection for (some) Americans.

“I know this is a tough group of people,” Trump says to Nieto about the leaders of Mexico’s drug cartels. “And maybe your military is afraid of them, but our military is not afraid of them, and we will help you with that 100 percent because it is out of control—totally out of control.”³ As Nieto continuously clarifies throughout the conversation that a physical wall is *not necessary*⁴ and that Mexico *will not* pay for it, Trump is quick to activate another more specific vision of harm in the service of operationalizing his increasingly militarized borderscape:

Up in New Hampshire—I won New Hampshire because New Hampshire is a drug infested den—[it] is coming from the southern border. So, we have a lot of problems with Mexico farther than the economic problem. We are becoming a drug-addicted nation and most of the drugs are coming from Mexico or certainly from the southern border... We have a massive drug problem where kids are becoming addicted to drugs because drugs are being sold for less money than candy because there is so much of it.⁵

In this instance, Trump’s tactic is clear: he concretizes a supposed “crisis” in border security by evoking one specific image of unacceptable American vulnerability: the “ordinary” American child who suddenly begins popping pills trafficked in from the southern border like candy and is promptly re-made in the image of opioid despair—addicted, desperate, and weak.⁶

In the leaked conversation with Nieto, then, Trump effectually frames the specter of opioid-related harm in the U.S. as a rising threat to the organization of life-as-we-have-known-it—one that can and will justify “new” modes of surveillance, accounting, and resource mobilization. The border, as we will see, is only one anticipated solution to neutralizing a range of threats which, if we follow Trump’s political rhetoric, index an alarming series of losses for “ordinary” Americans today. And in centering New Hampshire—a nearly 94% *white* state in the U.S.⁷—as a *key* site of that harm, Trump

further clarifies that white bodies and white harm will always be at the center of what we understand to be “ordinary” (and precious) about life-as-we-have-known-it. As such, Trump once again reminds us that the threat of crisis—the sense that there is something “totally out of control”—has long been an effective strategy for advancing state political agendas.⁸ And successful American politicking, he tells us not so subtly, is all about who leverages the *fear* of crisis most effectively, especially when times are tough. There is nothing innovative or novel about mobilizing a politic of fear to consolidate the authority of U.S. state power.⁹ In every century, racialized ideals of belonging and worth have been leveraged by the U.S. state to securitize its own power in and through the cultivation of anxious othernesses. What is innovative, however, is the ways in which opioids currently occupy the center of this calculus of fear as they shuttle deeply historical ideas about racial belonging, bodily security, national defense, and individualized relief directly into Trump’s Modern America where white victimhood reigns supreme.

Given the many blossoming invectives to the sure supremacy of “ordinary” American whiteness, stoking and feeding public fears of (white) opioid despair is, as this chapter will explore, an increasingly effective (although nonetheless racist) strategy for getting the right (white) people tuned into the right (white) trill of crisis to reveal and remedy the presumably unacceptable presence of mounting (white) vulnerability.¹⁰ On a daily and even hourly timetable, popular media, scientific, and political bodies alike continue to churn out seemingly nuanced explications of the causes and impacts of the opioid crisis. And yet, the intense productivity of what I call *ordinary whiteness* continues to linger—unannounced and unaccounted for—amongst the public mania of overdose and death. Locating the political work of the opioid crisis in the messy, albeit

nonetheless lucrative, intersections of racial difference, claims to loss, and strained relations to national belonging reveals much about the ways in which the problematic of opioid despair is deeply intertwined with the ongoing work of redressing the increasingly unacceptable specter of white vulnerability using the might of any (lucrative) tools at hand.

Fictions of the continuously capacitated and always-already resilient white body have sustained promises of American Greatness since well before the time of Donald J. Trump. In the previous chapter, I explored the fictioning of racially differentiated sensory regimes as part of the (false) story of American Clinical Greatness. By looking to the ways in which collective processes of white racial formation and individual claims to pain have operated together to sanction some bodies as valuable and some as disposable in sites of clinical care, I showed some of the ways in which bodies of clinical power have themselves become increasingly capacitated as they arbitrate and assign meaning to the many discomforts of extraction—affective and otherwise. In this chapter, I turn those historical processes of clinical mattering outwards—away from the presumed “privacy” of the clinic and towards the emergent “public” of the opioid crisis—to ask after the ways in which racially differentiated *populations* are being made (and re-made) through ongoing investments in opioid despair today. In defining and making evident the many insidious routes through which *ordinary whiteness* is produced and fortified as a kind of capital across U.S. geographies of loss, the opioid crisis emerges as yet another way to ensure that systems of capital and systems of care alike continue to protect, nurture, and properly resource ordinary whiteness, even as it falters.

In the crucible of the opioid crisis, then, state-backed promises of individual relief, collective resiliency, and the persistent hope for recovery *for some* live in deep, historical tension with state-backed legacies of structural violence, racial denial, and the sure promise of death for others. The collective “us” that animates the opioid crisis is, I will argue, a contemporary configuration that gains its vital power in and through *ongoing* investments in *histories* of white racial formation that privilege the clinical apprehension of white pain, just as they “un-see” sensory experiences of color. How, I ask, are these fictions of racially differentiated feeling capacities enlivened and enfleshed today? What political work do they do? And what kinds of futures are being securitized as those fictions continue to flourish? To answer these questions, I mobilize an understanding of the historical capacitation of whiteness in formations of clinical power towards a consideration of the ways in which struggling bodies “matter” differently in public health and recovery systems in the wake of the emergent opioid crisis today. This temporal shift in focus demands attention to the ways in which some processes of white racial formation that were forged across the 19th and 20th centuries—the “age of human sacrifice,”¹¹ according to geographer Ruth Wilson Gilmore—have been capacitated, strengthened, and put to good use by 21st century U.S. systems and structures that both rely upon and reproduce the underlying conditions of ordinary whiteness.

I begin by returning to Trump’s leaked conversations with Nieto in order to track some of the ways in which the rhetorics of injury, loss, and harm that permeate opioid politics index larger crises in the presumed political and bodily efficacy of ordinary whiteness today. Lauren Berlant’s work on the political economy of the “ordinary” as well as George Lipsitz’s work on “possessive investment in whiteness” and Robin

DiAngelo's concept of "white fragility" help to illuminate some of the ways in which long-nurtured visions of whiteness-as-we've-known-it are both deployed and mourned in Trump-dominated political-economic landscapes flush with the feeling of white dispossession. In asking after the specific racial and economic geographies that constitute Trump's visions of American Greatness, I explore opioid politics as a kind of petition made by increasingly estranged white bodies and white communities back into the fold of national (white) belonging. I assert that the political work of the opioid crisis reveals shifts in ordinary whiteness as a kind of belonging-in-strength to a kind of belonging-in-weakness. This shift, I suggest, fashions the presence and recognition of individualized white harm into an image of national emergency as whiteness is put on the line and made to "count" in different ways.

Attending to the frenzy of white death in public conversations about loss and remuneration in the crucible of the opioid crisis likewise reveals the integral role that corporate-driven science and Big Pharma have played—and continue to play—in mediating fearful breakdowns in ordinary whiteness to the tune of billions of dollars in revenues. Jodi Melamed's framework of racial capitalism usefully situates the political economy of extraction in relation to the problematic of "ordinary" opioid despair today. By looking specifically at two U.S. "geographies of loss"—New Hampshire and Appalachia—I explore some of the ways in which the extreme marketing of extraordinary relief throughout the 1990s and 2000s has led to clear investments by Big Pharma in the decapacitated white body. In this analysis of the political work of the opioid crisis, acceptance into the fold of ordinary whiteness is not just a contingency of race, but also a contingency of labor and one's proximate position to the many processes

of extraction that keep the “ordinary” in place. The opioid crisis, I show, is due in no small part to the ongoing cooperation of race and capital in the consolidation of returns on the promises of ordinary whiteness.

Finally, I turn attention to public health regimes in the U.S. to explore the ways in which both private (corporate) and public (health) entities are putting the political work of the opioid crisis to good use in and through collective investments in better, more efficient, and more technologically savvy methods of recognizing and responding to bodies of ordinary whiteness in crisis. Attending to what I call the *biopolitics of opioids* helps to clarify that in accepting certain claims to pain as a kind of human capital—as a way to render, interpret, and mobilize resources—we are also collectively invested in re-pacing and re-composing a de-composing sense of ordinary whiteness. The end goal of securing a right to that de-composing capital is, no doubt, a return to the falsities of Greatness—a reaping of seeds that may just have begun to rot. As such, mobilizing the political work of the opioid crisis otherwise requires naming and then de-activating an emergent politics of mattering, which works in concert with Trump-era political praxis, such that affiliations with the “ordinary” will no longer securitize the differential rights to care and attention that whiteness has so long demanded.

II. Ordinary Whiteness, Ordinary Crisis or, What Whiteness Used to Be

Trump is not wrong when he asserts that the current “drug problem” in the United States is “massive.” News, media, and research bodies alike have churned out ample statistics that highlight rising rates of opioid overdose and overdose-related deaths throughout the U.S over the past 15 years.¹² The Centers for Disease Control—the federal agency responsible for aggregating and reporting nation-level statistics for opioid-related

events—reports that more than three out of five drug overdoses in the U.S. today involve some kind of opioid (including prescription opioids and heroin)¹³ and that presently, nearly 115 people die every day from an opioid overdose in the U.S.¹⁴ This statistic is particularly resonant alongside the CDC’s report that in 1999, cocaine killed almost twice as many people as heroin.¹⁵ Since 1999, the rate of opioid-related overdose deaths in the U.S. has increased by more than five times.¹⁶ Although some reports suggest that in certain states, including Massachusetts, the rates of overdose are beginning to ease slightly,¹⁷ other statistically-driven analyses suggest that the impact of the opioid crisis continues to proliferate across many major markers of public health in the U.S. A June 2017 report from *The New York Times*, for example, drew on analyses of data from “hundreds of health agencies” around the U.S. and found that drug overdoses are now the leading cause of death for Americans under 50.¹⁸ Likewise, a recent study published in the *Journal of the American Medical Association* suggests that the rising rates of opioid overdose between 2000–2015 are resulting in an overall *decrease* in life expectancy for American adults for the first time in decades.¹⁹ Paired with recent conversations on the overall reduction in white births in comparison to black and Latino births in the U.S., an ostensible loss of statistical supremacy looms.²⁰ White death, as these statistics tell us quite plainly, is the ultimate harbinger of public harm in the crucible of the opioid crisis.

When read critically, however, these widely-cited CDC statistics on the reach of the opioid crisis likewise reveal that not all deaths are, in fact, quite so crisis-inducing as others. One key CDC statistic in particular tell us that in 2016, “the states with the highest rates of death due to drug overdose were West Virginia (52.0 per 100,000), Ohio (39.1 per 100,000), New Hampshire (39.0 per 100,000), the District of Columbia (38.8 per

100,000), and Pennsylvania (37.9 per 100,000),”²¹ and that the regions experiencing the most significant increases in drug overdose death rates from 2015-2016 were the Northeast, Midwest, and South Census Regions.²² That same body of CDC data also shows that whites and Native Americans have experienced, “the largest rise in death rates, particularly when it comes to opioid-related fatalities.” By 2014, the report says, “whites and Native Americans were dying at double or triple the rates of African-Americans and Latinos.”²³ This last statistic has been cited virally since the report’s publication, sparking and sustaining the public perception that certain U.S. geographies (namely, northeastern and southern white communities) are, in fact, *uniquely* impacted by opioid despair. The subsequent fact that Native communities throughout the U.S. are likewise significantly and uniquely impacted by opioid despair (and so many other insidious legacies of structurally-expressed genocide) remains largely (and unsurprisingly) unexamined and uncirculated in public health, clinical, and popular culture machines alike, as does the impact of opioid-related despair in predominantly black communities.²⁴

The widespread availability of these statistics makes possible a range of public perspectives and opinions on the magnitude of the perceived “opioid crisis,” all the while eschewing the specificity of what we even mean when we refer to “opioid” (or “crisis,” for that matter). In a later section, I will unpack more carefully the power of public health definition building and the emergent “statistical imaginary” in opioid politics. More specifically, I will show the role that “death counting” statistics and statistical analysis play in producing racially differentiated practices and ethics of care in relation to the many kinds of harm and despair that circulate in the opioid crisis.²⁵ First, however, we

must return to the specific task of defining and outlining a framework of “ordinary whiteness” to more clearly understand the charged power of loss that circulates in contemporary landscapes where opioids, pain, and trashed political economies of racial capitalism collided.

Whiteness reigns supreme in opioid coverage, providing legibility to an economy of loss that tells us *this crisis* is the *only crisis* that matters. The results are effusive. The very fact of (white) people dying justifies a critical media landscape that is invested in examining the less visible and more nuanced roots of the “crisis” to shore up new frameworks of (public) health intervention and empathy. The very fact of (white) people dying drives a popular culture machine that is keenly invested in taking up the specter of death for profit. The very fact of (white) people dying drives a political climate that is invested in extending contingent recognitions of harm (bodily, fiscal, psychic) to preserve a certain kind of familiar supremacy. The very fact of (white) people dying produces a collective investment in action, and we needn’t look further than interstate highway billboards or neighborhood street corner banners that tout treatment and prevention rather than captivity and punishment in predominantly white communities to see what these investments look like or how they unfold. In the crucible of opioid despair, the individual body held in the rapt attention of clinical power is indelibly white. As such, those who can successfully embody an identification with “ordinary whiteness” beget the prize: a designated affiliation with the possibility of relief and respite, just as long as one doesn’t rock the boat too much.

Looking plainly at *claims* to injury and harm reveals much about the ways in which seemingly disconnected political artifacts—Trump’s border wall and the public

explosion of an opioid crisis—are in fact deeply intertwined, both ideologically and in practice. Sutured by the cohering mechanism of the *perception* of unacceptable white vulnerability in *certain* U.S. geographies, the threat of crisis contained in both the border wall and in the opioid epidemic gains its political power through the nagging, affective injunction that “we” may never again “know” American Whiteness on “our” own terms: whiteness-as-we’d-like-to-know-it; whiteness as unintimidated by the rising power and agency of otherness; whiteness as resilient, capacitated, and, of course, free. Whiteness as ordinary. The opioid crisis thrives, I want to suggest, in the ever-widening gap between what whiteness *used to be*—what promises it carried, what guarantees it could make—and what whiteness is *becoming* as it is increasingly made accountable to the structures of violence and harm contained within itself. In other words, in order fully understand the political work of the opioid crisis, we must attend to an emergent shift in whiteness as a kind of belonging-in-strength to whiteness-as-belonging-in-weakness.

What, then, did whiteness used to be? We have at our disposal a million versions of this story. The fictive might of American Clinical Greatness in the last chapter told us much about how whiteness-as-we-know-it was formed through clinical apprehensions of the sensing, feeling human body. Following Omi and Winant’s articulation of race as, “a concept which signifies and symbolizes social conflicts and interests by referring to different types of human bodies,”²⁶ one story of whiteness-as-we’ve-known-it has been made in and through the experience of inhabiting a specific *kind of body that can be seen as worthy of recognition and attention*: strong, resilient, self-reliant, free. Whiteness is, as both J. Marion Sims and Parke-Davis have showed us, an ideological well that continuously replenishes and fortifies these concepts to materially collectivize and

organize regimes of hegemonic feeling and belonging. Whiteness is a *racial project* in its effectiveness in building strategies of belonging and mattering. In the very current moment, that looks like Trump's instrumentalizing and capitalizing on a border wall that will symbolically assure *some* Americans that they *can be* safe, that they *can be* protected, and that they *can be* immune to the mounting losses (of control, of relevance, of security) and pains (in necks, in backs, in knees) that increasingly give meaning to the lives of many white, working class people in the U.S. today.

Part of the challenge of naming what whiteness *has been* involves coming to terms with the fact that whiteness has historically gained its strength as that thing which has gone *unnamed*. First articulated in a now-classic 1995 article, American studies scholar George Lipsitz suggests that whiteness operates in the U.S. as that, "unmarked category against which difference is constructed."²⁷ It is that thing which "never has to speak its name, never has to acknowledge its role as an organizing principle in social and cultural relations."²⁸ Crucially, there is nothing natural about the arrangement of whiteness-as-we've-known-it. Following Lipsitz again, the "fictive identity of 'whiteness'"²⁹ has, rather, been activated and circulated in the U.S. not only through the register of the human body but also through a wide range of cultural practices and social policies developed in the U.S. throughout the 19th and 20th centuries. From minstrel shows to modern advertising, Lipsitz shows that an "imagined community" of whiteness was brought into cohesion in the U.S. through shared investments in the "solidarity of white supremacy."³⁰ Here, we get a sense of the multiple vectors of social and political life that work in the service of cohering and consolidating the work of whiteness as that which perseveres and protects itself. As white bodies and white communities continue to

occupy center stage in the collective performance of the opioid crisis, it is imperative to track the ways in which the cultural practices *and* social policies generated from sites of opioid despair cohere a *story* of racial solidarity that is hard to refute as it speaks compellingly through images of white death and white despair.

Here, we can begin to excavate a framework for locating and naming the forms of harm and injury that are emerging as many forms of whiteness—both individualized and collectivized—are being made to speak their own name over and over again for the first time.³¹ Robin DiAngelo’s work on white fragility helps to further frame what is at stake for bodies of whiteness when the surety of that category is thrown into question, either by one’s own failing physical body, or by the creeping perception that one’s social, political, or economic position is likewise failing:

White people in North America live in an social environment that protects and insulates them from race-based stress. This insulated environment of racial protection builds white expectations for racial comfort while at the same time lowering the ability to tolerate racial stress, leading to what I refer to as White Fragility. White Fragility is a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviours, in turn, function to reinstate white racial equilibrium.³²

Frameworks of white fragility help to name—explicitly—some of the ways in which whiteness has been able to solidify its own unilateral political power in the U.S. by evading affective *and* political challenges to its own authority.

Furthermore, the power of whiteness is, no doubt, about cohering and making stable the utility and productivity of white feelings. “The direction of power between whites and people of color is,” DiAngelo clarifies, “historic, traditional, normalized, and

deeply embedded in the fabric of US society.”³³ Given the directional power of whiteness as that which is both embedded and normalized, DiAngelo’s work on white fragility tells us much about the ways in which white feelings that are experienced at the *individual* level are so effectively deployed and operationalized at the *national* level. White fragility works, it seems, by first sanctioning and then cohering the significance of white feelings *across* the boundaries of individual and nation. As such, *individual* hurt white feelings contain more than enough justification for enacting the nation-level “defensive moves” ostensibly demanded by both the border wall and the heightening crisis of opioid despair. As the promises of equilibrium that bodies of whiteness have been taught to expect are, following DiAngelo, continuously being challenged, the exact nature of these defensive moves are brought into relief.³⁴ As both the border wall and the opioid crisis continue to unfold, we must vigilantly watch and name the ways in which the feeling of collective injury are made tenable through the ongoing expression and performance of feelings of individual white hurt and white loss in the crucible of the opioid crisis.

Throughout so many of the emergent exercises of attention and recognition being extended towards suffering white people in the opioid crisis, the affective charge of ordinary whiteness continues to affirm and prop up the collectively nurtured assumption that these experiences of white harm are, no doubt, both exceptional and unacceptable. Following the work of Lauren Berlant, the “ordinary” operates here as a, “zone of convergence of many histories, where people manage the *incoherence* of lives that proceed in the face of threats to the good life they imagine.”³⁵ Promises and fantasies of “the good life,”³⁶ Berlant helps us to see here, ultimately function as mechanisms of racial coherence in our current moment by fashioning *some* bodies into a national

collective through an invitation to both expect and enjoy the fictions of entitlement that have fortified claims to white supremacy for centuries. Berlant's articulation of the "ordinary" as a "zone of convergence" further illuminates Linda Martín Alcoff's recent assertion in *The Future of Whiteness* that whiteness itself "is, after all, produced by a complex of historical events, rather than a single originary moment. Whiteness," she tells us, "is far from ontologically empty."³⁷ As a "zone of convergence," then, *ordinary whiteness* culls together many disparate and even tensional histories and visions of white racial formation to present to us a model of what belonging-in-strength *can* and *should* look like in the U.S. today, given our predominant frameworks of mattering and the histories that have delivered them to us.

The shaky construction of belonging-in-strength as a central tenet of ordinary whiteness is, no doubt, built on the proliferation of narratives of exceptionality that need revealing if we are to move through the violence they make possible. The fictive might of American Clinical Greatness has no doubt served as one particular set of tools to quite effectively tell the story of why certain kinds of pain, injury, and harm are outrageous and unacceptable, just as some others are entirely necessary in order to keep the wheels turning. Crucially, Trump is quick to activate another set of tools towards that towards the same pervasive sense of vulnerability in the leaked conversation with Nieto—the might of American Military Greatness:

I just wanted to mention that when you talk about people coming across the border—because times will be tough and times will be good—that when times are tough, that is why we have a wall, because we do not want people to come across the border. We do not want them coming across. We have enough people coming across; we want to stop it cold. General Kelly is one of the most respected generals in the entire military system and he is a very fair man, but he is a tough man.³⁸ And we have the drug lords in Mexico that are knocking the hell out of

our country. They are sending drugs to Chicago, Los Angeles, and to New York...”³⁹

Here, Trump articulates a not-so-subtle reminder that for those who hold administrative power in the U.S., the long-nurtured legacy of American Military Greatness always already serves as a vital ideological resource in confronting the multiple forms of “invasion” that can trouble easy expressions of a white status quo. Interjecting Kelly’s militarized vision of borderland drug warfare into a dialogue on economic development confirms that Trump can and will leverage as political fodder the deeply felt tensions between inherited (albeit false) visions of American Might (also packaged as American Greatness) and the creeping sense that “we” are losing—or may have already lost—something infinitely precious.

As an extension of the political work of the opioid crisis, this language matters. As Trump relies over and over again on grammars of “we” in the leaked conversation with Nieto, he effectively manages the exceptionality of certain kinds of white harm through a militarized vision of border security. Crucially, this vision is made tenable by the collectivizing concept of ordinary whiteness as homogenous in both need and desire: “we” do not want people coming across the border; “we” have the drug lords knocking the hell out of “us.” In the construction of an “us” vs. “them” grammatical binary, Trump draws on a key technology of white racial formation in the U.S: the effective displacement achieved as “we” always actually in fact means “us” (white folks). “In grammars of American whiteness,” black feminist theorist Hortense J. Spillers reminds us, “personal pronouns are offered in the service of a collective function.”⁴⁰ This collectivizing function is, no doubt, about the preservation of an imagined thread of whiteness-as-solidarity and whiteness-as-belonging-in-strength which gains its own

strength by culling together stories of its own might to intimidate and secure its own name.

However, as the many arms of the opioid crisis continue to stretch and pull at the stitches of the U.S. social fabric, we can identify myriad rising challenges to that kind of sure and strong belonging. These are challenges that no doubt *feel* very bad to the many people who are beginning to sense that their sure place in the social fabric is suddenly being made untenable. Old models of capital accumulation and inheritance continue to unravel in a world being re-made in the image of the austerity regimes that followed the 2009 recession. In the process, class- and race-backed promises of belonging that securitized the safety of whiteness and middle-class-ness for so long are likewise unraveling. These tensions in the presumed security and belongingness of whiteness cannot be ignored. Instead, we must understand that the tensions that structure ordinary whiteness may, in fact, actually constitute the kinds of claims to pain, harm, and injury to which opioids discourse responds.

Crucially, Lauren Berlant's articulation of "the ordinary" contains within itself the persistent gnaw of incoherence—the affective un-surety of whether one can in fact keep a hold on that which has been deemed normal and expectable in experiences of ordinary whiteness. "Crisis," Berlant clarifies, is "not exceptional." It is, rather, "a process that is embedded in the ordinary that unfolds in stories about navigating what's overwhelming."⁴¹ A framework of ordinary whiteness, then, names the contemporary capacity of whiteness as that which is both exceedingly "normal" *and* in crisis. It speaks to the overwhelming project of *being* white today—what Alcoff, following José Esteban Muñoz, calls "the unbearable whiteness of being"⁴²—when our tightly wound narratives

of desirability and worth are necessarily unraveling. It tells the story of what happens when American Greatness is made to look at its own reflection in a mirror held up by a hand that does not look like its own. It looks like the strange strangle of impending insignificance. “Most such happenings that force people to adapt to an unfolding change,” Berlant continues, “are better described by a notion of systemic crisis, or “crisis ordinariness.”⁴³ Ordinary whiteness *is* crisis ordinariness, then, and attending to it as such tell us much about the flow of resources—fiscal and otherwise—in the crucible of the opioid crisis.

III. Tracking Possessive Investments in Opioid Despair

As the statistical rates of opioid-related overdoses and deaths continue to rise across the United States, the messy, meandering effects of system-level harms and injuries are, no doubt, increasingly smoothed out and refined by machinations of clinical power that have been well primed to convert and channel all that is *systemic* onto the body of the individual. Processes of white racial formation that make ordinary whiteness into a tangible bodily feeling of harm are, no doubt, inextricably tied up with the assumption that “we” as a “nation” can and should respond to individual crises in bodily integrity as if they were a *national* crisis. Regular Guy can tell us something about that. His pain? It is not a palpable reminder of the small role he plays in a political-economic system designed to incapacitate him until it can use him no more. It is, rather, his and his alone; born from his body and the work that it does to support his own wife and kids. As we remained trapped within individualized frameworks of mattering bodies of ordinary whiteness, the individual body in pain remains at the center of opioid clinical praxes and politics, reifying normative (and highly racialized) approaches to discomfort, harm, and

pain. As such, the subtle implications of Trump's pro-military call for protection against Mexico's "drug lords" are likely not lost on those who always already fall outside of Trump's grammatical "us."

The major U.S. cities that Trump mentions to Nieto (Chicago, Los Angeles, New York) are not the *actual* hinge in his arguments justifying a border wall by mobilizing popular discourses on U.S. drug politics. Trump is instead eager to link up the devastating effects of illicit drugs moving throughout the U.S. to sites much less large—and much less racialized as primarily black or -of color—than places like Los Angeles or Chicago. You are now entering: New Hampshire. Crucially, the call-to-arms that Trump performs in the leaked phone call that began this chapter is clearly not focused on the wide-scale economic and geographic devastation faced by urban and rural communities of color due to the inherited legacies of the failed War on Drugs. Trump is happy to leave those memories (i.e., mandatory minimum sentencing, an explosive growth in the U.S. prison population) in the grave with Reagan. His focus is, rather, a small, rural, and definitely majority white state in the northeast which was, at the time of the exchange with Nieto, engaged in a highly public campaign to draw attention to its own rising rates of opioid overdose, addiction, and death.

New Hampshire is significant to how we tell the story of the crisis of opioids because in many ways, the small, New England state contains within itself and its history that selfsame, powerful vision of whiteness-we-as-we'd-like-to-know-it: whiteness as individual and self-directed, nostalgic, maybe even idyllic in its pursuit of the fictions of American Greatness. Whiteness is *not* a structure here. Even though the most recent census data tells us that 93.6% of New Hampshire residents self-reported as "white

alone,”⁴⁴ whiteness here simply refers to a mythic, individualized state of being that is at once neutral, natural, and overflowing with potential. With its state slogan of “Live Free or Die,” New Hampshire tells us that the freedom required to achieve American Greatness is ours to take, if we want it. Death, as the slogan makes evident, is the only other viable option—an option that one can *choose* if freedom is denied. This means that *death* is not a structure here, either. And yet, the specter of death is alive and well in New Hampshire, posing some real challenges to the solid legacy of (white) “freedom” born from a geography that was at the heart of some of the most violent periods of European colonization in the Americas. Capacity indeed. If even this idyllic place is in ruins, if even these good white folks can’t live free and well without dying, Trump seems to say, then you could be next.

It *is* significant, then, that Trump chose to return to New Hampshire to unveil his national plan to address the opioid crisis in March 2018. Doing so no doubt affirms and re-calibrates the exceptionality of white harm in a place where whiteness has been so historically and surely entrenched as an infinite resource.⁴⁵ Speaking from a community college in Manchester, New Hampshire several months after his empty declaration of the opioid crisis a “public health emergency” in October 2018, Trump’s speech largely recapitulates his “law and order” approach for dealing with the threats of harm posed by the opioid crisis. He begins by thanking the many federal agencies—including the DEA, ICE, and federal and state law enforcement—that have “kept drugs out of our communities and criminals off our streets.”⁴⁶ With “law and order” checked off his list of top priorities, Trump then shifts his focus to the familiar narratives of exceptional white harm as he centers the many “ordinary” families that have been impacted by opioid

despair in New Hampshire. Zeroing in on the apparently exemplary overdose-related death of New Hampshire youth Adam Mozer, Trump invites the young man's parents to the stage and asks them to tell the "tragic" story of their son's struggle. The story is, for all intents and purposes, a story about the decline of ordinary whiteness in action: a smart, "great," highly educated kid from a "rural" small town in New Hampshire, Adam studied actuarial science—"the science of forecasting risk," according to his mother—before he found prescription pills in his parent's medicine cabinet.⁴⁷ Mozer quickly became hooked, began buying heroin off the street when he could no longer sustain the prescription opioids, and died from an overdose of fentanyl shortly after. Just as Adam's mother finishes her story, Trump dismisses her from the stage with an all-too derogatory "Thank you, darling..." and proceeds to unveil a new website—www.crisisnextdoor.gov—where "Americans can share their stories about the danger of the opioid addiction and addictions."⁴⁸ Finally, Trump effectively transitions back to law and order where he blames Mozer's death directly on the nearby city of Lawrence, Massachusetts—a city populated almost entirely by Latino people—for supplying the fentanyl to New Hampshire that killed Mozer. He likewise references the Lawrence-based street gang MS-13—"They don't use guns—they would rather use knives because it takes longer and is more painful"—even though the gang has no apparent ties to the opioid crisis.⁴⁹ In highlighting the many ways in which good, old fashioned American Greatness is faltering even in these freedom-loving places (Immigrants! Knives! Poison! Gangs! Fentanyl! China!), Trump carefully re-consolidates the power of whiteness away from the story of its strength and towards the burgeoning menace that lives, for all intents

and purposes, “right next door.” In the process, one’s “own” (white) bodily security is made perilous alongside the nation’s security.

Trump’s calculated response to the emergent opioid crisis in New Hampshire tell us that much can be done, and that much will be done, to rectify the sure capacity of some to LIVE FREE or DIE, while others never experience the promises of freedom and still die, unexceptionally. By effectively assembling the specter of individual white death alongside images of the proximate crisis of otherness, Trump no doubt fashions a national emergency out of the opioid crisis in a way that doesn’t actually require him to move resources around all that much. In the process, however, the affective dimensions of ordinary whiteness begin to turn. As the sureties of white strength are re-calibrated towards the fear of infiltration, the threat of harm to the nation is located, following Trump, in the specific kinds of racialized otherness living right next door – crisis ordinariness, indeed. Here, affects of fear are a resource all their own, and whiteness begins to look like that thing we need desperately to hold on to if the world is not to crumble down around us.

Trump offers, it seems, a specific kind of investment into opioid despair that we must pay attention to if we want to actively consider the intersections of race and capital in this crucible. As he centers New Hampshire is his own performance of opioid politics, he opens a schism around where and how we extend *differential* recognition to the bodies and places ravaged by opioid despair. Even within whiteness-as-we’d-like-to-know-it, there is an un-evenness in the investment being offered to us. New Hampshire carries with it clear allegiances to the “right” kind of whiteness: New England born yet freedom loving, anti-Big Government and not yet wholly tarnished by the many kinds of

incapacity that mar so many other de-industrial sites across the country. New Hampshire reminds us that in the U.S., the structure of whiteness is in fact about possession—about who and what can “stick” to the sureties of whiteness effectively, and who and what is sloughed off when they are no longer lucrative or tenable.

This vision of whiteness as both eternally conserved and always already policed for breach further illuminates the political work of Lipsitz’s “possessive investment in whiteness.” “Conscious and deliberate actions have institutionalized group identity in the United States, not just through the dissemination of cultural stories,” Lipsitz argues, “but also through systematic efforts from colonial times to the present to create a possessive investment in whiteness for European Americans.”⁵⁰ Those systematic efforts, following Lipsitz, include social policies that, “widen the gap between the resources available to whites and those available to aggrieved racial communities.”⁵¹ As such, a possessive investment in whiteness, Lipsitz shows us, is about hoarding, preserving, and nourishing the specific conditions, practices, and policies that structurally widen the gap in access to resources. Possessive investments in whiteness, Lipsitz argues, emerge from “a fused sensibility drawing on many sources at once—on antiblack racism, to be sure, but also on the legacies of racialization left by federal, state, and local policies towards Native Americans, Asian Americans, Mexican Americans, and other groups designated by whites as ‘racially other.’”⁵² Here, we get the sense that a possessive investment in whiteness isn’t just about a possessive investment in resources; it’s also about a possessive investment in the bodily and psychic conditions made possible by resources—health and wellness, environmental safety, meaningful connections to one’s community and the institutions that comprise it. In Trump’s opioid storytelling, we can, then, locate a

structure of ordinary whiteness that clearly seeks to re-direct the flow of resources towards the kinds of “bad feelings” that arise as bodies of whiteness begin to belong differently and matter differently to our visions of Greatness. Furthermore, it becomes clear that as we tell stories about opioid despair that re-entrench regimes of ordinary whiteness, we are likewise re-entrenching possessive investments in the idea that bodies of whiteness are the only bodies that can and should be get better.

Parsing both possession of and investment in whiteness no doubt magnifies the endemic contradictions that underpin some of the founding assumptions of state responsibly to injury and care under practices of U.S. (neo)liberalism. Although the U.S. superficially prides itself on a political economy predicated on liberal individualism, Lipsitz clarifies that there is nothing *individual* about the structures of whiteness at work here. “Disciplined, systemic, and collective group activity,” Lipsitz argues, “has structured white identities in American history.”⁵³ As such, attending to the political work of the opioid crisis through possessive investments in whiteness means telling the story—over and over and over again—of what whiteness has evaded. It means telling the story—over and over and over again—of the ways in which whiteness itself is a contingent function of capitalism, one that relies on its own fantasies of individual capacity to continuously reinforce and invigorate systemic expressions of white violence.

IV. Fictioning Racial Geographies of Greatness, Finding Contingent Geographies of Whiteness

Many of the popular stories and narratives being generated from the crucible of the opioid crisis confirm and amplify the assumption that opioid politics are about

extending compassionate recognition to some bodies of suffering that used to be understood as degenerate and unspeakable. As opioid politics recuperate addiction into frameworks of medicalized harm in need of (public) health remediation, racial difference unsurprisingly continues to mediate who and what is scooped into the fold. How, this section asks, do political geographies of ordinary whiteness operate outside of the (neo)liberal northeast, particularly in places where whiteness itself has not always guaranteed an enthusiastic enfolding into the heart of the nation, as we've seen in New Hampshire? Gilmore again provides useful context for thinking through the ways in which race and place cooperate to secure differential responses—both fiscal and affective—in the crucible of the opioid crisis. She suggests that in order to truly “see” the complexities of race and geography together, we must center the “fatally dynamic coupling of power and difference signified by racism.”⁵⁴ Trump's expressive and unapologetic displays of (white) nationalism in calling for the construction of the border wall—and his quick attribution of blame directly to *certain* geographies of otherness—no doubt communicate the convergence of power and difference in a particular space (here, the scene of the border) in order to produce effects that can very well be fatal. But what of the many kinds of fatalities that are not so swift and relatable as Adam Mozer's death in New Hampshire? Where and how do some visions of whiteness always already fall outside of the ordinary and, therefore, fail to measure up to the kinds of Greatness Trump aspires to reassert? And what have our investments in ordinary whiteness come to look like in places where whiteness is not *necessarily* a matter of New England birthright, but rather of one's contingent ability to keep laboring—to keep *producing*—in the service of fictive Greatnesses?

Although New Hampshire occupies the star spot in Trump's own tallying of opioid harms, much of the popular media's focus has likewise been directed to the geographic region of Appalachia, which includes West Virginia, Tennessee, Kentucky, and parts of Ohio and Pennsylvania. "Hard numbers" in the form of CDC data sets tell the story of the impact of opioid despair in this region, but so do other modes of accounting. The *New York Times* report from June 2017 that includes the viral opioid overdose statistics also includes statements from the county medical examiner in Summit County, Ohio, who says that given the 46% increase in drug overdose deaths between 2015 and 2016, the county morgue has had to request refrigerated trailers three times to store the influx of bodies that would not fit in the morgue's normal storage spaces.⁵⁵ Likewise, a joint report from the *West Virginia Gazette-Mail* and *HuffPost* reveals that West Virginia's Department of Health and Human Resources doubled the money they spent over two years on contracts with companies that transport deceased bodies due to rising demands from opioid-related deaths.⁵⁶ In these accounts, opioid despair is no doubt firmly entrenched in the many tensions of ordinary whiteness, particularly as the death toll in this region climbs above and beyond the many kinds of routinized injuries and harms that subtend industrial mining and extraction.

However, even within these many visions of death and despair, Appalachia itself is not, crucially, the reason *why* visions of individual white death have blossomed into a national crisis, as we've seen so clearly in New Hampshire. Appalachia has been constituted, no doubt, by tense and often interrogated relations to the category of whiteness itself. In her analysis of the work of racial difference in the field of Appalachian studies, scholar Barbara Ellen Smith suggests that historically,

“...Appalachian whites of different classes and genders positioned and defined *themselves* and the region’s institutions *in racial terms*—often through social and cultural distance from what they defined as ‘blackness,’ regardless of the actual presence of African Americans.”⁵⁷ As such, the organizing tenets of ordinary whiteness—that which is free, easy, and unearned—have never been quite as efficacious here as in other regions of the U.S., where institutionally validated ties to European colonization figure bodies of whiteness accordingly. Whiteness, then, is something one must work hard to claim in Appalachia; whiteness is earned and hard-won.

As such, strained ties to the “right” kind of white belonging suggest that the *ongoing* de-capacitation of ordinary whiteness in Appalachia has not been of major national concern for very long. In fact, Appalachia has long retained its use and value to U.S. political-economic imaginaries not through its successful inhabitation of “proper” ordinary whiteness, but because it has served as one of the nation’s key regions for domestic fossil fuel production. “The southern mountains are half a billion years old,” Steven Stoll writes in *Ramp Hollow*, “but Appalachia did not exist before the industrial invasion of those uplands during the nineteenth century. It appeared as a location within the capitalist world when its coal and labor ignited the American Industrial Revolution.”⁵⁸ Extraction, as Stoll so usefully explicates, has largely defined Appalachia as an object of concern. This no doubt tells us something about the ways in which whiteness itself is not only a contingency of bodily comportment and capacity, but also a contingency of place. Labor—and one’s class position in relation to labor—is no doubt a central point of refraction in the pain-relieving capacities of opioids and in the social worlds they make permissible.

Today, the sureties of belonging that once accompanied the spoils of extraction are more tenuous than ever. The raw material of ordinary whiteness—labor—is ever depleted in political economies of de-industrialization. According to reports issued by the Appalachian Regional Commission (ARC), overall coal production in Appalachia declined by nearly 45% between 2005 and 2015, which is more than double the amount of the reported national decline in coal production.⁵⁹ As a result, coal industry employment likewise fell by 27% in the same time period.⁶⁰ “While poverty has been higher in the mining counties of Appalachia compared to non-mining counties for many years,” states the ARC report, “poverty has risen substantially in both groups of counties in recent years.”⁶¹ The ARC report begins to render for us a region where the sureties of ordinary whiteness are more contingent than ever. In a troubling evocation of loss, the guarantee of a good day’s work is no longer at least one route through which to make this specific kind of whiteness matter.

How, then, does the contingency of ordinary whiteness in Appalachia matter to the political work of the opioid crisis? Attending to major and unexpected shifts in voting patterns in Appalachia during the 2016 election offers much for thinking through why and how those who are significantly impacted by the kinds of injury and harm made specifically in coal country resonated so powerfully with Trump’s promises of redemption, or of a newfound affiliation with that which labors to belong-in-strength, finally. Historian Kathleen Frydl’s work on what she calls the “Oxy Electorate” effectively situates for us the ways in which complex perceptions of (white) vulnerability across Appalachia have, perhaps, contributed to that region’s significant “swing” towards Trump in the 2016 presidential election. Frydl’s methodology reads CDC data on

overdose rates in each of the counties in Pennsylvania, Ohio, and New Hampshire who report such data against the total numbers of voters in each county who voted for Obama in 2012 and switched to a vote for Trump in 2016. Ultimately, her work sought to track rising rates of opioid overdose in specific counties alongside the political turnarounds that made Trump successful in so many of the places he was originally predicted to lose. Her analysis demonstrates that in Ohio, all counties except for two who reported at least 20 overdoses per 100,000 people saw at least a 10% surge in the number of voters who turned out for Trump in 2016 as opposed to Romney in 2012 and/or a 10% drop in voters who turned out for Obama in 2012 as opposed to Clinton in 2016. In Pennsylvania, 29 of the 33 high-overdose counties followed the same pattern of flipping from Democrat to Republican in the most recent election. Frydl draws the following conclusions from this compelling research:

Although the apparent correlation between the places most under siege by the opioid epidemic and those that flipped or went more heavily for Trump is striking, it is only suggestive, and not by itself explanatory. It does nothing to undermine the convincing evidence that these voters were motivated by ethno-nationalist appeal, for example. Instead, it supplements it, providing a premise to help explain why a narrative of identity, place, and belonging would have such resonance among them. Success will come to most any strategy that exalts the value of people living in places that country has, in its collective indifference, discerned little.⁶²

Frydl's smart take on the identity politics of Trump's win—and the ways in which those politics are tied to mainstream evocation (and evasions) of white vulnerability—remind us again of the many complex ways in which many forms of whiteness have been produced, leveraged, and mobilized in the crucible of the opioid crisis. Frydl's analysis shows not only that the emergent shift in whiteness as belonging-in-strength to whiteness as belonging-in-weakness that we've tracked at a more national level is no doubt alive

and well in coal country. It likewise reveals a deeper seated, historically situated, and geographically strained relationship to national belonging that has as much to do with the *contemporary* affectivity of white loss as it does with the *historical* realities of white, working class harm and injury that have marked the bodies and landscapes of Appalachia for centuries.

Put another way, there is nothing new about the bad feelings that come from the insidious harms of extraction here. As those who have carried out the unique labor of securing America's right to unfettered natural resource production and consumption in our "own" nation, Appalachia's white, working class communities are saying, it seems, that they have a right to despair, too, and that the specific concerns of white New Hampshire matter (and feel) differently here. Appalachia's white opioid despair no doubt seeks invitation into the kinds of belonging to Greatness that have often evaded this region, particularly because of its close relation to the historical and contemporary intimacies of blackness. Here, the "threat" of that which is both familiar and strange to ordinary whiteness—American blackness—really does live "next door." As such, we must consider the ways in which opioid politics in this specific geography attempt to re-affirm and re-claim affiliations with the many kinds of belonging that come from inhabiting ordinary whiteness in the "right way" in other national spaces. Calling for this kind of consideration reflects a larger trend in Appalachian studies to re-figure and explicitly name the work of whiteness in consolidating Appalachia as both a distinct region and one that is comprised of white people who are "really" white. As Barbara Ellen Smith has shown, "...the making of Appalachia has been simultaneously the making of whiteness—not merely in popular (and inaccurate) representations of the

region's racial 'purity,' that distanced it from the lowland South, but as an intentional historical dynamic."⁶³ As such, securing possession of the category of whiteness here has meant establishing active and vigilant distance from the many kinds of racial "confusion" that emerge when cultural and historical attachments to the right kind of whiteness cannot always be directly accounted for.⁶⁴ As we consider the stakes of claims to injury and harm in the crucible of the opioid crisis, then, it becomes increasingly important to track the ways in which specific geographies of opioid despair map onto specific geographies of political-economic extraction that have been made in and through petitions to racial belonging—the surety of ordinary whiteness. Doing so allows us to continue tracking the ways in which individual claims to pain feed (or don't) our available frameworks for national mattering.

Sarah Kliff's work at *Vox* on opioid addiction in everyday life in Williamson, West Virginia is a compelling example of a kind of popular storytelling that affirms the reality of opioid despair in Appalachia and attempts to make sense of those realities by unraveling tense knots of bodily debility, individual poverty, and the larger-scale political-economic instabilities that so many rural and post-industrial regions face across the U.S. as our investments in their productivity have waned. Kliff's work attempts in particular to illustrate the ways in which unstable political-economic realities are lived as a kind of daily pain in places that rarely receive national attention (and compassion) in ways that places like New Hampshire have managed to secure:

On the first weekend of each month, when public benefits like disability get paid out, the local fire chief estimates the city sees about half a million dollars in drug sales. The area is poor—29 percent of county residents live in poverty, and, amid the retreat of the coal industry, the unemployment rate was 12.2 percent...and those selling pills are not always who you'd expect. 'Elderly folks who depend on blood pressure medications, who can't afford them, they're selling their

[painkillers] to get money to buy their blood pressure drug,’ Williamson fire chief Joey Carey told me... ‘The opioids are still \$5 or \$10 copays. They can turn around and sell those pills for \$5 or \$10 each.’⁶⁵

Here, we get closer insight into some of the ways in which *certain* state-backed promises of relief and support—including the “benefits” of federal disability and unemployment—have been made available to the white working bodies of Appalachia, albeit with the contingency that there is and always will be an ongoing need for exploitable bodies of labor in landscapes where the dangerous work of extraction is a necessity to keeping the nation running on Greatness.

What does white and working class look like, then, without work? How does it feel? As factories and mining operations continue to operate across Appalachia and extraction continues to become all the more violent and environmentally destructive, that burden is, in fact, a kind of pain that still hasn’t quite been accounted for in our available frameworks of clinical and national mattering. Kliff’s research connects her with Dino Beckett, a primary care doctor who opened a clinic in Williamson, West Virginia in 2014. Beckett regularly, “sees older women who suffer from compression fractures up and down their spines, the result of osteoporosis. He sees men who mined coal for decades, who now experience persistent, piercing low back pain. ‘We have a population that works in coal mines or mine-supporting industries doing lots of manual labor, lifting equipment,’ he says. ‘Doing that for 10 to 12 hours a day for 15 to 20 years, or more, is a bad deal.’”⁶⁶ The “bad deal” that Dino Beckett mentions is, in part, the unnamed variable in this equation of crisis—the one that remains unacknowledged by Trump, as well as the larger public health community more widely: the exercise of racial capitalism taken to its logical end. The imperative to work one’s body to the bone only to be let go when the

company you've invested your life in decides to downsize, close, or relocate out of the country sheds light on the multiple dimensions of vulnerability—bodily, economic, political—that many white people have felt for a very long time in Appalachia. Here, opioid despair is only the most recent expression of a kind of despair that blooms when one's laboring body is the only meaningful contribution one can make to the nation.

Kliff's portrait of small-town Appalachian communities and their unique struggles with the intersections of isolation, poverty, and pain provides compassionate attention to the kinds of *personal* strains that accompany the loss of factory and mining work, including benefits like employer-sponsored health insurance and paid sick time. However, attempts to recognize and respond to the many kinds of pains that contribute to opioid overdose and death in West Virginia still reside largely within individualized frameworks of harm and injury. Princeton economists Anne Case and Angus Deaton, for example, coin the term “deaths of despair” for such harm in their work on rising rates of deaths related to alcohol use, drugs, and suicide in white communities in the U.S.⁶⁷ Deaths of despair are, according to Case and Deaton, evidence of the ways in which rising mortality rates for U.S. non-Latino whites with a high school education or less are being driven by increased insecurity that comes with no longer being able to compete in a rapidly changing economic climate. Whiteness is *still* not a structure here, although it does, no doubt, affect one's specific location in relation to promises of state care and the amelioration of need. Whiteness *still* remains unnamed here, although it is, no doubt, constitutive of the many claims to belonging being voiced from these spaces. What remains unnamed, too, are the ways in which access even to the basic tools of relief—health insurance (with copays), disability payments (which are never enough)—are

always already mediated through the participation in and negotiation with systems and institutions designed largely in the image of whiteness itself. These “deaths of despair” register as countable entities only for the people who register as having lost the benefits they were promised in the first place.

In New Hampshire, the efficacy of ordinary whiteness tells us that white bodies in despair are in fact a top priority, not only for national security, but also for national public health and national morale. In Appalachia, the contingencies of ordinary whiteness tell us that despair is endemic. We better get used to it. The next task at hand is figuring out how to put despair to work in the right way, before someone else profits from it. Even if whiteness is not a structure here, the political economy of pain is, and that can, no doubt, yield some pretty profits. Throughout the 90s and 00s, those profits were generated directly by the truckloads of opioid pills being shipped into the region by competing pharmaceutical distribution networks. Tending to opioid despair in Appalachia means forging deep and crucial associations between strained claims to national (white) belonging, the bodily realities of illness and chronic pain in the region, and the potential for profit that Big Pharma invested in as the extractive economies of mining left all manner of pain in their wake. Doing so reveals the ways in which the political economy of racial capitalism is fed and fortified by ongoing petitions into the fold of ordinary whiteness. In the next section, I turn attention more directly to the ways in which the bodily debilities of extractive mining and the contingencies of whiteness in Appalachia have been co-opted and re-routed quite intentionally by targeted pharmaceutical opioid distribution networks that cannot be—by definition—accountable to those it has further harmed. In the process, I seek to better understand the ways in which the political

economy of racial capitalism always already situates and strengthens ordinary whiteness as that which can surely “bounce back” from even the most endemic harms. If, of course, you swallow your medicine right.⁶⁸

V. Lucrative Circuits of Racial Capital in Crisis

In the contemporary formation of the opioid crisis, pain, politicking, and profit indelibly collide across clinical and corporate boundaries. Crisis, as Craig Wilse and Patricia Clough remind us in the introduction to *Beyond Biopolitics*, is not only conducive to cohering mechanisms of social control, as Trump so brazenly shows. It can also be highly lucrative: there will always already exist an opportunity for profit—both political and economic—from the mining and extraction of what Clough and Willsee call “living death, or deadly living” in their Introduction to the edited collection *Beyond Biopolitics*.⁶⁹ How do our current approaches to the many forms of “deadly living” that underpin opioid despair update and revise old frameworks of political, economic, and clinical mattering? And what kinds of accumulations and “returns” can and should we expect as we collectively respond to a manufactured crisis whose currently proposed solutions no doubt labor to preserve the boundaries of whiteness-as-we-know-it? Anchoring the political work of the opioid crisis around the many emergent crises of “ordinary whiteness” reveals much about the ways in which the problematic of opioid despair is likewise deeply intertwined with the many racialized circuits through which capital is (and always has been) managed and routed in the U.S.

There are many ways to track and name the intersections of race and capital in the specific context of Appalachia, as well as in other geographies of opioid despair across

the U.S. Eric Eyre’s Pulitzer Prize-winning investigative journalism at the *Charleston Gazette-Mail* in West Virginia is one example of on-the-ground work being done to expose and reveal the ways in which Big Pharma manipulated and built up unregulated networks of drug distribution across Appalachia in order to fuel the current landscape of opioid overdose and death that we now call a crisis. As we consider the many pain-full shifts unfolding in the kinds of affiliation and belonging that structure ordinary whiteness, we can begin to track the ways in which corporate investments in the insured/ensured presence of pain here have made possible the accumulation of a kind of capital that is, despite its affiliation with health “care”—sick. “In six years,” Eyre’s reporting from West Virginia shows, “drug wholesalers showered the state with 780 million hydrocodone and oxycodone pills, while 1,728 West Virginians fatally overdosed on those two painkillers...The unfettered shipments amount to 433 pain pills for every man, woman, and child in West Virginia.”⁷⁰ Published between May and December 2016, each of Eyre’s three pieces explores some facet of the explosion in prescription opioid production and distribution in this region.⁷¹ Working against a wholesale distribution industry that wanted desperately to keep its sales numbers secret, Eyre and his team obtained “previously confidential drug shipping sales records sent by the U.S. Drug Enforcement Administration to West Virginia Attorney General Patrick Morrissey’s office. The records disclose the number of pills sold to every pharmacy in the state and the drug companies’ shipments to all 55 counties in West Virginia between 2007 and 2012.”⁷² This detailed, confidential dossier revealed unconstrained distribution networks that made it possible, for example, for one small “mom n’ pop” pharmacy in Oceana, West Virginia to receive 600 times as many oxycodone pills than the RiteAid up the

street. Eyre's work reveals some of the very specific ways in which Big Pharma has managed to leverage consolidated clinical power in the service of accumulating unprecedented profit through the ongoing work of exploiting both the physical capacities of the working body and that body's desire to belong, if not in strength, then at least in weakness.

With this crucial data set opened, we can clearly trace some of the ways in which U.S.-based Big Pharma has, over the past 15 years, successfully engaged and worked through the rhetorical register of white-pain-as-crisis to solidify and concentrate its own unstable market power in geographies of white loss and white harm where the endemic injuries of capitalist extraction wear down in very real ways on the bodies laboring in its service. In the process, we get a deeper sense of enduring legacy made possible in the wake of Parke-Davis' own twisted pharmaceutical entitlement to the vision of American Medical Greatness explored in the previous chapter. One such practice that Eyre's work reveals is the West Virginia Board of Pharmacy regularly giving "spotless inspection reviews" to small town pharmacies that ordered more opioids than would ever make sense for treating typical chronic pain.⁷³ Eyre also found that the three major U.S. drug distributors—McKesson, Cardinal Health, and AmerisourceBergen Drug Co.—supplied more than half of the pills to pharmacies in the state and profited a combined \$17 billion in net income. CEOs of these major opioid distribution companies culled some of the highest bonuses and salaries in the nation; McKesson's CEO is currently the highest paid CEO in the nation.⁷⁴ Eyre's reporting also showed that distributors manipulated pill strength in order to boost sales: "Between 2007 and 2012, the number of 30-milligram OxyContin tablets increased six-fold, the supply of 15-miligram pills tripled and 10-

milligram oxycodone nearly doubled,” the DEA records show.⁷⁵ In each of these instances, if we “look” right, we can “see” that the *historical* work of white racial formation—which has no doubt positioned white bodies in favorable alignment with bodies of clinical power—shapes and impacts the ability for this kind of system to run un-checked for so long. Big Pharma reps (most likely white) come together with small town America pharmacists and physicians (most likely white) and in that alignment, gross abuses of clinical power and mismanagement of local resources become the *de facto* norm as the consumer is always already imagined to be white. As that cooperation is sustained through rich rewards and financial kickbacks, the hegemony of ordinary whiteness is preserved, and the image of capital as that which gives us worth and matter remains intact.

Hinged on the problematic of both unacceptable bodily pain *and* the demand for a quick, sure solution to that pain, opioid despair contains within itself a relation to U.S. capitalism that is unique to the white body’s historically cultivated *expectation* of always already increasing value and worth. “Race,” as critical ethnic studies scholar Jodi Melamed argues, “remains a procedure that *justifies* the nongeneralizability of capitalist wealth.”⁷⁶ In extricating the specific machinations of whiteness from this framework, Melamed helps us to see some of the ways in which process of white racial formation work to securitize white people’s perceived right to attention and resources in the crucible of the opioid crisis. It does this through the unspoken—yet wholly constitutive—organizing principles of a kind of capitalism that has been nurtured and fed on fictions of racial difference. In clinical and public health systems that have been continuously governed through long-term investments in ordinary whiteness, this relation to capitalism

no doubt sanctions the perception of racial difference as a key mechanism in how the vulnerability and harm that underpin opioid despair are acknowledged, recorded, and addressed. Here, whiteness is a kind of capital that promises big relief, and, as Big Pharma has shown us, relief can indeed be delivered to those to whom it has been promised. It's just that your relief might very well look like a stultifying opioid bath, if you will just trust your doctor, please.

The unspoken perception that whiteness is that which instigates and validates the accretion of capital no doubt structures research programs like the one undertaken by Nathan DeWall, a psychology professor at the University of Kentucky.⁷⁷ DeWall's work attempted to trace potential connections between the pharmaceutical treatment of physical pain and the pharmaceutical treatment of emotional pain. First published in 2010, one of DeWall's studies found that acetaminophen—the active ingredient in Tylenol—appeared to reduce feelings of rejection for some study participants who were intentionally left out of a virtual ball tossing game.⁷⁸ According to brain imagining in the study, acetaminophen dimmed activity in the part of the brain associated with processing social pain. Later studies that built on this research found that acetaminophen may likewise diminish emotional highs and lows, and another study connected the pain pill to an apparent reduction in empathy.⁷⁹ As we continue to create and fund studies that sanction and confirm the emotional pain-relieving capacities of pharmaceuticals for some, we continue to teach those who are listening that the servants of clinical power (here, scientific capitalism) can, indeed, “fix” all “your” problems, as long as your problems fit into a framework of comprehensible harm. In the process, we can more fully see the ways in which the promises of ordinary whiteness—the promise of protection,

relief, and re-capacitation—are always already built into pharmaceutical networks of capital accumulation, which then feed back into sustaining whiteness-as-we-know-it. Here, the emotional promise of protection that has been built into the affectivity of white fragility can indeed be secured by swallowing the right pill.

In this dovetail of race and capital, we can locate the work of what critical theorists over the past 30 years have called, quite plainly, racial capitalism. First articulated by Cedric Robinson in his pivotal 1983 text *Black Marxism: The Making of the Black Radical Tradition*, frameworks of racial capitalism have been taken up by a range of critical projects that seek to name the specific ways that capital securitizes relations of extraction in and through explicit processes of racial formation that unfold across social, political, and economic life worlds. “Capitalism *is* racial capitalism, Jodi Melamed clarifies. “Capital can only be capital when it is accumulating, and it can only accumulate by producing and moving through relations of severe inequality among human groups.”⁸⁰ As such, Melamed argues, “these antimonies of accumulation require loss, disposability, and the unequal differentiation of human value. Most obviously,” Melamed continues, “[racial capitalism] does this by displacing the uneven life chances that are inescapably part of capitalist social relations onto *fictions of differing human capacities*, historically race.”⁸¹ Here, Melamed offers much for parsing the emergent breakdown in one of most continuously invigorated structures of American political economy: the idea that whiteness—as a specific kind of human capital—has and will continue to offer the kinds of protection needed to survive in an economy that eagerly and incessantly mines the capacity and value of the human body right alongside endless other “natural resources.”

Another more uncomfortable, albeit perhaps clearer, way to name the “unnamed” work of whiteness within political-economic systems designed in the structures of racial capitalism is to say explicitly that in the U.S., whiteness is produced through a relation to an other’s death. Doing so will, no doubt, illuminate the very real stakes of mounting state response to opioid crises that rely on producing and responding to the specific needs of “ordinarily” white people, first, and “ordinary” white populations, eventually. Ruth Wilson Gilmore explicates racism as such in her pivotal definition offered in the opening to *Golden Gulag*: “Racism, specifically,” Gilmore tells us, “is the state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death.”⁸² Here, the hierarchies of ordering and mattering that racial capitalism abides by in the crucible of the opioid crisis are made clear. State and corporate responsibilities to redress opioid despair begin with clear imperatives to account for *individual* harms done to white bodies who can make coherent claims to a kind of pain we recognize. Then, those individual claims are harnessed and channeled towards populational mechanisms that can fully “invest” in a collective (white) return to proper relations of death and dying. David Theo Goldberg is useful once again in more fully explicating what a “proper” relation to death looks like in regimes born from racial capitalism: “If one’s own survival is heightened by the reassuring spectacle of another’s death, as Achille Mbembe insightfully puts in in his writing about ‘necropolitics,’ then national survival is borne out of keeping death at bay, by ensuring that if there is to be death it is the death of those not one’s own.”⁸³ Here, we begin to get a sense of the co-imbrication of individual survival and “national” survival in the crucible of the opioid crisis. As a specific kind of relation to the state, then, racial capitalism tells us much of what we need to know about how to

belong to the fold of American Greatness. It is, as Melamed confirms, a machine to discern and calculate many kinds of disposability, which no doubt illuminates the *ongoing* labor of fictioning human difference as a kind of difference in capacity.

The widescale production of individual crisis as national crisis is, no doubt, fully fortified and sanctioned by the political work of the opioid crisis. According to Melamed's reading of Gilmore, racial capitalism is not just a technology of differentiation; it is likewise a key technology of *anti-relationality*. This framework is useful for tracking the political work of the opioid crisis as it moves towards the terrain of what I call *opioid biopolitics*. As we've seen, the logics of racial capitalism produce and frame our currently available logics of valuation and mattering by forcing bodies and communities through specifically racialized mechanisms of differentiation. If we can learn the logics of racial capitalism, Melamed shows us, we can more fully "name and analyze the production of social separatedness—the disjoining or deactivating of relations between human beings (and humans and nature)—needed for capitalist expropriation to work."⁸⁴ As the structures and processes of racial capitalism continue to "invalidate terms of relationality," following Melamed again, it becomes all the more urgent to track the emergent ways in which shifts in U.S. identities and modes of belonging are, in fact, being produced and recognized as shifts in population.⁸⁵ Doing so will illuminate some of the many ways in which technologies and techniques produced in response to opioid despair are, in fact, producing the "fact" of white communities as a targeted object of re-investment. In effectively closing the emergent gap in the conditions of racial capitalism, the opioid crisis, is, I will argue, a key technology of populational differentiation that we must understand as such if we want to imagine "solutions" otherwise. In the next section,

I turn attention to some of the more specific ways in which race is increasingly registering *as* population in the crucible of the opioid crisis, and furthermore, the ways in which populations are being forged through image of re-capacitated state and clinical power.

VI. Charting Bodies of Evidence: Opioid Biopolitics and the Data Mattering of White Death

We have at our disposal so many bodies in this crisis—bodies of research, bodies of overdose, bodies of evidence, bodies of governance and regulation. How, I wonder, are we making use of these bodies? How do we make sense of them? As the many kinds of capital that have been invested in ordinary whiteness are being increasingly re-directed towards unexpected, exceptional, and unacceptable death, the flow of vital life that has been promised to many in the U.S. is compromised in a system long organized by the tenets of racial capitalism. Bodies of whiteness are not living and thriving. Bodies of whiteness are, rather problematically, weak and injured. As such, a return to “proper” relations of death in the contemporary U.S. no doubt looks like a return to visions of American Greatness where the people who are dying no longer look white and our mechanism of accounting for harms tell us that they deserved death. What, then, do we need to know to refigure the direction of energy, capital, and resources in the crucible of the opioid crisis?

Attending to the political work of the opioid crisis requires that we look critically at the productive power of resource mobilization that is targeted at the recuperation of (white) health and (white) wellbeing. This is in order to reveal the specific mechanisms

through which state, corporate, non-profit, and clinical systems designate and police the boundaries of life and death. In a set of lectures delivered between 1975 and 1976 at the College de France, Foucault outlines a framework of biopower that continues to inflect the ways in which we might understand the political work of the opioid crisis today, particularly its role in reifying and consolidating bodies of ordinary whiteness. At the end of *Society Must Be Defended*, Foucault theorizes a key shift in disciplinary techniques of power which had, up until the second half of the eighteenth century, taken as their target object the individual capacities of individual human bodies—man-as-living-being. In the shift, Foucault argues, the target of this emergent technology of power shifts, rather, to the “multiplicity of men”⁸⁶: “So after a first seizure of power over the body in individualizing mode, we have a second seizure of power that is not individualizing but, if you like, massifying, that is directed not at man-as-body, but at man-as-species.”⁸⁷ This “massifying” shift effectively produces a “biopolitics of the human race,”⁸⁸ following Foucault. In this framework, biopower is, “continuous, scientific, and it is the power to make live...the power of regularization.”⁸⁹ Measurements of human vitality—birth rates, death rates, fertility and reproduction—become the de facto “material” of this kind of power, and demographers, Foucault helps us to see, are agents of this praxis of mattering as they produce, name, and give legibility to the specific populations that become the target of control (for some) and resource funneling (for others).

Although Foucault does not address processes of racial formation specifically, his analysis is clearly useful for thinking through the ways in which racial difference is increasingly made to “matter” at the populational level through tools and regimes of measurement and assessment. The biopolitical power of “regularization” is, in many

ways, the productivity of ordinary whiteness—that which names and frames the regular *as* the ordinary so that we can more clearly delineate that which falls outside of the ordinary. In political-economic systems governed through biopower, Foucault helps us to see, population is, no doubt, far more than a composition of individual subjects made to matter together. The power of population lies in its potential abstraction. “The population,” according to Patricia Clough, “is a technical object, a political object of management and government—not necessarily a collection of individual subjects...the matter of population is life-itself.”⁹⁰ As such, Clough continues, “population is an effect of statistical analysis, a matter of probabilities, a measure of risk that constitutes an actuarialism, a racist actuarialism, that is productive rather than merely representational...”.⁹¹ Here, we get a sense of the ways in which population as a “technical object” comes alive in its utility for state and private entities in the crucible of the opioid crisis. The life of population is gained in and through exercises of mis-capture, whereby the individualized harms of ordinary whiteness are visioned as harms to the social body. That vitality, as Clough helps us to see, is forged in and through a kind “racist actuarialism” that cannot categorically understand and respond to that which does not “register” as a problem in the first place. She deems the result “populational racism,” in which the “calculations and measures of population in a variety of contexts—territory, class, ethnicity, gender—are put in terms of an analysis of biological activity”.⁹² In the enfolding the structures of “ordinary whiteness” into our available measures of the scope of the opioid crisis, we can clearly trace the ways in which a biologization of opioid despair through “death counting” no doubt sanctions and re-certifies the rush of resources back towards whiteness-as-we-know-it.

What then of the productivity of populational racism? How and where do we account for its reach in the crucible of this crisis? In the explosive emergence of public health mechanisms designed to count and see opioid death in increasingly novel ways, for one. As we've seen, population is not simply a "measurement" of human vitality or capacity—it is, rather, a "technicity."⁹³ Population is made in and through the productivity of certain kinds of willing and naming and cohering. Much like the productive capacity of whiteness, the productive capacity of population lies in its ability to retain coherence against the mechanisms that challenge it. In *Society Must Be Defended*, Foucault speaks to the technicity—the formational and productive property—of population as he links the emergence of biopower as population-management to the formation and consolidation of specific *practices* in clinical medicine, "whose main function will now be public hygiene, with institutions to coordinate medical care, centralize information, and normalize knowledge."⁹⁴ Here, we get a sense of some of the ways in which population is driving an explosion in new kinds of "public health" knowledge-making where we are increasingly being taught to "see" the fact of individual white pain as a kind of populational pain that will no doubt threaten the stability of the nation. Clough, following Roderick Ferguson's work in *The Re-Order of Things*, locates the productive power of this kind of knowledge-making in a kind of "will to institutionality."⁹⁵ Public health systems, I want to suggest, are indicative of where, exactly, a will to institutionality is unfolding in the crucible of this crisis.

One emergent mechanism that ensures an institutional will to "objectively" count and tally the impact of opioids in sites of whiteness and to simultaneously not count the entrenched impact of despair and myriad other forms injury and harm in non-white

communities includes the gradual adoption of “syndromic surveillance” in public health reporting apparatuses focused on the opioid crisis. Syndromic surveillance is, according to a 2004 report by the New York City Department of Health and Mental Hygiene on behalf of the CDC, a data-driven method for identifying clusters of illness *prior to* confirmed diagnoses in order to mobilize rapid responses and reduce mortality.⁹⁶ Originally developed as a method for more rapidly recognizing and responding to large-scale bio-warfare attacks in the period immediately following the NYC terrorist attack of September 11, 2001, syndromic surveillance has evolved quite significantly as a public health data aggregation tool over the past 10 years. It is, no doubt, part and parcel of the, “data-fication” of the 21st century.⁹⁷

Today, syndromic surveillance facilitates the real time sharing and analysis of patient electronic health records (EHRs) across clinical, urgent care, ambulatory, and public health sites with the goal of more readily preparing medical and public health systems for action and response in the wake of major health threats. Participating public health agencies typically receive data downloads every 24 hours, and the reported information includes patients’ genders, races, zip codes, chief complaints, and discharge diagnoses. Patient identities are typically restricted to a “pseudonymized identifier” in the data transmission given HIPPA restrictions. However, treating facilities can typically re-trace the link between the identifier and patient name, if necessary.⁹⁸ Both reporting bodies (ERs, urgent care sites) and receiving bodies (public health agencies) currently also receive incentives from the Centers for Medicare and Medicaid Services (CMS) for enrolling their institutions in syndromic surveillance systems.⁹⁹ “Meaningful Use” guidelines have been established and disseminated by the International Society for

Disease Surveillance for guiding the development and implementation of the practice on a wide scale. These incentives suggest that syndromic surveillance is an evolving practice that clearly ties together state- and federal-level public health apparatuses of capture to more local and regional systems of care.¹⁰⁰ The result is the production of a particular kind of seeing—and counting—that matters tremendously to the project of tracking the political work of the opioid crisis.

Syndromic surveillance is operationalized through a robust clinical and public health re-configuration of the concept of “syndrome.” The CDC’s 2004 publication on syndromic surveillance suggests that, “categorizing symptoms and diagnoses into syndromes is a fundamental component of syndromic surveillance systems that use clinical data sets. Although the majority of investigators have devised broad categories aimed at early detection of biologic terrorism, validation of syndrome definitions is only beginning.”¹⁰¹ Crucially, then, syndromic surveillance requires that we have already established—if not validated—clinical language and methods of observation that are capable of knitting together particular behaviors, affects, and bodily states into cohesive medical categories (syndromes) that can then be counted, aggregated, and assigned with forms of meaning that make sense to the cultural norms and expectations of particular clinical bodies.

Under syndromic surveillance, the statistical aggregation of a “crisis” begins, then, with patients who have access to medical providers who can say with the authority of an institutional power behind them that a particular kind of bodily experience (opioid dependency) is one thing (a health problem requiring medical and public health responses) and not something else entirely (a moral or cultural deficit requiring

incarceration and/or dispossession). Crisis is cultivated and tended as those body-verdicts are fed into the networked machine of exchange called syndromic surveillance, which sutures together well-resourced communities that have the knowledge, time, staff, and desire to adopt these technologies of legibility. Crisis is materialized as certain populations—and, eventually, certain communities—are invited to shape, guide, and participate in the production of solutions to a set of problems that are deemed worthy of our collective attention.

As a method of statistically aggregating harm—and the potential for emergent harm— syndromic surveillance also neatly ties together the concepts of population and community, ushering in a new horizon upon which to arbitrate worth. As demographic aggregates of harm (i.e., the graspable statistical presence of white opioid deaths) are attached to specific geographic mappings (i.e., rural white counties across the U.S.), we can track the ways in which ordinary whiteness coheres as a kind of statistical belonging. This consolidation into an opioid-impacted community ushers in the possibility of participating in the collective work of remediating harm, which is increasingly understood as happening at the level of the community. As we'll see in the next chapter, the production of a coherent sense of community is one mechanism that is touted as central to lifting off the collective work of recovery and to enlivening collective practices of health making. As such, an attention to where depictions of cohesive “community” are being produced by public health practices of statistical accounting reveals the differential ways in which basic models of community-based, cooperative caring and mobilization are made tenable to population-level aggregates—or not.

As we continue to materialize opioid-affected populations across the U.S. using tools like syndromic surveillance, we manage to see the proliferation of harm only where our tools can reach. And these tools, we say, will produce statistical “proof” of where resources and attention are most needed. Crucially, however, this is not a value-neutral, or more specifically, a race-neutral process. Methods of attention, response, and resource distribution driven by practices like syndromic surveillance are not simple exercises that will clearly provide us with “data driven” or “evidence based” frameworks for change. They are, rather, yet another way for us to bear witness to the uneven distribution of practices of care across geographic and demographic landscapes. They are, rather, yet another way for us to visually produce communities that matter. They are, rather, yet another way for clinical systems to quite efficiently and elegantly—under the tenor of increased capacities—turn pointed attention towards the bodies and communities who were already presumed worthy of medical investment and, by extension, rehabilitation, in the first place. Biopolitics works through dividing those that matter from those that do not.

In the world of counting and making sense of opioid despair, the work adding up—of marking and sorting bodies into “syndromes” for the purposes of system-wide identification and the mobilization of response—gives shape to some of the ongoing machinations of statistically-driven clinical power in the crucible of the opioid crisis. These machinations, crucially, have their roots in systems of European colonial governance and administration, which required the production and circulation of certain fictions of truth in order to justify the unending reach of colonial power into both bodies and territories of otherness. Tim Rowse and Tiffany Shellam usefully outline the

eighteenth-century roots of this kind of consolidated clinical/statistical power in their work on the emergent role of statistics as “proof” in justifying the public health management and administration of colonial “populations” under British rule in the eighteenth century. “In the early Victorian era,” they argue, “while advocates of statistics believed ‘the confusion of politics could be replaced by an orderly reign of facts,’ their pursuit of ‘facts’ was influenced by what they believed and by what they thought they knew about nature, sources, and remedies for the biological and social disorder of a governed population.”¹⁰² Here, we get a sense of the ways in which a will to the “datafication” of opioid despair may very well draw on colonial procedures of racial governance where a collective desire for an “orderly reign of facts” was eagerly channeled into novel methods of accounting for that which one has already chosen to see. This “statistical imaginary,” following Rowse and Shellam, is a generative framework for tracing the fortification of clinical power across varied landscapes of investment and disinvestment.

Understanding the problematic role of syndromic surveillance in emergent public health apparatuses focused on the opioid crisis requires, then, a deeper and more fully historicized understanding of the basic fact of racialized disparities in health and medicine in the United States, and it requires a keener acknowledgement of the ways in which mechanisms of capture and recognition are always already by definition uneven and unstable. Public health systems rely on the networked exchange of clinical data to animate rhetorics of harm, but they do not typically acknowledge the way in which clinical systems have always operated as arbiters of racialized worth. If we cannot imagine the animation of harm in co-production with the arbitration of worth, our

responses will always be whitewashed. They will always look to statistical evidence rather than localized knowledges to measure the scope of a problem. They will always favor the sites and spaces with access to definitional language, institutional power, and technologized networking to mitigate resources. And they will always continue to replicate a version of racialized dispossession that has been alive and well in the U.S. for centuries. Ultimately, linking up genealogies of racialized harm and differential attention in medical systems to the landscape of the opioid crisis is necessary in order to understand emergent—and entrenched—practices of biopolitics that underpin both public health and clinical medicine's conception of and response to the crisis. Attending to the biopolitical dimensions of the opioid crisis ultimately makes us accountable to the ways in which insidious genealogies of racially differentiated harm are fed into public health mechanisms of capture and spat out as neutralized.

We have so many tools available to us in seeing the opioid crisis from the vantage point of ordinary whiteness. Crucially, data-driven statistics and analyses of the impact of opioids on non-white communities are few and far between in a landscape dominated by narratives of white despair. The numbers simply don't count up. This disparity in statistical representation is fueled at least in part by research bodies' ongoing commitment to producing data sets that reflect the specific demography, geography, and quality of one kind of (white) death—the statistical imaginary of ordinary whiteness. The most widely cited body of research on non-white opioid-related fatalities comes from the CDC, who report that between 2010 and 2014, the rate of death from heroin overdose increased 267% for whites, 236% for Native Americans, 213% for blacks, and 137% for Latinos.¹⁰³ Reports that draw on this data set often use it to justify the flow of resources

and attention to white communities who look—at least statistically and from our available public testimonies—as though they’re suffering *more*. What these numbers don’t show, however, is that our public health mechanisms for making sense of the death count in the opioid crisis always already favor recognizing and responding to white harm.

Taken at face value, the above CDC statistic does as much to highlight the extreme impact of opioid-related deaths on Native communities as on white rural communities. However, this is a facet of the “crisis” that is rarely mentioned or discussed in mainstream accounts, even as the rate of deaths in this smaller demographic is, in some reports exceeding the rate of death in white demographics. Recent reporting from *The Washington Post* suggests that the rates of opioid-related deaths have risen as much as 500% for Native Americans and Native Alaskans, and still, this fact garners little media attention.¹⁰⁴ The disparity in media coverage and attention is only compounded by disparities in access to high quality supports and treatment services for Native people dealing with opioid despair who are also living on under-resourced reservation land. This fact highlights the material dimensions of the various erasures that make possible the centering of white harm. Even as our statistical accounts of white harm in the opioid crisis seek to deeply contextualize and justify the suffering that predicates opioid dependency (i.e., unemployment, chronic pain, fractured belonging), we fail to attach those same narratives to the kinds of dispossession faced by Native communities for decades. That is to say, we can afford to turn attention to structural factors like economic dispossession when white communities are the objects of analysis. However, the language and narratives we have available to talk about harm in Native contexts lacks the same sophistication and nuance.

One exception is an in-depth report authored by the Pew Charitable Trust, which explores grassroots and Native-led efforts to combat opioid abuse in the Muckleshoot tribe in Washington State.¹⁰⁵ Working from the premise of proliferating intergenerational trauma in Native communities, this work situates the despair that leads to drug abuse in the Muckleshoot area within multiple modes of historical and institutional dispossession. Then, it draws an intimate portrait of the high quality medical and recovery supports that this more affluent (by comparison) tribe has been able to assemble in response to the localized impact of opioid death. This kind of nuanced and place-based portrait is, however, uncommon. The majority of available research on the deep impacts of opioids and other substances in Native contexts comes from academic and public health sources that continue to replicate clinical language and frameworks (i.e., epidemiology, etiology) at the expense of human-centric and ecologically oriented portraits of the complexities of suffering.¹⁰⁶ Even as some attention is granted to social and historical facts in this kind of research, it ultimately renders Native suffering as an abstract clinical problem requiring more institutionally led research to solve.

Another exception to the shortage of media reporting on non-white opioid-related deaths comes from a 2016 report by PBS' *Frontline* on the ways in which the "heroin epidemic" differs in communities of color. Crucially, however, this work does not draw primarily on statistical evidence of disparities in impact or on clinical or public health framings of the problem. Instead, the research begins and ends with interviews with community outreach workers from around the country who provide depth and context to the localized ways that opioid-related suffering manifests in their communities. Jacqueline Robarge is founder and director of the organization Power Inside, which is

based in Baltimore and works mainly with drug users who are black women. Robarge says, “Our job is to help those services really make it deep into the community. And if they aren’t going to arrive, we want to have an accounting that these people have been suffering for decades. It really is disingenuous if the resources are only going to be directed at the suburbs and the counties where, basically, the white folks are getting high.”¹⁰⁷ Robarge’s call for a different “accounting” of suffering in her local Baltimore community reflects the fact that the numbers that matter—the numbers we can count and the numbers off of which we mobilize resources—have never really shown up in the project of making life (and death) visible in urban Baltimore.

These two pieces that provide context and depth to the impact of opioids across primarily non-white communities and demographics crucially do not rely on statistical evidence to enliven landscapes of dispossession and suffering. Instead, these researchers go to on-the-ground sources who live, work, struggle, and recover in the places many researchers do not want to go to in order to glean better understandings of systems of harm and systems of care—of lived experiences of harm and lived experiences of care. In the increasingly data-driven fields of public health and medicine that are being mobilized *as* responsive agents in the opioid crisis, these kinds of perspectives and insights are flattened at best. Instead, the production of the opioid crisis through the lens of statistical evidence re-entrenches modes of tracking and anticipating harm that disproportionately extend visibility—and, necessarily, resources—to white populations. All the while, mechanisms for capturing and naming the ways in which drugs and overdose have marked non-white communities for death and disposability remain drastically untenable. An attention to mechanisms of counting, of making visible, and of representing the

presence of white pain and death demonstrates that the productivity of the crisis is not just discursive; it is also deeply invested in the production of new public health tools and administrative processes that make this uneven method of harm-capture even more pervasive.

VII. Conclusion

The current socio-political climate in the U.S. is once again concerning itself with the same out-of-paced-ness that Fanon astutely attributes to “the fact of blackness.” Yet today, the “falling behind” with which we concern ourselves has to do with the gradual awakening—at least in certain places—to the incremental losses that the supremacy of whiteness faces across myriad sectors in the U.S. Trump’s imperative to “Make America Great Again” indexes the many ways America has apparently been made “un-Great” through ongoing violations and infractions against protected—and quite nostalgic—understandings of what it means to be a human with power today. Trump’s blatant attacks on immigration and borders, queer, trans, and women’s issues, and the movement for Black Lives in the U.S. reflect mounting fear around who retains the power to define relations to a collective norm and “ordinary life” in the midst of increasingly loud and unapologetic calls for different kinds of mattering.¹⁰⁸

In this landscape, we must account for the political work of opioids if we want to imagine ourselves into different frameworks of mattering going forward. Opioid politics holds within itself so many of the visions and stories we are collectively telling and sharing about what hurts and why. It both sanctions and reveals as incoherent our prevailing logics of mattering, and it shows us what it looks like to turn towards certain

kinds of harm and away from others on a daily basis. In the process, we are highlighting over and over again the rules we must abide by in order to belong to the kinds of Greatness America has, supposedly, always labored for.

We are, then, at a pivotal moment in responding to the historically poisonous intersections of race and capital, which no doubt shape and inflect our understands of care and need. Given the weight of the baggage we carry, how can or should we respond to the “crisis” of opioids such that the response does not in fact replicate the burden of ordinary whiteness for those who have shouldered it for the longest—those whose pain still does not matter? We can already see the ways in which perceptions of loss and injury are creating opportunities for backlash from myriad sites of clinical power. “Perspective” pieces that pose rhetorical questions about how doctors “should” respond to the people who “really” hurt, much like the one published in June 2017 by Dr. Susan A. Glod in the *New England Journal of Medicine*, confirm that bodies of clinical power are not likely to give up their lucrative hold on despair any time soon.¹⁰⁹ That would, no doubt, result in a significant loss in profit for those systems who are invested in the many technologies of visioning that “see” and respond to racially differentiated patient populations using varied means.

And backlash isn’t related only to sites of clinical power, either. The political work of the opioid crisis is creating numerous fiscal opportunities for the servants of corporate science and politicians alike which are always already hard to resist. This is illustrated compellingly by the recent controversy over West Virginia Attorney General Patrick Morrisey’s Republican campaign for Senate.¹¹⁰ As West Virginia AG, Morrisey gained notoriety after his successful campaign to sue the DEA for allowing unchecked

and unregulated production of opioid pills over the past 15 years. Many expected his work battling opioid despair in the state to positively affect his chances in a U.S. Senate bid. However, opponents and the media at large quickly began calling Morrissey out for his personal history of pharmaceutical lobbying, as well as the fact that his wife was still employed as a lobbyist for one of the biggest pharmaceutical conglomerates in the nation—McKesson—during Morrissey’s various opioid-related lawsuits.¹¹¹ Rather than exceptional, this contradiction is, I suspect, endemic to what we will get if we stay invested in the same frameworks of mattering that have led us to where we are now.

Rather than insistently re-mobilizing our currently existing models of clinical mattering by ostensibly “pulling in” those who we see have been “left out” in the crucible of the opioid crisis, I want to suggest that we attend to the weight of the baggage directly. This means that as we collectively attempt to make sense of the possibility of opioid futures, public and private systems of “recovery” cannot replicate the same investments in racialized circuits of capital and the procedures of mattering that structure ordinary whiteness. In the next chapter, I turn attention towards the third keyword in this project – “Recovery” – in order to examine and attend to the many machinations of recuperation that attempt to shuttle bodies and communities out of the grasps of opioid despair. Recovery systems, I argue, must come to terms with both the racialized baggage of clinical power and the (bio)political work of ordinary whiteness if they expect to offer visions of the future that look like more than whiteness coming back to itself, finding new ways to re-cover its shameful past.

Notes to Chapter 2:

¹ For a full transcript of the conversation see Miller, Vitkovskaya, and Fischer-Baumt, “‘This deal will make me look terrible.’”

² Trump's Presidential Announcement Speech from June 2015 infamously refers to Mexico's migrating citizens as criminals and rapists. For a full transcript see, *Time* Staff, “Here's Donald Trump's Presidential Announcement Speech.”

³ Miller, Vitkovskaya, and Fischer-Baumt, “‘This deal will make me look terrible.’”

⁴ Perhaps, as Nieto suggests in the phone call, we should instead turn attention to the influx of illegal weapons imports from the U.S. which largely supply the violent work of the cartels. Miller, Vitkovskaya, and Fischer-Baumt, “‘This deal will make me look terrible.’”

⁵ Miller, Vitkovskaya, and Fischer-Baumt, “‘This deal will make me look terrible.’”

⁶ Trump's choice to focus the unacceptable vulnerability of the American *child* is particularly problematic following forced separation mandates at the U.S.-Mexico border, which he so enthusiastically touted throughout 2018. See Hennessy-Fiske, “Trump administration transfers hundreds of migrant children to border tent camp.”

⁷ U.S. Census Bureau, “Quick Facts: New Hampshire.”

⁸ The speech Trump delivered at the Republican National Convention in 2016 formally accepting his presidential nomination is a testament to his effective rhetorical leveraging of crisis. According to Trump, “Our convention occurs at a moment of crisis for our nation. The attacks on our police...Homicides...Illegal immigrants with criminal records...Our national debt...Our roads and bridges are falling apart. Terrorism of our cities threaten our very way of life. America is far less safe and the world is far less stable than when Obama made the decision to put Hillary Clinton in charge of America's foreign policy. This is the legacy of Hillary Clinton. Death, destruction, terrorism, and weakness. There can be no prosperity without law order. I am the law and order candidate. These are the forgotten men and women of our country. These are people who work hard but no longer have a voice. I am your voice.” *BBC*, “Donald Trump says US is in ‘moment of crisis.’”

⁹ What critical theorist Sara Ahmed calls an “ontology of insecurity,” may, in fact, be constitutive to the kinds of politics (racial and otherwise) the U.S. has historically engaged in, particularly around the anxious site of the border: “... the politics of fear is often narrated as a border anxiety,” Ahmed argues. “Fear speaks the language of ‘floods’ and ‘swamps’, of being invaded by the inappropriate others, against whom the nation must defend itself,” she continues. “We can reflect on the ontology of insecurity within the constitution of the political: it must be presumed that things are not secure, in and of themselves, in order to justify the imperative to *make something secure*...” Ahmed, *The Cultural Politics of Emotion*, 76.

¹⁰ Activists across the world, including the Movement for Black Lives in the U.S., continue to reveal and reject the veiled apparatuses of white supremacy that have been sealed into the American Dream. Recent BLM actions include supporting families of

color in the Cambridge, MA public school system who face ongoing racism from administration. This action reveals BLM's broad attention to expressions of systemic and institutional racism and confirms the organization's commitment to revealing the sites where racial violence has remained silenced and unnamed. Black Lives Matter, "Black Lives Matter Cambridge." Physical monuments to Great (White) Heroes continue to topple. The statue of J. Marion Sims referenced in Chapter 1, which occupied a site of prominence on the corner of Central Park and 103rd Street in Manhattan, was removed in April 2018 amidst cheering crowds. Lockhart, "New York just removed a statue of a surgeon who experimented on enslaved women." And the most recent demographic data from the U.S. Census predicts that the U.S. will no doubt become "minority white" by 2045. Frey, "The US will become 'minority white' in 2045, Census projects."

¹¹ Gilmore, "Fatal Couplings of Power and Difference," 16.

¹² According to the National Institute on Drug Abuse's analysis of the most recent CDC data, there were more than 72,000 fatal drug overdoses in 2018. 49,068 of those are attributed directly to opioids (a combination of prescription, synthetic/non-prescribed, and heroin), and NIDA projected a 4.1-fold increase in opioid-related deaths in 2018 as compared to similar data from 2002-2017. National Institute on Drug Abuse, "Overdose Death Rates."

¹³ CDC, "Data Overview."

¹⁴ CDC, "Opioid Overdose."

¹⁵ Cited in Nolan and Amico, "How Bad is the Opioid Epidemic?"

¹⁶ CDC, "Data Overview."

¹⁷ Freyer, "Is the opioid epidemic easing in Mass.?"

¹⁸ This statistic in particular says much about the flattening of racial difference in most mainstream reports of the opioid crisis. Ultimately, it begs the question of how (and why) this statistic might look different if the group examined was black men or black women only. Katz, "Drug Deaths in America Are Rising Faster Than Ever."

¹⁹ Dowell, Arias, and Kochanek, "Contribution of Opioid-Involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015."

²⁰ Frey, "The US will become 'minority white' in 2045, Census projects."

²¹ CDC, "Opioid Overdose."

²² CDC, "Opioid Overdose."

²³ Race-specific interpretation of the data seems to have been eliminated in the CDC's most recent update to the "Opioid Overdose" site, perhaps gesturing towards the impact of popular critique on the presumed white-washing of opioid overdose and death coverage. However, the same information is cited in Scott, "Native Americans, among the most harmed by the opioid epidemic" and Nolan and Amico, "How Bad is the Opioid Epidemic?"

²⁴ Take, for example, two cities in Wisconsin—Milwaukee and Madison. Both face devastatingly high opioid-related fatalities within black communities, but rarely receive national attention as a visible "site" of the crisis. For a perspective on the opioid crisis local to Wisconsin's black communities, see Dahmer, "Town Hall Tonight Will Address Surging Opioid Crisis in Black Community."

²⁵ This is particularly relevant to tracking differential state responses to the crisis of opioids and what has come to be known as the "crack epidemic," another ostensible "crisis" that generated very different popular and public health responses, presumably

because of its perceived entrenchment in poor black and Latino communities in the U.S. in the 1980s. See Reinerman and Levine, “Crack in the Rearview Mirror” for a critical reading of the punitive policy effects of the crack epidemic, particularly in the explosive rise in rates of incarceration for blacks and Latinos upon the state’s mobilized “response” to the threat of crack. “The new laws against crack,” Reinerman and Levine remind us, “helped to drive the most massive wave of imprisonment in the history of the United States. The number of persons incarcerated increased each year from 1986 through 2000, helping to triple the prison population and giving the U.S. the highest rate of incarceration in any modern democracy. The numbers of drug offenders in prison grew eightfold, from about 50,000 in the early Reagan years to about 400,000 at the start of the Bush administration. This bulging prison population was disproportionately comprised of poor people of color, most of whom had not committed violent crimes.” Reinerman and Levine, “Crack in the Rearview Mirror,” 183.

²⁶ Omi and Winant, *Racial Formation*, 55.

²⁷ Lipsitz, “The Possessive Investment in Whiteness,” 369.

²⁸ Lipsitz, “The Possessive Investment in Whiteness,” 369.

²⁹ Lipsitz, “The Possessive Investment in Whiteness,” 370.

³⁰ Lipsitz, “The Possessive Investment in Whiteness,” 370.

³¹ The #SayHerName hashtag has regularly trended on social media platforms since its inception in February 2015. The hashtag intends to reveal the intersectional harms faced by black women in relation to police violence specifically and anti-black violence more broadly. This movement is a powerful demonstration of the ongoing labor of making speakable the many kinds of harms that have traditionally gone unspoken in systems governed through white supremacy and racial capitalism. See Kanya Bennett, Legislative Counsel at the ACLU’s Washington Legislative Office writing about “Say Her Name” for more specific engagement with #SayHerName as survival tactic.

³² DiAngelo, “White Fragility,” 54.

³³ DiAngelo, “White Fragility,” 56

³⁴ DiAngelo, “White Fragility,” 58

³⁵ Berlant, *Cruel Optimism*, 10.

³⁶ Berlant, *Cruel Optimism*, 2.

³⁷ Alcoff, *The Future of Whiteness*, 10.

³⁸ John F. Kelly was then serving as newly-appointed Secretary of Homeland Security; he currently serves—rather contentiously—as Trump’s Chief of Staff.

³⁹ Miller, Vitkovskaya, and Fischer-Baumt, ““This deal will make me look terrible.””

⁴⁰ Spillers, “Mama’s Baby, Papa’s Maybe,” 65.

⁴¹ Berlant, *Cruel Optimism*, 10.

⁴² Alcoff, *The Future of Whiteness*, 1.

⁴³ Berlant, *Cruel Optimism*, 10.

⁴⁴ This same data set tells us that 1.6% of the population self-reported as Black or African American, alone; 2.8% reported as Asian, alone; 0.3% reported as American Indian and Alaska native, alone; and 3.7% reported as Hispanic or Latino. U.S. Census Bureau, “Quick Facts: New Hampshire.”

⁴⁵ New Hampshire tells the story of its own history clearly in these terms. According to a brief written by R. Stuart Wallace, former director of New Hampshire’s Division of Historical Resources, the “history” of New Hampshire begins not with the 12,000 years

of continuous indigenous occupation of the land (they didn't have any written language, we don't know much about it, he says), but with burgeoning European interest in extracting myriad natural resources from the land beginning in 1500. "Throughout the 1600s," Wallace posits, "people in New Hampshire made their living through a combination of fishing, farming, cutting and sawing timber, shipbuilding, and costal trade. By the first quarter of the 1700s, the provincial capital of Portsmouth had become a thriving port, exporting timber products and importing everything from food to European finery. As the population grew, the original four towns subdivided into towns of smaller areas." Wallace, "New Hampshire History in Brief." As commercial farming became less able to compete with Midwest agriculture in the mid-1800s, New Hampshire secured railroad access and plugged into a thriving network of logging exports. Here we can see some of the historical ways in which whiteness in New Hampshire—indexed historically as "European"—has operated as a kind of guarantee to the unfettered extraction of the region's natural and human resources. It is, as this narrative tells us, almost a birth right. Although this is also the case across many geographies of colonial New England, New Hampshire's clearly white-dominated demography shows us some of the ways in which those historical legacies may contribute to a larger sense of "belonging" to the "right" fold of the nation's history. For more on white entitlements to belonging on settled land see Chapter 3 and my work on legacies of indigenous genocide in Franklin County, MA.

⁴⁶ For a complete transcript of Trump's speech, see *Boston Globe*, "Read a transcript of Trump's remarks in N.H."

⁴⁷ *Boston Globe*, "Read a transcript of Trump's remarks in N.H."

⁴⁸ *Boston Globe*, "Read a transcript of Trump's remarks in N.H."

⁴⁹ *Boston Globe*, "Read a transcript of Trump's remarks in N.H."

⁵⁰ Lipsitz, "A Possessive Investment in Whiteness," 371.

⁵¹ Lipsitz, "A Possessive Investment in Whiteness," 372.

⁵² Lipsitz, "A Possessive Investment in Whiteness," 372. Lipsitz further cites concrete examples of policies and practices that have served to widen the race-based gap in accessing resources, including the New Deal's Wagner Act and Social Security Act, which excluded farm workers and domestics from coverage; the race-based mortgage exclusions written into the Federal Housing Act of 1934 which barred most black people from accessing federally backed mortgages; and the fact that in urban Houston, "more than 75 percent of municipal garage incinerators and 100 percent of the city-owned garbage dumps are located in black neighborhoods" (375).

⁵³ Lipsitz, "A Possessive Investment in Whiteness," 383.

⁵⁴ Gilmore, "Fatal Couplings," 15.

⁵⁵ Katz, "Drug Deaths in America Are Rising Faster Than Ever."

⁵⁶ Eyre, "Opioid crisis drives a grim business in WV."

⁵⁷ Smith, "De-Gradations of Whiteness," 44.

⁵⁸ Stoll, *Ramp Hollow*, 7.

⁵⁹ Bowen, et al. "An Overview of the Coal Economy in Appalachia," 4.

⁶⁰ Bowen, et al. "An Overview of the Coal Economy in Appalachia," 4.

⁶¹ Bowen, et al. "An Overview of the Coal Economy in Appalachia," 5.

⁶² Freydl, "The Oxy Electorate."

⁶³ Smith, "De-Gradations of Whiteness," 43.

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- ⁶⁴ The wealth of critical (and not-so-critical) work on the mixed-race category of “melungeon” gestures towards the anxiety of boundary policing in Appalachia. For more on the racial history of melungeon and its tensional relations to categories of blackness, whiteness, and indigeneity, see Puckett, “The Melungeon Identity Movement and the Construction of Appalachian Whiteness” and Everett, “Melungeon History and Myth.”
- ⁶⁵ Kliff, “The opioid crisis changed how doctors think about pain.”
- ⁶⁶ Kliff, “The opioid crisis changed how doctors think about pain.”
- ⁶⁷ Case and Deaton, “Mortality and morbidity in the 21st century.”
- ⁶⁸ One more line of investigation for this section, or after this section, is the politics of corporate-scientific knowledge production using Klein’s concept of corporatist politics in *The Shock Doctrine*. There, Klein argues that corporatist politics which are politics that facilitate the transfer of public wealth to private hands. Klein, *The Shock Doctrine*, 15. This concept resonates interestingly with the increasing critical attention to the ways in which scientific research and knowledge production is increasingly directed and shaped by corporate interests, particularly at public universities. See McHenry, “Biomedical Research and Corporate Interests.”
- ⁶⁹ Clough and Willse, “Introduction: Beyond Biopolitics,” 8.
- ⁷⁰ Eyre, “780M pills, 1,728 deaths.”
- ⁷¹ The other two pieces in the Pulitzer series are Eyre, “Pill Rules Not Enforced” and Eyre, “Drug firms fueled ‘pill mills’ in rural W.Va.”
- ⁷² Eyre, “780M pills, 1,728 deaths.”
- ⁷³ Eyre, “780M pills, 1,728 deaths.”
- ⁷⁴ Eyre, “780M pills, 1,728 deaths.”
- ⁷⁵ Eyre, “780M pills, 1,728 deaths.”
- ⁷⁶ Emphasis mine. Melamed, “The Spirit of Neoliberalism,” 2.
- ⁷⁷ I found DeWall’s work through Allison Aubrey’s December 2017 piece for NPR, “Tylenol May Help Ease The Pain Of Hurt Feelings.”
- ⁷⁸ DeWall, et al., “Acetaminophen reduces social pain.”
- ⁷⁹ Cited in Aubrey, “Tylenol May Help Ease The Pain Of Hurt Feelings.”
- ⁸⁰ Melamed, *Racial Capitalism*, 77.
- ⁸¹ Emphasis mine. Melamed, *Racial Capitalism*, 77.
- ⁸² Gilmore, *Golden Gulag*, 28.
- ⁸³ Goldberg, *The Threat of Race*, 27.
- ⁸⁴ Melamed, “Racial Capitalism,” 78.
- ⁸⁵ Melamed, “Racial Capitalism,” 79.
- ⁸⁶ Foucault, *Society Must Be Defended*, 242.
- ⁸⁷ Foucault, *Society Must Be Defended*, 243.
- ⁸⁸ Foucault, *Society Must Be Defended*, 243.
- ⁸⁹ Foucault, *Society Must Be Defended*, 247.
- ⁹⁰ Clough, “Rethinking Race, Calculation, Quantification, and Measure,” 437.
- ⁹¹ Clough, “Rethinking Race, Calculation, Quantification, and Measure,” 437.
- ⁹² Clough, “Rethinking Race, Calculation, Quantification, and Measure,” 437.
- ⁹³ Clough, “Rethinking Race, Calculation, Quantification, and Measure,” 437.
- ⁹⁴ Foucault, *Society Must Be Defended*, 244.
- ⁹⁵ Clough, “Rethinking Race, Calculation, Quantification, and Measure,” 435.
- ⁹⁶ Henning, “Overview of Syndromic Surveillance.”

⁹⁷ Clough, Clough, “Rethinking Race, Calculation, Quantification, and Measure,” 435. Citing Hansen, *Feed-Forward*.

⁹⁸ International Society for Disease Surveillance, “Electronic Syndromic Surveillance,” 18.

⁹⁹ Recent updates to this program are described at Centers for Medicare & Medicaid Services, “Promoting Interoperability.” According to the memo, “The Centers for Medicare & Medicaid Services (CMS) is dedicated to improving interoperability and patients’ access to health information. To better reflect this focus, we’ve renamed the EHR Incentive Programs to the Promoting Interoperability (PI) Programs. Through this rulemaking, we are also streamlining the programs to reduce the time and cost required of providers to participate. Stay tuned for more information.” Hopefully this means the agency is intentionally seeking to address community disparities in clinical access to such a tool.

¹⁰⁰ International Society for Disease Surveillance, “Electronic Syndromic Surveillance.”

¹⁰¹ Henning, “Overview of Syndromic Surveillance.”

¹⁰² Rowse and Shellam, “The colonial emergence of a statistical imaginary,” 927.

¹⁰³ Cited in Nolan and Amico, “How Bad is the Opioid Epidemic?”

¹⁰⁴ Scott, “Native Americans, among the most harmed by the opioid epidemic.”

¹⁰⁵ Vestal, “Fighting Opioid Abuse in Indian Country.”

¹⁰⁶ For a relevant example, see Whitesell, et al., “Epidemiology and Etiology of Substance Use among American Indians and Alaska Natives,” which is cited in the Pew article.

¹⁰⁷ Childress, “How the Heroin Epidemic Differs in Communities of Color.”

¹⁰⁸ Boyer, “Trump takes aim at Black Lives Matter.”

¹⁰⁹ Glod, “The Other Victims of the Opioid Epidemic.”

¹¹⁰ Morrissey lost the November 2018 Senate mid-term election race to the Democratic incumbent, Joe Manchin. WSAZ News Staff, “Manchin beats Morrissey to keep U.S. Senate seat.”

¹¹¹ Zuckerman, “Pharma industry fueling Morrissey’s US Senate campaign.”

CHAPTER 3:

Re-Rooting the Cut: Making and Un-Making Recovery Ecologies in Franklin County, MA

I. Gifts of Treatment, Gifts of Rage

On the night of Tuesday, February 8, 2017, Daniel Dowd delivered himself to the lobby of the brand-new Franklin Recovery Center in Greenfield, Massachusetts and promptly extinguished his own life with two bullets to the head. According to a letter discovered by law enforcement at the time of the suicide, the 63-year-old man intended to present his dead body as a self-proclaimed “gift” to Nancy, the head nurse of Franklin Recovery Center (FRC).¹ In the letter, which Dowd calls his “swan song,” he alleges that Nancy had twice “kicked him out” of the clinical in-take process at FRC over the previous two days, citing that Dowd had the “wrong insurance” to access the detox services that he sought for his addiction to alcohol. “She spoke with invectives,” Dowd writes in his suicide note about the second time that an administrator allegedly made him leave the FRC—or what locals simply refer to as “the new detox.” “She was adamant. She called me names....,” Dowd says, “...so I left meekly, tail between my legs, beat down. Injured in my emotions by a cruel human named Nancy.”² In addition to self-identifying as an alcoholic, we know that Dowd was also a veteran. He was disabled. He regularly experienced the dizzying effects of military service-connected PTSD. By all accounts, he was struggling. And regardless of the particular state of his wellbeing on the night of his very public suicide, it seems that by the end of his life, Dowd was ready and willing to offer up his own broken body as material evidence of the gross failures that comprise the “treatment” systems we continue to rely upon in the aftermath of the opioid crisis, even as they reproduce many of the same harms they purport to treat.

Upon his death, Dowd's suicide letter quickly began circulating on social media. It generated passionate expressions of anger and outrage from local Franklin County residents, many of whom had also been waiting through over 6 months of unexplained delays for the doors of the new detox and stabilization units to open.³ Over the two years prior to the FRC's opening in May 2017, the facility had been praised as an imminent beacon of hope by local and regional judges, law enforcement officials, health care administrators, and direct service workers alike. It would be the only medically supported detox facility of its kind in the poorest and most rural county in Massachusetts. The "old detox," which had been located on its own campus at the local hospital, permanently shuttered its doors in 2001. Given all that had been invested in the "new detox"—emotionally, fiscally, clinically—the suicide was particularly jarring to those who saw it as a long-overdue rejoinder to the rising tide of opioid despair that continues to wash across northwestern Massachusetts and southern Vermont, just as it washes over so many other regions similarly engaged in decades-long processes of de-industrial transition.

The explicit rage and resentment contained in Dowd's letter also resonated with the many people outside of this small, once-bustling industrial New England city who liked, shared, and commented on the Facebook post that Dowd's friends used to circulate his final words. It seems there was something deeply familiar about the specific kind of body-centered hopelessness that Dowd ostensibly felt prior to his death. Although his was not an opioid despair, per say, it was a kind of despair that was similarly held and nourished and identified in his increasingly decapacitated body: "You can have my body which I delivered here for healing, and I'll be done with it," Dowd states at the end of his suicide note. "My body is now yours."⁴ Here, the unacceptable weight of having a body

that is no longer useful or productive—a body that can no longer be recuperated into something of value, or at least into something worth living for—is palpable. In an effort to prove his deservability, Dowd describes his own treatment-seeking body as, “docile and supple asking for help,” effectively demonstrating an identification with and performance of the “right role” of patient in clinical systems that tell us we must embody certain kinds of vulnerabilities in order to receive the “gift” of treatment. And yet, even as Dowd attempted to take “right responsibility” for his own cycles of harm by tapping into the tools that he had been encouraged to use by friends, family, and the doctors he trusted, he was *still* prevented from accessing that standard of care due, at least in part, to the gatekeeping mechanisms of health insurance access and the discerning judgements of clinical and administrative staff. That’s a burden, Dowd seems to say, that should not be shouldered alone.

In the online life of Dowd’s letter, military veterans in particular boosted his story, highlighting the sacrifices Dowd had made for his country during his Navy service at Guantanamo Bay and the ludicrousness of being unable to access life-sustaining care in the aftermath of those sacrifices.⁵ Dowd’s own words confirm that same outrage at being denied entry into the protective realm of clinical treatment by detox administrators, even though Dowd ostensibly served—and became disabled—to protect *their* lives: “Those people at the Greenfield detox are pure evil,” Dowd writes. “I depart raising my middle finger. This veteran wonders why I served to protect them.”⁶ For the many who responded to the news of Dowd’s public suicide in the detox lobby, there was, it seems, also a kind of collective (and largely white) identification with the pain of compromised access—to space, to care, to empathy and compassion. The quick administrative

dismissal of Dowd's pain—by a woman, no less—ostensibly confirms for Dowd and for the many commenters on his suicide note, that even when we have labored on behalf of certain “right” visions of American Greatness for our whole lives—even when we have given *our whole body* to some mythic version of American Greatness—that body *still* may not be enough to secure for itself a tenable future in the contemporary moment.⁷ Dowd's actions—and the public's response to them— evoke a quite productive (and lucrative) disconnect between long-nurtured promises of clinically-assured re-capacitation and recovery for some and the grim reality of continuous, unaccounted for unraveling for the many who have been taught to trust that they can and will be protected from such harms.

On the surface, Dowd's very public suicide makes evident the continuous breakdowns—in one's own body, in one's ties community, in institutional promises of recovery—that are fed as we invest post-opioid crisis futures into the same curative and economic structures that delivered us to the point of crisis in the first place. Top-down, insurance-driven systems of care will never make us less sick, as Dowd's death certifies, and they will never deliver us in moments of crisis towards the possibility of something different in the aftermath. Rather, they will only ever re-consolidate the fiscal and evaluative logics of mattering through which clinical power has fed on and been capacitated by over the past 150 years. Despite some affiliations with certain markers of entitlement (ordinary whiteness, for one), Dowd did not make the cut, and that hurt. However, in looking beyond the catastrophes endemic to clinical mattering, Dowd's rage—and the compromised sense of entitlement he shared with so many who responded to his story online—can likewise tell us something crucial about the ongoing wrench of

yet another brand of American Greatness—American Industrial Greatness—in the resourcing, structuring, and production of post-opioid recovery futures in the U.S. today. Crucial to telling that story is the fact that the “new detox” in which Dowd committed suicide was—perhaps unsurprisingly—carved out of the decaying and quite toxified remains of the old Lunt Silversmiths factory on Federal Street in Greenfield. The Lunt works was one of many such properties in Franklin County that once put locals to work churning out commodities like silverware and fine sterling in endless cycles of industrial production. Today, its future has been re-visioned, and now the property puts locals to work churning out half treated bodies of opioid despair and tenuous promises of clinical salvation in endless cycles of de-industrial re-production.

In mobilizing the apparent paradox of toxic-factory-cum-detox-factory, this chapter seeks to explore how and why a human detox factory is no better than a toxic silverware factory for re-visioning right relations to ourselves and to the places we live in the aftermath of the opioid crisis. Put another way, in exploring the connections between post-opioid recovery futures and post-industrial recovery landscapes, I seek to show the lucrative re-entrenchments (of capital, of whiteness, of life-as-we’ve-known-it) that are unfolding in geographies of de-industrial despair as the work of recovering from the contemporary crisis of white opioid despair in the U.S. is increasingly grafted on to the work of “recovering” former sites and spaces of American Industrial Greatness. As the previous two chapters have explored, formations of ordinary whiteness have both been produced by and are complicit in the many fictions of Greatness that feed narratives and visions of white supremacy (or, at least, white capacity) in the U.S. American Medical Greatness (Chapter 1) and American Military Greatness (Chapter 2) are only two such

arms of a many-armed beast that has been mobilized over and over again to securitize the norms of ordinary white belonging throughout U.S. history, particularly in moments of cultivated crisis.

In exploring a third vision of American Greatness—American Industrial Greatness—this chapter poses a series of questions about the conditions and visions that will be necessary for producing futures otherwise in the aftermath of the opioid crisis: what, I ask, are the implicit connections between civic imperatives to “rehab” crumbling industrial infrastructure and public health imperatives to “rehab” the many bodies of despair that are likewise deeply concerning—an emergency, even—to publics of ordinary whiteness? How are exercises of clinical power—both non-profit and for-profit—complicit in the continued extraction of surplus labor from the site of the factory as it shifts to a site of “recovery”? And, most importantly, what opportunities are being *lost* in our post-opioid recovery responses as we continuously fail to recognize that the same deeply injurative structures of extractive capitalism that once fed fantasies of endless capacitation in the deployment of American Industrial Greatness are simply being re-routed back into the “revolving door” of clinical treatment and recovery under the guise of something new?

Franklin County, the site of Dowd’s suicide, is a place like so many others (New Hampshire and West Virginia alike) where the labors of remediating crises of opioid despair are deeply enmeshed with the labors of remediating crises in ordinary whiteness.⁸ As Franklin County and surrounding geographies turn to address the crisis of opioid despair using the might of any tools deemed necessary, we can begin to track the emergence of lucrative opportunities for the few who hold—and who have historically

held—the means of production (and construction) here. Those opportunities center around making civic sense of long-since-useful infrastructures of local industrial manufacturing that once promised (some) residents unfettered access to the spoils of American Greatness—upward mobility, endless productivity, bottomless resourcing, assured individualism, claims to continuous re-capacitation. In order to develop a future vision of post-opioid recovery worldmaking that does not simply re-entrench the mythic—and violent—conditions of ordinary whiteness, I argue that we must necessarily divest from the reproduction of clinical “treatment” systems that have been designed quite explicitly in the image of the factory and in the false promises of endless re-capacitation that have been produced and reproduced there. Clinical divestment must necessarily put distance between the labor of care and the deeply rooted and lucrative attachments to the extraction of profit from bodies and sites of harm—attachments which no doubt remain unnamed in the hopeful production of opioid-futures. Only by making those divestments will we be able to move beyond the endemic need for continuous replenishment of populations of harm, which no doubt securitize streams of profit and racially differentiated entitlements to treatment that are embedded in contemporary political economies of care under the guise of treatment and recovery.

Developing praxes of clinical divestment are necessary if we are ever to understand “recovery” in the aftermath of the opioid crisis as something other than an individual, one-time, contingent investment in rehabilitating an individual body’s capacity to “matter” in clinical-capitalist frameworks of worth. Instead, by making evident and then divesting from the extractive conditions of the recovery-factory nexus, we can begin to understand the work of post-opioid recovery world-making as something

quite a bit more collective and, dare I say, radical: “recovery” as world re-making in the image of what’s been disavowed. This formulation of post-opioid recovery futures posits the labor of recovery not as an individualized, neoliberal project of endless return, but rather as a cross-community commitment to making evident past harms (personal, historical, ecological) and then actively re-rooting into—rather than extracting from—the local ecologies that will sustain us once more *if* we finally turn towards them with reparation rather than extraction in mind. Franklin County is a unique place to undertake this kind of inquiry because it already contains the seeds of a different kind of recovery world-making—one where the collective work of re-rooting to place is well under way alongside the labor of fortifying “new” clinical-curative structures.

On the one hand, we have the FRC—the “new detox”—the place where agents of clinical power (clinical administrators, nursing staff, agency public relations workers) continue to enfold bodies into the drama of institutional management based on systems of contingency: right insurance, right conduct, right blood pressure, right personal transportation to the site of care. Dowd’s suicide no doubt tells us much about the kinds of clashes that occur as people who have been taught to anticipate their own exceptionality within such contingencies are increasingly expunged from the historically-ensured protections of ordinary whiteness. We also have the RECOVER Project (RP)—a peer-to-peer recovery community that formed at the grassroots level just after the “old detox” closed in Greenfield in 2001. Although I spend the bulk of this chapter attending to the tensions and legacies embedded within the “new detox,” I return to the RP in the Coda to more fully explore what post-opioid recovery futures can look like as we divest from clinical power and turn to the vital registers of ecology, alternative healing

modalities, and collaborative world-making practices outside of state structures and systems.

I begin the work of this chapter by more fully exploring the tense yet vital intersections of factory-pasts and recovery-futures in Franklin County. In attempting to name and historicize the fortification of ordinary whiteness as a structure here, I look first at the “local” history of Franklin County in order to locate and frame what I call the “raw materials of Greatness” in this region—17th century settler colonial entitlements to indigenous land, bodies, and resources. Settler colonial studies scholars Jean M. O’Brien and Patrick Wolfe help to contextualize some of the ways in which white settler genociding and subsequent extraction of the natural resources of Franklin County in the 17th and 18th centuries no doubt the laid structural groundwork for white investments in and horded claims to the spoils of American Industrial Greatness later on. Attention to the specific settler colonial economies of silver and silversmithing, which took root and grew in Franklin County in the early periods of colonization, likewise demonstrates the kinds of historical relations to natural resources, cultural value, and labor that propped up the elaboration of extractive capitalism in the region.

In the next section, I take the colonial history of Franklin County’s industry forward by working to show how early settler colonial disavowal of their own exercises of violence in consolidating resources and power in Franklin County no doubt forged the conditions of possibility for the ascendancy of ordinary “working class” whiteness in the region. Lunt Silversmiths is significant here because in many ways, the silver factory-cum-detox factory carries within itself the uncomfortable story of the rise and fall of ordinary whiteness as it has been forged in and through nostalgic visions of industrial

capacitation, both in this specific region of northwestern Massachusetts and across the U.S. more broadly. Knowing and coming to clear terms with that story is necessary for making sense of where, how, and why we are mobilizing particular nostalgic attachments and particular streams of resourcing to re-invest in particular sites of de-industrial decay in response to the many crises of opioid despair that bloom in post-industrial landscapes across the U.S. DuBois' treatise on the "White Worker" in *Black Reconstruction* and Roedinger's *Wages of Whiteness* likewise begin to unpack some of the historical details that shape why post-opioid recovery futures must necessarily divest from factory-based profit streams that fortified them in the first place. In first re-routing the question of recovery futures and recovery world-making directly into the historical and ecological specificity of this place, we can begin to clearly locate and name the colonizing roots of "treatment" systems that wrap and wind around the crumbling remains of brick and mortar factory buildings which rose to Greatness on the backs of so much disavowed harm.

Drawing on this critical worker history of whiteness in Franklin County, I then turn to the last period of true "Greatness" at Lunt Silversmiths—the World War II period—to track the ways in which the emergence of a nascent military-industrial complex in Franklin County drafted white workers into the labor of preserving and resourcing ordinary whiteness as a strategy of both national security and profit making. By looking at the entrenchment of weapons manufacturer Raytheon inside the Lunt works, we can begin to notice the ways in which factory logics coalesce in the exceptionality of white lives as Franklin County laborers go to work producing the

components of weapons of mass destruction and then quickly forget the project ever existed in the region.

In the last section, I turn back towards the contemporary fortification of the Lunt factory as a site of recovery-future making by examining its cumulative toxicity and the kinds of punitive frameworks and logics from which administrators and staff vision this site of clinical opioid treatment. In attending not only to the many lucrative partnerships and civic “rehabblings” that unfolded on the eve of the opioid crisis in Greenfield, this section ultimately works to show how post-opioid recovery futures are being re-made in the historical image of ordinary whiteness itself in Franklin County. This re-making is, as I will show, part of the larger implication of the non-profit industrial complex in securitizing a constant “industry of fear” and a constant stream of populations of harm in order to re-wealth and re-sustain the agents of extractive capitalism that supposedly carry out the work of recovery.

In the conclusion, I turn back to Daniel Dowd’s spectacular suicide at the doors of the Franklin Recovery Center to summarize the processes of accounting undertaken here. Dowd’s very public self-narrated suicide illuminates some of what can happen as the evaluative logics of deservability (i.e., do you act right?) and profitability (i.e., can you pay right?) collide to bar those who should, by all accounts, “deserve” entrance. In the process, the figure of Daniel Dowd helps to highlight the many kinds of quieter deaths that unfold as folks are turned away from that which has been promised will save them.

II. Historicizing the Structure of Ordinary Whiteness in Franklin County

Troubling the Raw Materials of Greatness: Settler Colonial Genociding and Silvering

Franklin Recovery Center—the site of the cut for Daniel Dowd—is, as we now know, housed within the old Lunt Silversmiths factory complex on Federal Street in Greenfield. Lunt Silversmiths operated in Greenfield—a once-robust industrial mini-city and county seat of government here—from paterfamilias George C. Lunt’s much-celebrated acquisition of the property in 1902 up until the Lunt family’s corporate bankruptcy and sale of the business to a competitor in 2009.⁹ The factory property and commercial business had been in the Lunt family for over a century by that point, illustrating only some of the deep ties the Lunt works and its owners had to the tenor of everyday life in Franklin County, both historically and contemporarily. At the time of the company’s bankruptcy, the President of the company was James H. Lunt, a direct family descendent of the factory’s founder. Although James H. Lunt effectively coordinated a short sale of his family’s business as part of the bankruptcy proceedings, the deed to the factory buildings and surrounding land went to the Town of Greenfield as payment for the several hundred thousand dollars in unpaid back taxes and water bills that the corporation owed to the Town following its post-recession collapse.¹⁰ Although the Lunt factory once existed in Greenfield as a striking emblem of American Industrial Greatness that no doubt attested to the strength and productivity of white working class labor in this region, by 2009 it was on its way to becoming something else entirely as it sat vacant, largely abandoned to decay. Much like other uncomfortable sites of de-industrial transition that exist here and in communities of ordinary whiteness across the U.S.—the storefront-cum-methadone-clinic, the neighborhood grammar school-cum-public-

housing-complex—the Lunt factory would begin to evoke for some long-term (white) residents nostalgic attachments to what was once-upon-a-time both ordinary and robust in this region and, perhaps more importantly, painful reminders of why and how the loss of that sure strength hurts so badly today.

But what exactly are the “lost” histories and severed attachments to the Industrial Greatness of Lunt that have been so mourned by Franklin County residents since the silver factory went to bed for the last time in 2009? And how might a reconsideration of those histories and attachments today make further palpable the false visions of (white) re-capacitation that are no doubt embedded in the resurrection of the factory’s bones once more, almost a decade later? To begin with, the industrial history of the Lunt works in Greenfield mirrors the industrial histories of so many of the other major sites of manufacturing across southern New England. These formidable sites no doubt rose from the ashes of the relentless colonial genociding of local indigenous populations throughout the 17th and 18th centuries and the subsequently relentless mining and extraction of the natural environment that followed the forced removals and exterminations of those who originally dwelled here. “United States colonialism,” Alyosha Goldstein astutely reminds us, “is a continuously failing—or at least perpetually incomplete—project that labors to find a workable means of resolution to sustain its logic of possession and inevitability by disavowing the ongoing contestation with which it is confronted and violent displacement that it demands.”¹¹ In heeding Goldstein’s call to attend to the constitutive disavowals of U.S. colonialism and to see those disavowals as necessary to sustaining *fantasies* of resolution, then, we must first return to the quite bloody origins of colonial possession (and dispossession) in Franklin County in order to imagine the story of the future. Doing

so further illuminates the logics of colonial disavowal that preceded the historical fortification of ordinary whiteness as a kind of industrial investment in the region. Tracking the fortification of Lunt as a local emblem of American Industrial Greatness through its largely disavowed connections to historical and ongoing exercises of death and injury ultimately shows us quite plainly what we're re-investing in today as we put historical sites steeped in the imaginative fortitude of capitalist extraction back to "good use" in our visions of re-capacitated post-opioid recovery futures.

The industrial history of Lunt is, as it turns out, just as violent and injurious as the history of Franklin County itself. The land which now comprises Franklin County was carved into its current formation through what is now known as King Philip's War, a bloody, 3-years long struggle (1676-78) that pitted British colonizers against local indigenous communities not only in the struggle for autonomous governance, but also for control over the strategic rivers and connective waterways of the region which would feed the growth of both capital development and accumulation.¹² Thinking the history of Lunt from within this colonial genealogy reminds us of some of the ways in which current infrastructure, ecology, and family wealth retain direct ties to the violences of displacement that preceded the rise of industry in this region.

By the time George C. Lunt acquired the Lunt works with two other local investors at the turn of the 20th century, the silversmithing business that was housed therein had already been a working metal shop in Greenfield for over 200 years.¹³ At that point, the company's roots were directly linked to gains made in the first "wave" of European colonization in New England in the early 17th century. The company from which Lunt purchased the works, A.F. Towle & Sons, rose to notoriety in the early 17th

century in the British settler colony of Newburyport, Massachusetts, which was first settled in 1635 as the Newberry Plantation.¹⁴ The Moulton family, which still lays claim to the title of longest continuously silversmithing family in America, carried the silvering tradition from Britain to the Massachusetts Bay colony, where descendants spread out across New England, set up shop, and established several lineages of the craft.¹⁵ Today, as we attend to the early colonial practices and ideologies of silvering in the region, we can open up larger understandings of the ways in which white entitlement to the land and other natural resources here was both resolved and justified in and through the elaboration of silver mining, extraction, and, eventually, manufacturing.

At the time of the settling of the Massachusetts Bay colony, silver was considered a highly precious metal and silver-working a particularly prestigious craft by European colonizers. Local silver mines would not be discovered in the Massachusetts area until the mid-19th century.¹⁶ As such, early colonial silver-workers had to rely on either melting down old silver coins and wares brought from Europe or on importing the raw material from other sites of colonial extraction around the world, including Mexico and Peru.¹⁷ White colonizers in those places largely relied on indigenous slave labor to do the extremely dangerous work of mining and extraction. In collaboration with the early titans of New England industry, they created new circuits of expropriation that linked up the forced removal of indigenous communities in early New England directly to the forced removal and enslavement of indigenous populations in the global south. In the process, silver became not only an emblem of increasingly fortified colonial trade and manufacturing routes, but also a kind of fetish object for settlers that communicated

purity, Godliness, and the triumph of colonial extraction. According to historian Richard Bushman, who writes for the Massachusetts Colonial Society:

Silver mediated between the high holiness of Christ's atoning body and the bodies of the communicants who accepted the tokens of his death into their mouths. Gleaming on the communion table, or raised to the lips, silver was the preferred material for approaching God. If the streets of heaven were paved with gold, silver was the earthly avenue to heaven's gates. In New England, no material was more sanctified, more dedicated, or more intimate with divinity.¹⁸

Here, we get a sense of the psychic, emotional, and even spiritual investments that were made in silver by early colonists and a sense of the kinds of attachments—to divinity, to class ascendancy, to the sublime beauty of the commodity—that those investments forged. In likewise making evident the violent paradoxes that constituted the early fetishization of silver in New England, Bushman suggests that, “like much of genteel existence, silver was a show, a beautiful surface, a magnificent pretense concealing many flaws. Rather than playing a part in a simple story of art and beauty, eighteenth century New England silver figured in a complex and ambiguous narrative of power.”¹⁹ Put another way, silver represented an always already shaky currency of possession, one that attempted to sanction the dispossession of indigenous labor in *other* places in order to fortify white settler accumulation of wealth in *this* place. Through the logics of possession precipitated by silver, white colonizers in New England no doubt forged their own narratives of valuation, beauty, and entitlement that made the later fortification of other industries not only swift, but also seemingly well-justified.

It is within these circuits of enslavement and (dis)possession that the work of silversmithing was made not only lucrative but also highly respected in colonial New England. As such, in making room for silver in Franklin County, we must necessarily ask

after the ways in which massacring white settlers carved out of those silver ingots and British coinages the conditions of possibility for their industrious family legacies—the many white, often middle- to upper-middle class families who still exist in the area today, cohered under the signature settler colonial moniker “Yankee” without ever acknowledging the theft and murder that made that now-prestigious identification possible.

We must also explicitly trace the ways in which the Lunt smithery’s roots are steeped in the settler colonial labor of displacement and eradication that unfolded across British colonies, including Massachusetts, in the mid- to late-1600s. The labor of those genocides no doubt engraved white settler claims into the land such that the artisan-based silvering shops that followed could thrive and expand unhindered by the limiting presence of those who were in fact here first.²⁰ In Franklin County, the massacring settlers who laid the groundwork for the rise to industry unquestionably rose to their own vision—and execution—of capacitated Greatness following the Battle of Turners Falls in 1676.²¹ Attending to the Battle of Turners Falls in the context of the rise of American Industrial Greatness invites the elaboration of new connections across the boundaries of time and place about the rise and fall of capacitated whiteness, both here and in other currently de-industrializing sites of settler colonization.

The Battle of Turners Falls took place between English settler colonizers led by Captain William Turner and several hundred indigenous families from Nipmuc, Narragansett, Wampanoag, and Pocumtuc tribes who gathered at Wissantinnewag-Peskeompscut—a fishing encampment on the Gill side of the Connecticut River just across from what is today known as Turners Falls—for the yearly cycle of fishing,

planting, and harvesting.²² According to accounts recorded by the descendants of white settlers in the 19th-century, Captain Turner led the infamous attack on May 19, 1676 as those who were a part of the Wissantinnewag-Peskeompskut fishing encampment slept on the banks of the Connecticut River just above Great Falls, the gushing, sacred waterfalls that served as a major hub of daily indigenous life in the region.²³ Turner's surprise attack was only one of many such ambushes that comprised King Philip's War. Today, we know that Turner's ambush was no doubt strengthened by the unconscionable fact that many white colonizers simply crept up to the wigwams in which the Peskeompscut people slept, stuck rifles inside, and fired. According to accounts recorded in the often-treasured "local histories" of the region, those who didn't die by direct gunfire alongside their family frantically jumped into the river in the middle of the night in an attempt to reach the canoes they hoped would somehow take them to safety. Turner's well-armed brigade had taken the tribe by complete surprise, however, resulting in the deaths of hundreds more indigenous people as they were shot, drowned, or tumbled down over the falls in panic. Local allied tribes rallied upon hearing the then-familiar sound of massacre on the east banks of the river and followed the retreating General Turner down into what is now called Greenfield. There, Turner and many of his men were killed in retaliation and defense. Turner's body was found near the site of his fall by English colonists a month later.²⁴ Today, a marker paid for by the Greenfield Kiwanis Club commemorates and honors Captain Turner's fall in Greenfield, further solidifying the event as a historical victory for the ancestors of the many white settlers who participated. In a far more explicit gesture of honor, the land on which the massacre took place has, since the town's official settlement in 1868 by a promising bastion of industry,

Alvah Crocker of Framingham, been named Turner's Falls.²⁵ Although many in the area advocate for changing the town's name from Turners Falls back to the name indigenous people gave to the site—Great Falls—there has been no coordinated effort to make such a change permanent.

In fact, the Battle of Turners Falls is only finally being acknowledged *as* a massacre rather than as a settler colonial victory by some area residents following a heated, several years long effort to cease use of “The Indian” as the Turners Falls High School mascot.²⁶ Despite many white community members' assertions that the mascot appropriately “honored” the indigenous history of the area, local indigenous groups—particularly members of the Nolumbeka Project, a non-tribal collaboration bringing together several New England indigenous communities—called attention to the fact that the “warrior” symbolized on the uniforms of the town's sports teams hardly resembled the actual historical or contemporary customs and attire of the indigenous communities of the area, today or historically. The mascot, these groups stated quite plainly across many local news outlets, was an insult, and local whites who pushed to preserve it should acknowledge both the histories and the present realities they are voiding in its preservation.²⁷ And yet, the school board's binding decision to finally change the mascot from Indian to something still undecided didn't change the fact that in a non-binding town vote, residents themselves elected 4 to 1 to keep the mascot as is.²⁸ The potential loss of the false legacy of capacitated Greatness that was no doubt secured by Captain Turner is, it seems, immensely concerning to the substantial majority who elected to ignore indigenous perspectives on the issue and stick to their own visions and versions of local history.

The substantial community divisions generated by this event remind us quite explicitly of the ways in which the dis-allowing of the fact of indigenous genocide in local memory and local history continues to structure and vitalize ordinary life—and ordinary community belonging—today. Furthermore, it reflects the production and fortification of settler colonialism in Franklin County not as a once-upon-a-time, long since forgotten *event* but rather, following a much-cited argument made by settler colonial studies scholar Patrick Wolfe, as a *structure*.²⁹ The Battle of Turners Falls no doubt laid the groundwork for the long-standing structural entitlement to the land and resources of Franklin County as settlers quickly went to work harnessing the gushing waters of the Connecticut into a series of canals and dams, which would provide crucial infrastructure to connect with other manufacturers down river, access raw materials and new markets, and, eventually, facilitate the development of hydroelectric power which would make the rise of industrial manufacturing here swift and formidable in the mid-19th century. Attending to the structure of settler colonialism here can no doubt tell us much about the tenuous white attachments and nostalgia that drive a re-vitalization of the image of the factory here today, particularly as that image's conditions of possibility hinge on the river's hydropower, which was to be generated by the same gushing, sacred waterfall that once carried the dead bodies of Peskeompscut people downstream and out towards the Atlantic.

In thinking the Battle of Turners Falls as a kind of structural antecedent to the local fortification of American Industrial Greatness in Franklin County, we can see the tension over the mascot what for it is—a violent re-capitulation of the narrative and material disavowals that structure and sanction the conditions of ordinary whiteness more

broadly here. In *Firsting and Lasting: Writing Indians Out of Existence in New England*, indigenous historical and settler colonial studies scholar Jean M. O'Brien further contextualizes the capacitating work of white settler disavowal in a way that helps to magnify its role in consolidating the structure of ordinary whiteness in a place with deep roots in the history of extractive—and genocidal—capitalism. Colonial New Englanders, O'Brien suggests, were shrewd at the work of fashioning and disseminating the narratives required to justify the many gross violences they inflicted across the region. That work was fortified by white settlers' mobilization of the nascent print culture of the era to their many advantages. O'Brien suggests that white settler colonization in New England was "obsessed over its self-fashioned providential history, and defined itself as the cradle of the nation and seat of cultural power."³⁰ Here, we get a sense of the specific seeds of Greatness that were being sown as white settlers took their own raw materials—guns, germs, silver coins, well-nurtured attachments to European hegemony—and manufactured the cargo of white supremacy here: silver and local history.

Furthermore, through these ongoing exercises of self-fashioning, the antiquarians writing the many local histories that we still rely on today to make civic sense of "New" England were making substantive investments in their own unquestionable modernity, a state of mind that no doubt further sanctioned their entitlement to the resources and lands they claimed through violence. "In the process of asserting their own modernity," O'Brien astutely notes, "local writers worked mightily to root the New England social order deeply...Collectively, the effect of their ideological labor is to appropriate the category 'indigenous' away from Indians and for themselves."³¹ Here, O'Brien spells out quite explicitly the ways in which the many narratives of indigenous massacre that were

produced by local New England antiquarians (including the one I consulted in my own interpretation of the Battle of Turners Falls above) reveal only some of the accretions of power that laid the groundwork for long-term white claims to this land. The second “Battle of Turners Falls,” which was waged over the figure of the false mascot, shows how those accretions of power move forward as bodies of ordinary whiteness-in-crisis feel entitled to their own persistence and re-capacitation, despite hearing more every day from “outsiders” (indigenous activists, white people learning their history) about the originary traumas and disavowals that made that entitlement possible.

Given the elaborate production of these “originary” narratives, what, then, do we need to know about the *ongoing* legacies of settler colonialism in Franklin County to re-fashion futures—particularly futures where harm endures—otherwise? And how is the strategic amplification of the figure of the white worker as an agent of protection embedded in the recapitulation of logics of ordinary whiteness, both here and across the U.S. more broadly? In the next section, I turn to Lunt’s ascendancy throughout the 20th century into an image of American Industrial Greatness in order to think through the ways in which ordinary whiteness has been consolidated and replicated in and through the labor logics and modes of local (and national) belonging that underpin the site of the factory. Once again, crisis functions as a driving market condition of the ascendancy of ordinary whiteness, encoding streams of profit for the few into the many mechanisms of response that we have put and continue to put into place to ensure protection from “outsider” harm.

Keeping Pace with Crisis Capitalism: White Workers Laboring for American Industrial Greatness in Franklin County

Much like in New Hampshire, where granite quarries drove the development of a thriving (always white) middle and upper middle class, the structural impressions of silver-driven settler colonialism in Franklin County run deep and continue to mediate who and what may be brought into the fold of the ordinary. Attending to the 20th century labor history of Lunt Silversmiths tells us much about the production and reproduction of the conditions of ordinary whiteness, and understanding those conditions is crucial if we are to formulate critical responses to the Lunt factory's re-certification as a site of recovery that aims to move us beyond the conditions of crisis we currently face. Part of that labor is working to make explicit the embeddedness of crisis in each moment of political-economic transition and how notions of crisis have always served to re-consolidate the tenuous workings of whiteness as it faced "threats" from outside of itself. In the wake of the region's violent settlement by white colonizers at the end of the 17th century there was, it seems, an imperative for the early heads of Franklin County industry to make fast sense of the material remains of the crisis of forced native genocide in the region. Crucially, those remains must have looked like quite promising fodder for the rapid installation of capitalist logics of accumulation and valuation here: rich river lands flush with fertile soil, gushing waterways fed by the cool White Mountains to the north and flooded with salmon and chad, dense hardwood forests teeming with wildlife and the raw materials for so much industry to come. Cottage industries in metal working and paper production blossomed in the settler towns and villages along the Connecticut River as the crisis of native genocide was methodically re-figured into some kind of fertilizer

for a more robust rise to industry during the region's industrial "hey day" from the mid-19th to the mid-20th centuries.

Tending to the story of Lunt Silversmiths' toxic coming-to-power in the era of Industrial Greatness no doubt demands an unpacking of the implicit connections between the political-economic conditions of crisis, the enduring myth of the ever-capacitated white worker, and all of the false investments that have been made in the "free" market as an arbiter of value and worth, both here and across the de-industrial U.S. Unpacking those connections shows us some of the ways in which earlier settler colonial crises of violence, disavowal, and forced removal would be effectively harnessed forward towards the production of an ever-capacitated, ever-ordinary, ever-white worker here, a worker that is no doubt increasingly advocating for right state protection in the crucible of the opioid crisis today. Attending to the capacitation of the figure of the white worker through a framework of crisis reveals much about the kinds of ongoing entitlements to the means of protection that have no doubt preceded the contemporary bloom of opioid despair in this region as those protections fail to secure the populations to which they were promised. It likewise sheds light on some of the ways in which the factory and its racial-capitalist ethics and praxes continue to inflect and shape processes of recovery in Franklin County, both for the people seeking treatment at places like the FRC and for the many direct service workers imbricated in the non-profit systems that fund such treatment sites. What, then, has the continual installment of crisis achieved in the productivity of labor and whiteness in Franklin County? And how have historical practices of U.S. imperialism and colonialism relied on the same logics to secure and validate their own claims to the Greatness of industrial capitalism?

In answering those questions, it turns out we can also name and make direct interventions into the many narratives of labor, capacity, and industrial fortitude that constitute the “official story” of American Industrial Greatness. Critical theorist and public intellectual Naomi Klein unequivocally asks us to confront the ways in which an “official story” has been fashioned and forged through a series of constitutive *lies* that we must come to terms with if our futures are to look any different. “This book,” Kline states in the introduction to her seminal text *The Shock Doctrine*, “is a challenge to the central and most cherished claim in the official story: that the triumph of deregulated capitalism has been born of freedom, that unfettered free markets go hand in and with democracy.”³² In revealing the central capitalist / free market falsities that constitute “official stories” of American Freedom, Klein further shows that, “this fundamentalist form of capitalism has been consistently midwived by the most brutal forms of coercion, inflicted on the collective body politic as well as on countless individual bodies. The history of the contemporary free market—better understood as the rise of corporatism—was written in shocks.”³³ If we heed Klein’s call seriously, the industrial history of Franklin County must necessarily be read through the lens of *recurrent* crisis and shock in order to link up 16th century crises of indigenous genocide to 19th century crises of early finance capital to 20th century crises of the World Wars to 21st century crises of opioid despair. In forging those connections, we can begin to see the ways in which the white accumulation of capital has likely been preceded by crisis at most every stage of the game. The history of Franklin County must be re-made explicitly with this concern in mind if we are to better understand the re-making of this place otherwise. If, as Klein asserts, the history of the contemporary free market has risen in and through the shock, how have historical

formations of crisis driven the production of long-standing white entitlements to protection from harm? And how have narratives of white industrial capacity fed those visions of entitlement?

A.F. Towle & Sons, the company that preceded Lunt, existed quite prolifically as a high-end producer of jewelry and tableware in the many formative years of Franklin County's coming to industrial power between the area's original violent "settling" at the end of the 17th century and its rise to true industrial power in the 19th and 20th centuries. The colonial history of silver outlines only some of the many forms of cultural and social capital that the elaboration of silversmithing made possible here, and it points to the kinds of racial and class attachments that silvering generated as the trade blossomed from an artisan craft to a full-blown industry. According to an 1891 "snapshot" of Franklin County businesses, what would eventually come to be known as the Lunt works was said to, "manufacture the finest grade of electro plated and sterling silver ware and have a well-established trade, sending their product to every part of the country, but selling to the jewelry trade only. The employees," the snapshot continues, "number 125, to which they are constantly adding to keep pace with their steadily increasing business."³⁴ This picture of what would become Lunt paints visions of productivity, connectedness, and affiliations with fetishized upper-class commodities: jewelry and tableware. The workers of early industrial Franklin County seem to have been well-engaged in the work of producing visible markers of class ascendancy and investing them with the stamp of New England's cultural approval. However, by 1893, the robust silversmithing operation that was once carried out by well-paid and highly specialized artisans and craftsmen in Greenfield was beginning to face concerning fiscal decline.³⁵ In a narrative that surreally

echoes Lunt's final days at the end of 2009, the business' first imminent decline was precipitated by the major financial crisis of 1893, which was partly driven by the national movement towards, quite interestingly, Free Silver.³⁶ That crisis did, it seems, open up the "traditional" manufacturing firm to an influx of new values, technologies, and organizational principles that would, if we follow the investments made in the works by George C. Lunt himself, deliver the struggling company to new heights of industrial capacity and productivity.

With Lunt as the newly installed head of the struggling factory by 1903, his revitalized shop would be one of several in Franklin County to begin fully capitalizing on the "groundbreaking" industrial manufacturing and metal-working technologies that were being developed nearby at other Greenfield works. Those technologies included a signature "tap and die" technology, which made it increasingly possible—and increasingly efficient—to mass produce pre-fabricated metal machines and machine components for the first time ever, thanks to John Grant's development of a new tool to effectively cut screw threads into steel in Greenfield in 1872.³⁷ Lunt Silversmiths would join other major producers in town, including Greenfield Tap & Die, who were likewise making the crucial transition from a contract-based, guild-driven labor force to a more "diversified" industrial workforce comprised of both skilled and unskilled laborers.³⁸ In this transitional economy, Lunt quickly went to work employing hundreds of "local" skilled machinists and unskilled laborers to direct his operation into both silver and steel working endeavors. Drawing on what local historian Tom Goldscheider calls the spirit of "civic capitalism," Lunt's factory, like others in Franklin County, differed in some key ways from the other major industrial works positioned down-stream along the banks of

the Connecticut River in Holyoke, Springfield, and Chicopee.³⁹ Attending to that difference opens up Lunt's history to a larger analysis of the co-production of commodity-capitalisms and structures of ordinary whiteness.

One key difference in Lunt's factory was the fact that like many other Franklin County operations, Lunt ostensibly "invested" in the "already existing" community of Greenfield by hiring, training and paying "local" labor well, rather than relying on transient—and often non-white—pools of "immigrant" labor that poured into the southern region from Western and Eastern Europe (mostly Poland and Ireland).⁴⁰ Central to understanding the political-economic utility of that difference is a recognition of Greenfield's strategic ecological positioning in regional economies of extraction and manufacturing: the power of being located upstream. Goldscheider summarizes this dynamic well: "Greenfield," he says, "is in the world but not of the world. It is perched upstream from all that it chooses to connect with." As such, "for many years, the plants people worked in were founded, financed, and run by people from town, forming a formidable barrier to unwanted interference from 'outsiders.'"⁴¹ According to the logic of the capitalists who funded these operations, making "investments" in the settler colonial strata of local society ostensibly meant that Greenfield would be able to avoid the many "social ills"—row housing, public health scares, overpopulation—that seemingly plagued cities and towns downstream. That "protection" from the many "invasions" of outside influence was no doubt secured by Turner's strategic capture of the upstream site of Great Falls so many centuries before.

Here, we can begin to trace the fortification of a labor-driven structure of ordinary whiteness in Franklin County, which no doubt inflects and informs both past, present, and

future visions of the “recovered” Lunt campus in local and regional imaginaries. Greenfield’s “choice” to connect to and invest in and pay well a “local” labor force no doubt erected long-standing barriers and excisions for the many who fell short of that heritage to participate in the wealth-generating structures that would secure the many capacitations of whiteness in the region. Furthermore, it contributed to the construction of a uniquely “Yankee” identity, one that ostensibly embodied the strengths and characteristics of the right kind of white-bred New England citizenship: fiercely independent, “self-taught,” and anti-government in a way that saw state support as pathetically paternalistic. That these strengths and characteristics were no doubt securitized in and through the psychic and material gains precipitated by genocides and claims to stolen property and goods remains unnamed and unexamined. In the process, Lunt and his Yankee white laborers erected the foundation of a local social hierarchy that looked on the surface as though it was based on individual merit and “hard work” (i.e., class-based), but was (and is) for all intents and purposes, a wholly racializing project. In strategically hiring—and, in the process, strategically valuing—the “local Yankee” community that remained firmly settled in Franklin County since the 16th century, Lunt and its industrial peers were directly responsible for the production of a white working class identity that felt privy to the spoils of industrial extraction and manufacturing and entitled to protection from the many kinds of harms that befell non-white labor pools in the region’s southern cities and towns.

Thinking through the excision of certain *kinds* of workers from the fiscal and ideological consolidation of ordinary whiteness in Franklin County tells us much about the structural imbrications of capitalism and racialized disavowal that remain fully intact

as we attempt to resurrect the factory in the image of re-covered capacitation in the midst of the crisis of white opioid despair. These racialized excisions from a shot at “well paid” labor are, if we follow radical black Marxist thinkers, foundational to the elaboration of what Cedric Robinson calls the “systemic privations of racial capitalism.”⁴² Robinson is particularly useful for understanding the ways in which systemic privation—or, systemic deprivation, if we look at the ongoing legacies of settler colonial disavowal—is the very condition of possibility for the ascendancy of ordinary whiteness through time. That ascendancy not only looks like excision from the visible and knowable structures of capital accumulation available (i.e., a good wage-paying job), but also excision from the many kinds of ordinary belonging that take their own fortification from capital accumulation, even if those processes remain hidden (i.e., invitation into certain social circles, a speeding ticket that is magically “taken care of” before it hits the books).

By making clear investments in the growing white, working class labor pool of the region, the Lunt family firmly established itself not only as a major employer of the area’s emergent industrial white working class through their provision of a “decent wage,” but also as a corporate benefactor to the family and friends of the industrial community it forged. Those benefactorial relations demonstrate some of the ways in which labor has been used as a de facto stand in for the many kinds of racial differentiations that drive disparities in Franklin County today. A recent exhibition featuring the Lunt factory and Lunt family history at the Greenfield Historical Society reminded visitors that Lunt Silversmiths regularly put on parades, hosted events, and sponsored a baseball team in Greenfield.⁴³ Today, the Lunt family still leases baseball fields to the Town of Greenfield for \$1 a year.⁴⁴ In a place where geographic isolation

and limited transportation resources historically affected all residents' abilities to forge and maintain outside ties, Lunt's offerings of recreational and social activity meant it no doubt played a crucial role in defining and policing the bounds of "ordinary" community belonging. An industrial by-product of that benefactorial relationship between Lunt and the town was the fortification of the idea that community belonging and personal identity are indelibly forged in and through white relations to factory work and industrial productivity.

Lunt's work of bringing certain kinds of "Yankee" whiteness into the fold of the ordinary had larger and more fruitful effects, too, particularly if we consider the ascendancy of the white worker and his perceived needs and capacities in a larger political-economic context. In *Black Reconstruction*, W.E.B DuBois lays out an incisive critique of the ways in which the coming to power of the white worker in the aftermath of 19th century black emancipation relied on the co-production of racial and class difference and was fortified through the mobilization of those differences in the realm of labor management and governance of workers. According to DuBois, the white "working class" laborer was (and, I argue, continues to be) a necessary and crucial agent of capitalist exploitation in his willingness to consolidate and privilege racial difference towards greater capital accumulation and lesser bodily toil:

The successful well-paid, American laboring class formed, because of its property and ideals, a petty bourgeoisie ready always to join capital in exploiting common labor, white and black, foreign and native. The more energetic and thrifty...caught the prevalent American idea that here labor could become emancipated from the necessity of continuous toil and that an increasing proportion could join the class of exploiters, that is of those who made their income chiefly by profit derived from the hiring of labor."⁴⁵

Here, DuBois offers an incredibly compelling framework for why the fortification the white laborer was and continues to be a key technology of racial capitalism. In Franklin County, Lunt's "well paid" white Yankee laborers were often able to buy property and build homes in the town's soon-to-be-affluent outskirts. Today, many of those homes are still occupied by the upper strata of the Greenfield community—"professionals" as many who don't belong to that class (or race) call them. Those homes, which were often built in elaborate Victorian styles with multiple levels and servants quarters throughout the end of the 19th and early 20th centuries, are quite often marked by their location in the Highlands neighborhood (another "upstream" advantage), which illustrates that many who did turn into the "petty bourgeoisie" of the region were able to successfully take their own raw materials (white privilege, a steady job, Yankee heritage) and turn them into a kind of belonging and stability—a kind of capital—that has lasted far past their own lifetimes.

DuBois' critiques of the white worker and his implication in capitalist structures of racialized accumulation and dispossession have been usefully taken up by a range of critical projects in addition to the radical Black Marxist tradition in which we might situate DuBois today. David Roediger's *Wages of Whiteness* is a foundational text in the field of critical whiteness studies that likewise draws on black radical thinkers to posit and frame the emergence of whiteness as the emergence of systems of capitalist and labor exploitation in the U.S. Roediger develops the term "white workerism" to think through the ways in which whiteness as a distinct cultural and racial identity has been forged in and through relations to labor, productivity, and value. In reading DuBois himself, Roediger suggests, "the pleasures of whiteness could function as a 'wage' for white workers. That is, status and privileges conferred by race could be used to make up for

alienating and exploitative class relationships, North and South. White workers could, and did, define and accept their class positions by fashioning identities as ‘not slaves’ and as ‘not Blacks.’”⁴⁶ In Franklin County, the reliance on “local” Yankee labor no doubt meant that the “pleasures” of a good wage were, of course, encoded into the unspoken hierarchy that governed boundaries between the ordinary and the other.

Furthermore, Roediger’s framework of white workerism tells us more about the ways in which the white worker became entitled to the fantasy of endless re-capacitation in and through its strategic fashioning of a kind of otherness that was, by necessity, always already incapacitated or at least de-capacitated. “Whiteness,” Roediger argues, “was a way in which white workers responded to a fear of dependency on wage labor and to the necessities of capitalist work discipline...the white working class, disciplined and made anxious by fear of dependency, began during its formation to construct an image of the Black population as ‘other’ – as embodying pre-industrial, erotic, careless style of life the white hated and longed for.”⁴⁷ As we begin to move out of a historical analysis of Lunt’s invigoration of white workerism in Franklin County and towards the contemporary moment where Lunt is being refigured as a site of recovery, this insight into fear of dependency is crucial. As we will see, current praxes of clinical addiction intervention and treatment no doubt rely on and replicate this same fantasy of racialized otherness as that which is indelibly dependent and needy, careless and unproductive, forever incapacitated in and through strained relations to labor and a “good day’s work.” Contending with the historical rootedness of this falsity is necessary if the factory is ever to move out of its endless cycle of reproducing racial difference in the service of re-fortifying formations of ordinary whiteness.

In his apparent commitment to practices of “local” hire, George C. Lunt eventually succeeded in securing both national and international markets for his factory’s products, which were forged and stamped and plated in silver and, eventually, steel—the next frontier of American Industrial Greatness mobilized by countless other exercises of extraction. In the process, Lunt no doubt cooperated in the fortification of a vision of ordinary whiteness here that continues to shape how and where we are willing to invest capital and other resources in excavating futures that are seen as worth living for.

Throughout the 20th century, the Lunt factory went on to produce fine sterling and stainless-steel flatware, hollowware, and giftware for a range of markets, such that the company’s insignia became a collectable for those who seek out and purchase mid-century silver wares. Signaling its increasing ties to the upper echelon of U.S. racial and class strata despite its “humble” Franklin County roots, in 1981 Lunt’s Embassy Scroll pattern was actually selected by the U.S. government as its official table and flatware design at all U.S. embassies and consulates around the world.⁴⁸ Crucially, this was not the first time the Lunt works would be co-opted into the production of technologies of U.S. nationalism and imperialism under the guise of American Industrial Greatness. In the next section, we move into the mid-20th century period of World War II-era crisis. Here, we can trace Lunt’s own expansion far beyond the geographic bounds of Franklin County as the corporation begins to tap into new and lucrative partnerships, profit streams, and labor practices which would deliver it to the head of industrialized Greatness in and through strategic relations to commodified crisis. Keeping these histories in check is once again crucial for clearly visioning the factory’s resurrection in and through another moment of opioid inflected crisis.

Fusing the Future: Manufacturing American Military-Industrial Greatness in Greenfield

The years that immediately followed George C. Lunt's ascension to head of the Greenfield works ushered in an era of new investments and partnerships that elaborated the reach of Franklin County industry far beyond the geographic boundaries of Greenfield or Turners Falls. Generated from yet another moment of emergent crisis—America's entrance into World War II after Pearl Harbor—Lunt's growing industrial capacities (and the industrial capacities of several other major Greenfield manufactures) would be harnessed towards a newly lucrative site of profit-making: war. Thanks to local Franklin County titan of industry Frederick H. Payne's "fortuitous" post to the War Department in 1930, Lunt would become one of several Franklin County factories to begin receiving lucrative contracts to manufacture "top-secret," cutting edge, modern warfare technologies.⁴⁹ Those technologies were being actively designed and quietly ushered through to production via many newly formed partnerships between all branches of the U.S. military that desperately sought new technology and manufacturing routes for strategic armaments; academic science and research bodies increasingly being tapped for classified government-sponsored research and development; and the corporate agents of U.S. industrialization (like George C. Lunt) who increasingly received kickbacks in the form of infrastructure upgrades and long-term defense contracts for bringing their works into the service of wartime "collaboration."⁵⁰ In a move away from silver and towards the materials of war, Lunt would begin to secure its own future via participation in increasingly obvious dubious alliances. In the process, the labor of ordinary U.S. whiteness was likewise resituated within new economies of extraction predicated on the

accomplishment of mass death. Today, we can recognize these budding “collaborations” as the nascent stages of the military-industrial complex (MIC). The MIC is formation that James Ledbetter, writing on its mid-20th century emergence, describes as “a network of public and private forces that combine a profit motive with the planning and implementation of strategic policy.”⁵¹ However, in Franklin County in 1940, those partnerships looked a lot less like the process by which the region which would link into much larger formations of war-profiteering that consolidated the profit-making potential for heads of industry, heads of government, and heads of academic R & D. Rather, it looked like Raytheon, a then-local-to-Massachusetts technology “start up,” quietly knocking on the basement door of Lunt Silversmiths, asking to be let in to mobilize production on one of the major mid-century developments in anti-aircraft technology: the VT fuze, or the proximity fuze.⁵²

Attending to the imbrication of the Lunt works in this nascent stage of military-industrial complexity no doubt elaborates the ways in which the near-history of the toxic factory shapes and informs other kinds of profiteering that unfold in the detox factory today. But how, specifically, did Franklin County get put “on the map” of the emergent MIC? And what does Lunt’s own “investment” in white, Yankee, “local” labor tell us about the co-optation of the “ordinary” in the service of expanded militarization of industry and of everyday life? That story begins with local banker Frederick H. Payne’s rise to power at another major Greenfield works, Greenfield Tap & Die. First a banker and financier, in 1912, Payne would successfully coordinate a forced (and quite hostile) merger of several small machining shops in Greenfield into “The Corporation,” an entity that would eventually become Greenfield Tap & Die (GTD). Working strategically with

Boston investors, GTD became the firstly publicly traded company in Franklin County's history. This is a move that would, according to local historian Tom Goldscheider, make the company increasingly vulnerable to "interference from outside investors" for the first time as the Corporation distanced itself from strategic affiliations with regional labor pools and domestic markets.⁵³ One effect of that merger—and, perhaps, an underhanded *invitation* to outside interference—was Payne's intentional move to secure lucrative military defense contracts for GTD on the eve of the U.S.'s entrance into the First World War. He was wildly successful. During WW I, Goldscheider notes that GTD, "exported up to half of what it manufactured and eagerly supplied both sides in the arms race in Europe."⁵⁴ In an apparent nod of approval to the opening up of Greenfield industry to outside markets that Payne made possible, the banker was offered and accepted the post of Assistant Secretary of War under President Hoover, a post in which he served from 1930 to 1933.

During his time as Assistant Secretary of War, it seems Payne worked tirelessly to connect Greenfield's burgeoning manufacturing-industrial economy to the burgeoning industry of technology-driven war-time militarization. According to a *New York Times* announcement of Payne's post, the War Department stated that since Payne became a Major in the Ordnance Department, he has, "taken a great interest in matters pertaining to the industrial activities of the War Department." As such, the announcement continues, "as the Assistant Secretary of War, he will have supervision over all military supplies and all matters pertaining to industrial preparedness for war."⁵⁵ Here, we can begin to see Payne strategically positioning his own "hometown" industries as necessary adjuncts to the war effort. Throughout this time in office, Payne attended many social events in New

York and D.C. and spoke widely as an “expert” on the vital need for an expanded industrialized munitions preparedness program that would focus on public-private collaborations in production and manufacturing.⁵⁶ Although Payne left the War Department as Hoover’s administration was replaced by Roosevelt’s, he was shortly thereafter appointed Vice President of the Army Ordnance Association, a “sustainment” branch of the U.S. Army responsible for supplying procuring, maintaining, and supplying weapons and ammunition to combat troops.⁵⁷ In this role, Payne continued to seed Greenfield industry with lucrative military defense contracts, a process that would “pay off” particularly well by the beginning of World War II as Greenfield industry was preparing to welcome itself into nascent military-industrial alliances.

Although the Lunt works itself was never co-opted into the corporate body of GTD itself, it no doubt remained a crucial ally in securing and implementing lucrative military defense contracts in Greenfield during World War II. Lunt benefitted directly from Payne’s efforts to first secure an influx of federal dollars that would improve and expand upon Franklin County’s industrial infrastructure in order to respond effectively to the demand for increased productivity of munitions and armaments. With those expansions in place by 1940, the major military defense contractor Raytheon arrived in Greenfield to collaborate with Lunt managers to set up a top-secret production facility inside the Lunt works.⁵⁸ Within that facility, local laborers went to work producing small components for a highly classified project that would remain classified until just a few years ago. Upon the project’s declassification, we now know that Raytheon was inside the Lunt works rapidly producing what is known today as the “third most critical secret program of WWII”: the VT fuze, or proximity fuze.⁵⁹

The proximity fuze was developed by another entity likewise co-opted into the rapidly expanding military industrial complex at the eve of WWII: The Johns Hopkins Applied Physics Lab. A result of collaborations between the academic science lab and military researchers from the U.S., Britain, and Canada, the fuze itself served as a small device capable of sending and receiving radio waves when placed inside the noses of anti-aircraft missiles and bombs. Once in flight, the fuze was designed to send out “feelers”—or probing waves—that scanned the approaching area containing the intended target. Once the probing feelers were close enough to an enemy target for waves to “bounce back” to the signal radio inside the fuze, an “actuating signal” was sparked, igniting the firing circuit and ultimately exploding the projectile. The proximity fuze was a major development in anti-aircraft warfare technology as it allowed operators to detonate explosives from a removed position just *before* they made contact with the intended target. The possibility of proximity without contact would, in effect, maximize damage by ensuring enemies could be taken by complete surprise.⁶⁰

The archives of Franklin County’s Museum of Our Industrial Heritage contains a filmstrip that describes the production of the VT fuze in depth.⁶¹ Produced by the Office of Scientific Research & Development, the Naval Bureau of Ordnance, and the Army Ordnance Department (with animation provided by the U.S. Army’s Signal Corps), the filmstrip tells us that the first model of the proximity fuze was put into production for naval use in 1942. By 1943, artillery that used the top-secret fuze component had accomplished its first casualty: a Japanese kamikaze pilot. The film goes on to note that the British Navy began using the proximity fuze technology shortly thereafter. At the hands of the British, the technology ostensibly helped to “save” London homes and

structures during heavy Axis shelling, and it contributed to Allied victories at the Battle of the Bulge and at Iwo Jima. The film concludes by insisting that the invention and production of the proximity fuze was, “a triumph of truly great achievement of our scientific and industrial organizations.”⁶² Once again, we hear from the agents of war-making themselves about the Greatness that is ostensibly encoded into their lucrative machinations of violence.

In that highly classified collaboration between the U.S. Department of War, the major defense contractor Raytheon, and Lunt Silversmiths, Franklin County industry was effectively invited into the nascent sphere of military-industrial partnership, which would soon begin to blossom into quite lucrative “home front” streams of profit for those at the top of each of the partnering structures. The workers who assembled the proximity fuze components were apparently understood to benefit from those partnerships by way of “trickle down” economics. The workers assembling those components were also—crucially—almost all women.⁶³ This fact begs the question of what the role of whiteness—and of white womanhood more specifically—is in the capacitation and replication of the predominant logics of mattering that unfolded in the factory at this specific moment of ostensible crisis. In the 2011 article, “‘Peace is Our Only Shelter’: Questioning Domesticities of Militarization and White Privilege, Jenna M. Lloyd contextualizes the many processes of *social reproduction* that were securitized in and through the idea of an industrially protected “home front” served and fortified by non-military agents of war—women, children, families. These processes, Lloyd shows, were first erected during the conflicts of WWII and were mobilized again and again throughout the Cold War period as the “work” of war was increasingly grafted on to the labor of

everyday processes of racialization and gendering. “Analyzing how militarized ideologies of home and home front intersect with material spaces of social reproduction not only grounds conflicted ‘domestic’ sites and ‘domesticating’ processes of militarization,” Lloyd argues, “but also enables us to recognize different sites of political mobilization and alliance. How,” she continues, “do gendered processes of militarization—that work in conjunction with white supremacy—produce and connect differently positioned ‘private’ spaces or home places?”⁶⁴ Here, Lloyd intentionally integrates critical analyses of the logics of domesticities and white supremacy into the mechanics of war-time social reproduction such that we can see the imbrication of the ordinary “local” white worker in producing and reproducing those mechanics—manufacturing them, if you will. In the process, Lloyd’s argument about the kinds of social ideologies and praxes of differentiation that are erected in the name of militarized “home front” protection speaks clearly to the production and reproduction of ordinary whiteness in Franklin County *as* a particular kind of labored investment in protection from outside threats of harm. The agents of that protection will it turns out, quite effectively continue to forge ordinary white, working life in Franklin County into a kind of capital in the many years after the “crisis” of explicit war has passed that continues to pay well.

As we trace the long-concealed specter of Raytheon from inside the Lunt works, we can, then, begin to see the ways in which those mid-20th century efforts at consolidating new military-industrial profit streams (or, put another way, war profiteering) continue to shape and inflect local ideals of belonging, protection, and the hopeful re-capacitation of the site of the factory as that which will once again save us from an abstracted, outsider otherness in the descent into opioid despair. Contemporary

frameworks of mattering are no doubt tied up with the recapitulation of what Lloyd usefully calls “militarized domesticities.” According to Lloyd, militarized domesticities name, “the material and symbolic use of the home and home front as the places that national security states claim to work to protect.”⁶⁵ Here, the militarized domesticities produced by the Raytheon-Lunt partnership are no doubt complicit in the fortification of the ordinary white worker as an agent of the state who will do her best to use her laboring body to manufacture the components of protection that are always already ordinary and white.

What no one told those workers in the secret basement workrooms at Lunt—the same basement rooms that now likely store apparatuses of clinical meaning-making and clinical mattering—is that the basic mechanical components they labored so hard to produce in the name of American Military Greatness would soon be put to work in a whole range of other military-industrial projects that continue to reproduce the exceptionality of some (white) lives and the endemic disposability of others. Those projects would largely *not* aim to eradicate foreign enemy targets in times of explicitly stated warfare, although the fuze would be great at that work. Rather, those projects would eventually contribute to the increased militarization of everyday life in every branch of U.S. law enforcement through the elaboration of drone technology. Today, the proximity fuze is still reviewed and discussed in military and law enforcement forums across the web as that which allows operators to put increasing distance between themselves and the many kinds of targets they police and surveil. It received a particular boost in late 2017 and early 2018 as the U.S. Army announced a new production partnership with Raytheon that would begin to install updated proximity fuzes into the

portable Stinger missile in order to increasingly combat unmanned enemy aircrafts (i.e., enemy drones).⁶⁶ At the time of its production, then, the fuze laid the groundwork for a kind of amplified estrangement from the effects of military-sanctioned violence. As such, the increased efficiency in targeting and securing death from afar would become built into modern expectations of warfare, no doubt confirming the exceptionality of (some) U.S. lives as they work tirelessly in service of the state to eradicate others.

What happens, then, if we situate the investments in detachment and excision that were made possible by the widespread manufacturing of the proximity fuze at Lunt directly in relation to the contemporary sphere of clinical opioid treatment which is unfolding today literally in the same physical site? How are abstracted claims to (white) bodily protection and (white) re-capacitation enfolded into treatment praxes at the FRC? And how do those entanglements echo the ring of Raytheon's fuzes hitting the conveyor belt in the service of national security? And, finally, how do lucrative public-private partnerships erected in the name of citizen protection actually consolidate and securitize the self-same structures of racial-capital accumulation that Lunt workers labored in the service of so many years ago? Long-since-made investments in the extraction of local resources—human and natural alike—have, no doubt, contributed to slow-burning crises of both despair and disparity that often go un-named as such. Looking plainly at the history of Lunt tells us much about the ways in which the increasing capacities of the military industrial complex in Franklin County have been shuttled forward to projects much less obvious, though no less harmful. In the process, we can begin to trace some of the ways in which the persistent and lingering *fantasy* of some white folks' "well earned" access to the "good life" in Franklin County has, no doubt, been shaped by personal—or

at least familial—attachments to the legacies of valuing, mattering, and belonging that were first established by the factory and its enmeshment in lucrative complexes of profit and policy-making. Next, we take this in-depth historical accounting of Lunt—and structures of ordinary whiteness in Franklin County more broadly—forward, as we begin to look at the ways in which the Lunt works are being re-fashioned in this contemporary moment of crisis into a site that will once again “protect” and “save” the precious bodies of some, while others become targeted refuse in the name of an ever-re-capacitated ordinary whiteness.

III. Making Civic Sense of Factory & Future

Securing Populations of Harm: Locating the Non-Profit Industrial Complex in Franklin County

Today, the Lunt complex is sandwiched between a hardware store and a tire shop: two emblems of ordinary whiteness in this town if there ever were any. Up until 2015, however, it appeared to be following in the footsteps of so many of the other previously industrial properties in the region that no longer pump out sterling silver flatware or reams of paper or leather shoes or machine parts fit for wars or homes or some combination of the two. Laborers, managers, and Franklin County locals visiting Lunt’s once-robust factory showroom no longer traversed the property’s labyrinthian structures as they had for over century. The industrial casts, molds, dies, and machines that once forged all manner of design and decoration into treated silver were long since auctioned off, the last of which went in 2010. And the countless toxic industrial chemicals that once drove countless toxic industrial processes that once elevated Lunt to the position of top

industrial manufacturer in this region of countless other industrial manufacturers were slowly seeping back into the rich soil underneath the factory's foundation. There's no telling where those chemicals have ended up after their "disappearance" from the factory floor decades ago. Downstream, most likely: into the soil, and into the roots, and down and out into one of the many rivers that crisscross rural Western Massachusetts, carrying all manner of material south, always downriver towards the more "urban"—and, today, far less white—cities like Holyoke and Springfield. Those down-river cities also, as we know, housed giant factories once upon a time, generating from the area's raw materials so many of the precious commodities of the 20th century. Franklin County is "unique" in that it is supported by the many kinds of renewal that come from deep, ancient water tables—lingering reminders of the fact that the whole region was once a deep glacial lake and that it is, no doubt, always a privilege to be upstream.

Many such properties—particularly those on the other side of the hilly pass that snakes above the banks of the Connecticut River connecting Greenfield to nearby Turners Falls—are likewise slowly returning back to the earth under a sometimes quick, sometimes slow process of de-industrial organic conversion. Brick and steel forms that once voraciously consumed the area's abundant natural resources—water, hardwood, granite—in order to churn out basic and luxury commodities alike appear to be getting eaten up again up by the land that they sit upon. Brilliantly green vines snake through the banks of cracked factory windows in the canaled bend of the river in Turners Falls, and not much is recovered there. Every now and then, Turners Falls receives inquiries from outside developers who are keen to investigate the cost of remediating the myriad toxins that permeate these structural husks in order to instigate the highly anticipated "second

coming” of the region: river-front condos. So far, none have succeeded. Sometimes, however, fires rage, dismantling what little is left of the infrastructure that once kept the region competitive in jobs and livelihoods alike.

Behavioral Health Network (BHN)—the local social services agency that operates Franklin Recovery Center—made the decision to lease the remaining structures that once comprised the Lunt works from the Town of Greenfield after the property had sat vacant for almost a decade. As a key player in the region’s competitive non-profit human services sector, BHN had already managed to secure a lucrative contract from the Massachusetts Department of Public Health in 2014 to administer state-licensed detoxification and stabilization services in Franklin County in the wake of the state’s burgeoning opioid crisis. The contract was the result of the first wave of major legislation passed by the Massachusetts legislature after former Governor Deval Patrick declared the opioid crisis a public health emergency in early 2014.⁶⁷ The legislation funded expanded addiction treatment and recovery programs across the state and in Franklin County specifically, a response that no doubt acknowledged the long-known fact that Franklin County residents were at a particular disadvantage in accessing clinical treatment options in cities like Springfield and Holyoke due to geographic isolation and poor public transportation options. The legislation likewise mandated insurance companies in the state to pay for at least 14 days of in-patient substance abuse treatment care for those in need.⁶⁸ At the time, opioid-related overdoses and deaths were continuing to climb in Massachusetts, and U.S. Senator Ed Markley went on record stating that it would be the state’s “moral responsibility” to respond immediately to an epidemic that was, it seemed, significantly impacting white communities across Massachusetts, particularly in places

like Cape Cod and Franklin County.⁶⁹ These were places where attachments and affiliations to working class, ordinary whiteness continued to serve as the de-facto norm, even if demographics were increasingly showing otherwise.⁷⁰

In this landscape of emergency-driven public health response and legislative mobilization, BHN was well-positioned to spearhead a re-negotiation of Lunt's post-industrial future in order to secure the site as a regional clinical addiction treatment hub. Crucially, that hub was already well-funded by the apparent moral imperative to combat opioid despair using state dollars. The only thing missing was a site. According to local news reports, BHN was the only entity that responded to Greenfield's calls for proposals for reuses of the property. Ironically, the only other proposal the Town seriously considered over the decade in which Lunt sat empty was made in 2009 just after the original factory's closing. That proposal was for a "foreign trade center" which both city officials and industrial interests hoped would allow Franklin County manufacturers to avoid costly import and export duties on tools, equipment, and raw materials if they committed to selling their products overseas.⁷¹ Dreams of a direct return to industrial re-capacitation never quite made it, however, and today, human-powered "growth and recovery," not post-industrial decay and rot, would mark the future of this site. And the quicker the better.

In preparation for the lucrative DPH contract generated on the eve of the opioid crisis in 2013, BHN quickly began negotiations with the Town of Greenfield to work with developers to clean up and "rehab" the Lunt works to meet the demand for a site for clinical treatment in Franklin County. Working with BHN, Greenfield accepted a pitch from a well-known pair of real estate developer brothers, Joseph and Raipher Pellegrino,

to undertake the factory's conversion from a long-since abandoned site of industrial manufacturing into a modern symbol of morally appropriate crisis response.⁷² The Pellegrinos were a likely pair to undertake this specific kind of re-vision. By 2009, they had already rehabbed an old wire factory for BHN, which came to house administrative offices for the large social services organization as well as the Hope Center, BHN's Springfield-based post-detox "step-down" program, which would become the model for the stabilization unit at FRC.⁷³ In addition to their work as real estate developers working specifically in industrial-factory conversions, the brothers also boasted deep ties to some of the most influential civic and legal structures in the region. Their father, Joseph A. Pellegrino, was a long-time judge in the Massachusetts Trial Court and served as both prosecutor for the city of Springfield and former Massachusetts Assistant Attorney General.⁷⁴ Raipher himself is a founding partner at a high-profile law firm in the region and served for two terms as Springfield City Counselor.⁷⁵ Together, they represent a stratum of local wealth and connectedness in this area that no doubt shapes access—and entitlement—to the many kinds of opportunities that arise when crisis comes a-knocking.

The decision to hire the pair to undertake a re-visioning of the infrastructure and values of the factory in Franklin County reveals some of the ways in which deeply embedded local hierarchies of ordinary whiteness—represented here by two heirs to regional structures of punishment and confinement—continue to shape and inflect funding, production, and clinical manufacturing of recovery. In a 2016 news article that reported on the factory conversion's progress, Joseph Pellegrino "joked" with reporters from the local news agency MassLive that he and BHN executives are "in the same business... 'I do buildings, and they help people do rehab,'" Joseph said.⁷⁶ Here, we get a

brief glimpse into the kinds of profit-driven logics that ostensibly reduce bodies of struggle—bodies of color in struggle, if we consider the demographics of BHN’s treatment sites in the area—to yet another raw material that will be taken up by the powers that be and converted into something more lucrative.⁷⁷ Furthermore, Joseph Pellegrino’s comment about the rehabilitation work that he ostensibly “shares” with BHN executives gestures towards the kinds of closed and behind-the-scenes partnerships and alliances that have leveraged the regional strain of opioid despair—and the imperative to establish a “moral response”—toward the erection of new streams of profit and new structures of surveillance in and through the revitalization of old industrial bodies, spaces, values and logics.

Given what we know about the seeding, elaboration, and fortification of ordinary whiteness in Franklin County in and through the productivity of both industry and crisis, there is something quite familiar about the investments, partnerships, and alliances that formed around the “dawn” of the opioid crisis in Greenfield. Much like the mid-20th century alliances that lined factory executives’ and government officials’ pockets with the spoils of lucrative defense contracts in the name of national security, our contemporary responses to the crisis of opioid despair here no doubt replicate the structures and processes of racial-capital accumulation that effectively consolidated and reproduced the conditions of ordinary whiteness here in the first place. This time, however, the “raw materials” of such accumulation are not silver ingots or hydropower or the mini vacuum tubes out of which the proximity fuze was fashioned. This time, the “raw materials” that drive the production of a new kind of Greatness—American Recovery Greatness—are the many (white and otherwise) bodies that make their way to

the lobby of the Franklin Recovery Center with desperate hopes to somehow, some way, get “clean” from the mess of opioid despair.

The dirt at the door, however, is thick. And we’ve no doubt made certain kinds of investments in keeping that dirt firmly in place for the many who continuously fail to measure up to the standards of valuation and mattering the outline the bounds of ordinary whiteness. Perhaps the only way to really “get clean” in the crucible of the opioid crisis is to look plainly at the messy baggage we bring with us to the door of the toxic factory with the hopes of finding that thing that can wash it and sort it and hang it out to dry. If, as we explored in the previous sections, there is in fact a *structure* to settler colonialism and a *structure* to white workerism and a *structure* to military-industrial partnerships that subtends all that we can and will know about the nexuses of pain and ordinary whiteness in Franklin County, what does the *structure* of non-profit administered clinical recovery look like? And how is that structure imbricated in the many false dreams of re-capacitation encoded into the factory’s resurrection?

Attending to the invigoration of yet another kind of “complex” here—the non-profit industrial complex—reveals much about the ways in which “industrialized” strategies of profit-making that were no doubt forged on the assembly line are not only aligned with, but also productive of, the kinds of recovery futures that FRC visions, invests in, and eventually makes possible in Franklin County. In a Foreword to the now-seminal collection *The Revolution Will Not Be Funded: Beyond the Non-Profit Industrial Complex*, compiled and edited by the radical feminist-of-color organizing collective INCITE!, Soniya Munshi and Craig Wilse articulate that structure quite clearly alongside INCITE!’s own definition of the non-profit industrial complex (NPIC). Generated out of

the first Color of Violence conference in 2000, INCITE! defines the NPIC as, “a system of relationships between the State (or local and federal governments), the owning classes, foundations, and non-profit/NGO social services and social justice organizations.”⁷⁸ In explicitly naming as a *system of their own* the individual actors that fortify systems of accumulation in and through human need, INCITE! invites critique of the embeddedness of logics of profit-mattering in clinical sites of opioid care. In Dylan Rodríguez’s contribution to the anthology, “The Political Logic of the Non-Profit Industrial Complex,” he expands upon INCITE!’s basic definition, suggesting that the NPIC is a, “set of symbiotic relationships that link political and financial technologies of state and owning class control with surveillance over public political ideology, including and especially emergent progressive and leftist social movements, since about the mid-1970s.”⁷⁹ In the BHN-Department of Public Health-Town of Greenfield collaboration, we begin to see the emergence of a structure of non-profit-administered clinical recovery that once again positions the “owning classes” at the forefront of the work of identifying areas and sites of harm, outlining possible interventions, and marshalling resources accordingly. Furthermore, this definition of the NPIC gestures towards the ways in which language, values, and “best practices” generated from Left and progressive organizing are eagerly co-opted by the agents of the NPIC into non-profit structures in a way that seemingly seek to mask the logics of accumulation that always already underpin that work.

In Franklin County, like in many places where ordinary whiteness predominates as the key organizer of social life, the “owning class” names not only the *visible* groups that hold and control fiscal, cultural, and material resources, but also the many who

identify as or closely affiliate with local agents of law enforcement, banking, non-profit administration and management, and/or bodies of governance and who benefit from that proximity and familiarity. This insight is key as we begin to consider who in fact is being invited to the table to contribute to the “architecture” of post-opioid recovery futures. If we consider the administrative structure of BHN, one of the key agents at the head table as the organization that runs the FRC, we can see quite clearly that the organizational structure itself does not in any way reflect the material realities of the people the organization aims to “serve.” In fact, the administrative and managerial structure appears to consolidate, re-entrench, and conserve the vitality of ordinary whiteness in post-opioid recovery future-making quite blatantly as the organization relies on rhetorics of empowerment, diversity, and “shared values,” just as they continue to maintain an Executive Management and Leadership team that does not contain a single person of color.⁸⁰ Aside from generating a keen desire to barrage the agency with a loud and clear call to DO BETTER, what does this fact tell us about the visioning of post-opioid recovery futures here? Who is invited and who is excised, even before anyone reaches the lobby door?

In addition to BHN, another key agent of post-opioid recovery world-making in Franklin County is the Opioid Task Force, which, like the FRC, came into being at the early vitalization of the “opioid crisis.” Formed in 2013, the Opioid Task Force is emblematic of the public health approach to the crisis of opioid despair in the region, one that seeks to generate “best practices” recommendations for treatment practitioners in the area, along with identifying and constructing avenues for distributing the significant state and federal monies that continue to pour into the area to remediate opioid harm.⁸¹ The

public face of the Opioid Task Force is, crucially, occupied by its three co-chairs: Christopher J. Donelan, Franklin County Sheriff; John F. Merrigan, Franklin County Register of Probate; and David E. Sullivan, Northwestern District Attorney. Each of these three figures represents one of the more clearly consolidated sites and agents of power in the region, including the jails, courts, and the DA's office. All "local" white men, all "professional" agents of the state, the Task Force co-chairs no doubt communicate a vision of post-opioid future-making that is well entrenched within the same bodies of governance and arbitration that currently funnel addicts into the coercive terrain of forced treatment just as quickly as they funnel them into the local county jail. The less public, albeit no less constitutive, agents of the Task Force are its "Team," comprised of four white women with a range of experience in public health and non-profit sectors. Although the Task Force no doubt generates some useful possibilities for collaboration with other less concentrated agents of power, it continues to rely on the presumed expertise and authority of white public officials in initiating the somewhat vague mechanisms of "Prevention" and "Treatment." Put another way, in its reliance on some of the most clearly identifiable agents of state power in the region, the Task Force ostensibly eschews the underlying structural (read: racialized) conditions of opioid despair in the region in favor of an individualized, medicalized model of care that looks on the surface to be quite progressive, but which in fact simply replicates and protects whiteness from threats outside of itself. In the process, it further alienates those most impacted by opioid use as it positions "help" just beyond the gatekeepers of "law and order" – figures that many in the depths of opioid despair have met in far less empowering contexts.

Thinking the terrain of post-opioid recovery futures within the framework of the non-profit industrial complex allows us to trace quite explicitly the ways in which the structure of post-opioid recovery future-making relies on the constant replenishment of populations of harm in order to sustain the (if not robust, than at least “enough”) salaries of white executives and white administrators, as well as the never-enough minimum wage paychecks of the direct service workers who police and discipline those populations into a narrow vision of “recovered” capacity. Furthermore, integrating a NPIC framework into post-opioid recovery future-making in Franklin County helps to illuminate the ways in which a racialized politic of fear always already drives the elaboration and securitization of the structure of the NPIC as a kind of recovery future-making. In considering who, exactly, earns the title of keeper of recovery futures in Franklin County, we can see that it is no doubt the agents of coercion (the courts, law enforcement)—the agents tapped to “protect” “us” from “outside” “harm”—that are invited into that privileged position. But what do we make of the many people seeking support in Franklin County—those both “born here” and those who travel from other parts of New England—who always already fail to register as an “insider” worthy of protection? What kinds of “rehabilitative” logics are being manufactured and produced at sites like the FRC, where the fear of outsider infiltration has long served as an arbiter of mobilization?

The political utility of fear, it turns out, is quite central to the construction of post-opioid recovery futures fashioned in the image of the NPIC. Dylan Rodríguez, writing on the liberation- and abolition-driven work of political prisoner Mumia Abu-Jamal, is once again useful for articulating exactly why and how white fear—and the attendant crisis of fear come-to-life—is constitutive in the maintenance and fortification of a non-profit

industrial complex reared on white supremacy. In explicating the ways in which an “industry of fear” maintains and invigorates the NPIC, Abu-Jamal argues that, “Americans live in a cavern of fear, a psychic numbing force manufactured by the so-called entertainment industry, reified by the psychological industry, and buttressed by the coercion industry (i.e., the courts, police, prisons, and the like).”⁸² Here, Abu-Jamal clarifies the ways in which the cooperation of the news media, clinical therapeutic models (i.e., “the psychological industry), and the agents of policing, surveillance, and incarceration are invested in the continuous generation of fear from a citizenry that Abu-Jamal says is constructed as necessarily “helpless” and “prone.”⁸³ In the crucible of the opioid crisis, we can see the mobilization of all three of these bodies as we turn again and again towards the many kinds of fear that underpin opioid despair (fear of losing one’s body, fear of losing one’s mind, fear of losing one’s kids, one’s job, one’s ties to “normal”) with the hopes of finding a solution there. Rodríguez further elaborates the psychic and material reach of this “cavern of fear” and its operationalization in NPIC as he poses the question of how that “cavern of fear,” echoes “the durable historical racial phobias of the U.S. social order generally?”⁸⁴ In posing this question, Rodríguez is in fact asking after the ways in which the continuous political utility of fear (and, I might add, crisis) might in fact mirror the long-standing, socially embedded fear of the *loss* of white supremacy as something reliable and endlessly valuable across all periods of U.S. history. Thinking that loss in relation to tensional structures of ordinary whiteness opens up a significant in-route for theorizing the mechanisms of control and surveillance that are embedded into the profit-logics of FRC as they attempt to manage and diffuse that fear

by integrating bodies of otherness into knowable structures of “recovery” and “rehabilitation” designed to re-entrench the status quo of white productivity.

Rodríguez puts his finger on the nose of the wrench of opioid despair in de-industrial sites across the U.S. and further illuminates one reason as to why futures designed *outside* of the image of the police, the courts, and the management-level administrators at clinical treatment sites might feel so very threatening to those in charge of visioning post-opioid futures. I offer a long quote from Rodríguez that must exist in its entirety in order to flesh out this conjuncture:

Does the specter of an authentic *radical freedom* no longer structured by the assumptions underlying the historical ‘freedoms’ invested in white American political identity—including the perversions and mystifications of such concepts as ‘democracy,’ ‘civil rights,’ ‘the vote,’ and even ‘equality,’—logically suggest the *end of white civil society*, which is to say a collapsing of the very sociocultural foundations of the United States itself? Perhaps it is the fear of a radically transformed, feminist/queer/anti-racist *liberation* of Black, Brown, and Red bodies, no longer *presumed to be permanently subordinated* to structures of criminalization, colonization, (state and state-ordained) bodily violence, and domestic warfare, that logically threatens the very existence of the still white-dominant US Left: perhaps it is, in part, the Left’s fear of an unleashed *bodily proximity* to currently criminalized, colonized, and normatively violated peoples that compels it to retain the staunchly anti-abolitionist political limits of the NPIC. The persistence of such racial fear—in effect, the fear of a radical freedom that obliterates the cultural and material ascendancy of ‘white freedom’—is neither new nor unusual in the history of the US Left. We are invoking, after all, the vision of a movement of liberation that abolishes (and transforms) the cultural, economic, and political structures of white civil society that continues to largely define the terms, languages, and limits of US based progressive (and even ‘radical’) campaigns, political discourses, and local/global movements.⁸⁵

In this excerpt, Rodríguez offers much for unpacking the kinds of relations to fear, control, and the need for ongoing commodification of harm that structure and subtend the clinical/opioid NPIC in Franklin County. In particular, Rodríguez tasks us with facing quite directly the question of what true “recovery” might mean for folks long positioned

at the margins of social and cultural belonging, both here and elsewhere. A critique of the Left that challenges the liberal praxes of “inclusion,” his incisive questions begin to reveal how the possibility of that true “recovery”—i.e., “recovery” as a kind of *radical freedom*—might upset and dislodge long-since-solidified structures of valuation and accumulation that so many rely on as a kind of ever-growing capital.

In suggesting that the possibility of true radical freedom hinges on a collective recognition of the emptiness of the structuring concepts of U.S. white exceptionalism—equality, diversity, and, as I’ve suggested here, a fully capacitated though nonetheless false image of American Greatness—we can begin to see why that possibility is so threatening to the many agents and stewards of whiteness-as-we’ve-known-it. Central to Rodríguez’s claims about fear, whiteness, power, and radical freedom is the unsettling possibility of re-signifying populations of harm and populations of otherness away from lucrative presumptions of permanent subordination or, in the terms of this project, permanent incapacity. Whiteness, as Rodríguez helps us to see, is and has always been invested in the maintenance of some populations of incapacity as a mechanism of possession, which is always already quite usefully a mechanism of profit-generation *and* a mechanism of social control. This investment in the incapacity of otherness, of non-whiteness, contrasts glaringly with the kinds of re-capacitation that are hopefully encoded into post-opioid recovery future making for the many bodies of ordinary whiteness lingering on the edges of incapacity for the first time.

Despite seemingly “liberal” legislation and policy recommendations pushed through on the eve of the opioid crisis and despite the Left’s ongoing demand to meet bodies of opioid despair with compassion, resourcing, and personal opportunity, there is

nothing to suggest that the officials and administrators invested in funding and visioning post-opioid recovery futures are actually interested in supporting the grassroots work of survival and transformation that has unfolded and continues to unfold from the many sites of despair that lurk around the edges in Franklin County. Rather, we can make quite plain the kinds of contradictions that are encoded into the hopeful future of post-opioid recovery worlds by illuminating the local organizations and non-profit executives who pat themselves on the back for a “moral” response to the crisis of opioid despair, just as they continue to implement and reinforce the recapitulation of harm within the sites they individually govern. Here, I’m thinking, for example, of recovery champion and Opioid Task Force co-chair Sherriff Chris Donelan’s decision in 2008 to sign a yearly \$3 million contract without an expiration date with Immigrations and Customs Enforcement (ICE) to house undocumented immigrant detainees in the Franklin County House of Corrections while they await pending legal action. The Franklin County House of Corrections receives \$1 million annually towards their own operating budget from the deal, while the other \$2 million goes to the state.⁸⁶ In addition to boasting the creation of a top-notch “medically assisted” recovery program within the county jail, Donelan is also responsible for keeping in place an in-house system of primary care that often leaves inmates sicker than when they went in.⁸⁷ These kinds of contradictions are endemic to post-opioid recovery world-making and further illuminate the ways in which agents of ordinary whiteness are invested in securing a constant replenishment of populations of harm—at the factory, at the jail, in the courts—in order to maintain and securitize the structure that supports their own well-being, including but not limited to excellent benefits, time off, and other “perks” of the job.⁸⁸

In keeping certain populations “under the thumb” of the multiple exercises of the NPIC—mandated treatment, probation, family courts, therapy programming that require reporting and surveillance—we can see how agents of ordinary whiteness mitigate and manage the fear of proximity to bodies who, if they did achieve radical freedom, would no doubt topple the regimes of valuation and mattering that constitute the ordinary. Recovery as true radical freedom would mean not only throwing off one’s personal yoke of addiction, but likewise acknowledging, de-activating, and divesting from collective participation in the major structures that keep radical freedom intangible and unlikely. These insights beg some important questions about the exact nature of recovery-world making both at the FRC and in sites otherwise undertaking the labor of post-opioid futures. What would it look like to posit and invigorate recovery as a kind of radical freedom that does not hinge on the surveilling and prohibitive capacities of ordinary whiteness? Whose comfort is troubled by that vision? And where should it unfold? In the next section, I turn back to the contemporary story of the FRC in order to finally draw out the exact toxic nature of the site and all that’s been in it as agents of ordinary whiteness meet, negotiate, and attempt to craft futures for those who fall outside of the norm.

De-toxing Factory Futures: Punitive Recovery-World Making at the FRC

Once the deal had been sealed between the Town of Greenfield, BHN, and the Pelligrino brothers, the exact toxic condition of the Lunt property began to reveal itself as something more than a minor hiccup in the swift movement towards the proposed 35,000 square foot treatment complex. In 2012, a report filed with Massachusetts environmental regulators stated that the industrial solvent trichlorethylene was found in groundwater

monitoring wells across the property and that the building itself contained asbestos, lead paint, and PCBs, a toxic chemical compound often used as a coolant fluid in various kinds of machinery.⁸⁹ Follow up reports confirmed the existence of metals such as arsenic and zinc in the surrounding soil. As such, the Lunt factory conversion would require significant additional influxes of capital from state and federal agencies in order to reach the standards required for safe medical detox and rehabilitation services. According to reporting at the time of the project's beginning, the federal Environmental Protection Agency was prepared to pay up to \$1.5 million for remediation of the many toxic chemicals that permeated the Lunt works, with additional funding for building demolition coming from the state agency MassDevelopment.⁹⁰ Together, a Superfund Technical Assessment and Response Team (START) contractor would eventually undertake the work of preparing the site for the proposed detox facility and, if we follow the re-zoning of the property in 2014 from industrial to partial-commercial, perhaps something a bit more explicitly income-generative, too.⁹¹

In the process of preparing for the Lunt works' transformation into a modern, cutting edge site of medically assisted opioid treatment, the site gradually revealed its own undeniable, on-going toxicity. The state's highly mobilized response to remediating that toxicity tells us much about the ways in which the emergency-level "moral" imperative to combat opioid despair is likewise a convenient route for targeting certain (well-placed) local geographies with millions of state and federal dollars in clean up resourcing just as endless other sites around the region continue to remain awash in the refuse of prior industrial manufacturing and contemporary industrial dumping. Mel Chen's work on toxicity speaks clearly to the kinds of political ends that are achieved by

the ascription of certain sites and spaces as problematically, visibly toxic while others remain so but without any recognition as such. In the Introduction to *Animacies*, Chen argues that, “political interest stokes public alarm towards ‘toxins.’ We must therefore understand the ways in which toxicity has been so enthusiastically taken up during times of economic instability and panic about transnational flow.”⁹² In following the opioid crisis as a moment of emergent instability and panic in Franklin County, the rush to address toxicity in the project of a re-capacitated silver factory-cum-human factory demonstrates where and how environmental investments are getting a boost from the labor of re-capacitating ordinary whiteness. Chen further asserts that “...interests in toxicity are particularly (if sometimes stealthily) raced and queered. Indeed toxins participate vividly in the racial mattering of locations, human and nonhuman bodies, living and inert entities, and events such as disease threats.”⁹³ In reading the lingering toxicity of the Lunt works as a kind of civic imperative towards clean up, we can more clearly see the ways in which the reinvigorated Lunt works is in fact also an attempt at producing a new kind of racial mattering at the site of its investment. In preparing it for an influx of the necessarily desperate white victims of opioid despair, the environmental cleanup further contributes to the preparation of the factory as yet another site of re-entrenched whiteness in need of—and deserving of—all the right kinds of protection. Who, this political interest in toxicity begs us to ask, are we cleaning it all up for? And how will the factory work once its constitutive elements—toxic chemicals, the raw materials of extraction—have been scrubbed away? And how will we manage, manipulated, and transform the factory’s new “raw materials”—human bodies—into a product worth investing in?

For over a year, the factory's industrial guts, which had been bathed in toxins and chemicals for over a century, were ripped out, neutralized, and replaced with standard clinical beds, partitioned intake cubicles, and all of the necessary medical equipment needed to wean a person off of opioids, or alcohol, or, more truthfully, a lack of access to basic needs. Despite the Center's ongoing delays in opening its doors due to concern over the continued presence of environmental toxins in a site ironically slated to undertake the labor of de-toxification, progress was made in the hiring and training of clinical teams and administrators who would undertake the "on the ground" work of recovery at the FRC. In the same 2016 MassLive article that quoted Michael Pellegrino discussing the rehabilitative work he shares with BHN executives, we also get an up-close accounting of the kinds of values, structures, and assumptions that were expected to be put into place once the doors finally opened. The person who provides that account is, interestingly enough, Nancy, the head nurse at the FRC to whom Daniel Dowd addressed his suicide letter in early 2017, just six months after this article was published. In thinking through Nancy's description of how, exactly, the FRC hoped to address the regional strain of opioid despair, we can begin to trace the ways in which the logic of the factory as a privileged site for some coalesces as a logic of treatment that continues to police and enforce a limited vision of "right" behavior, belonging, and productivity for the "clients" who make it through the lobby and into the treatment bed.

Dreams of a system that will ensure the "right" kind of re-capacitation and recovery are no doubt embedded in much of the promotional and media materials produced at the eve of the Center's opening. The 2016 article mentioned above begins with a quote from Susan C. West, the senior vice president of BHN, who says, "That's

why I like working in addiction recovery. There is a lot of hope in rehab...People can really get their lives back. They go back to their families. They go back to jobs and careers. I've seen it. We have people who work for us who have gone through rehabs and recovery."⁹⁴ Here, it's worth considering the kinds of vacant promises that ostensibly constitute the "hope" that is infused in the work of rehabbing factories and bodies together. In the desire to establish and enliven a clinical structure for opioid recovery that will allow people to "go back" to their same lives after undertaking medically assisted detox, we can locate the ongoing pull of the desire to maintain hegemonic and exploitative systems of ordinary whiteness that will always already prevent and head off radical freedom. Furthermore, in blithely calling attention to the fact that "some of their own" have been through the detox and recovery process, West illuminates the capitulation of an "us versus them" logic of treatment and recovery that no doubt further alienates and isolates the people seeking treatment here who cannot or do not want to re-trench themselves in the places and practices that delivered them to the door of the still-toxic rehab factory in the first place.

The Republican, a local newspaper owned by MassLive, produced a video featuring both Susan West and Nancy Elmer, which is also embedded in the article at hand. In the opening scene of the video, we are introduced to the figure of Nancy as she stands in an institutional cafeteria-looking space (presumably the cafeteria at FRC) comfortably surrounded by and conversing with two female police officers. "The reason we're opening this center for BHN," Nancy explains, "is because of the need for beds in this area to help with the first step of recovery. It's a great need in the area, and we will be able to keep our clients local."⁹⁵ Echoing George C. Lunt and other titans of early

Franklin County industry who desired to keep their labor force “local” so as to avoid infiltration from outsider otherness, we can see Nancy establishing and visioning a post-opioid recovery future here that is no doubt “for” those who can properly petition themselves into the fold of the ordinary—white people. And, if that petitioning is not quite successful—if folks cannot quite “measure up” to the right performative standards of recovery here—Nancy has a lot to say about the kinds of system-level checks and “balances” that will no doubt be in put place to police those standards and contingently distribute recovery treatment accordingly.

Further in the article, Nancy begins to outline what the everyday will look like at FRC: “Patients get to keep up to three changes of clothes and no more,” she says. “Everyone gets toothpaste and deodorant issued to them when they enter, since there is no telling what illicit substances might be secreted in outside toiletries.” The intake process, as the article summarizes, “might take as little as 20 minutes but involves a complete search.” Although many are too sick to participate in things like “group therapy, counseling sessions, Alcoholics Anonymous meetings or activities like art or board games,” Elmer says, “they aren’t allowed to stay in bed for long. Soon everything becomes mandatory. ‘This isn’t come in and sleep it off,’ she says. ‘You have to participate in your recovery.’” Once patients have completed the five- to seven-day detoxification program, Elmer says they can then move “upstairs” to the stabilization unit. There, patients begin to receive assigned chores and become responsible for taking their own medications. “Cleaning the bathrooms,” Elmer says, “You might have to clean the bathroom and not just the area you used. At mealtimes, you might be in charge of wiping down tables and putting things away...” In this brief introduction to the tenor of

treatment life at the FRC, it's clear that certain normative markers of productivity—deodorant, for one—become symbols of comfortable compliance. And, if one steps outside of those bounds, Elmer is quick to remind us of a sort of chilling truth: “We are always watching them.”⁹⁶

The kinds of recovery posited and elaborated by the administrative and nursing staff of the FRC no doubt reflect a relationship to recovery that is anything but radical freedom. Rather, the vision of recovery being manufactured at the old factory reflects a much more conservative and individualized vision that concerns: 1) the ensured protection of agents of extraction and 2) the continuous policing of populations of harm. In the article, “Uncovering Recovery: The Resistible Rise of Recovery and Resilience,” David Harper and Ewen Speed usefully problematize the rapid growth of discourses of recovery and resiliency in mental health policy contexts by attending to the misguided politics of recognition and redistribution that are encoded therein. This critique resonates clearly with the kinds of interventions needed in order to reveal the limiting frameworks of clinical recovery outlined at the FRC more broadly, and more specifically, the ways in which those frameworks sanction and implement ordinary whiteness as that to which we should all endlessly strive. The critique for Harper and Speed hinges on a recognition of the fact that recovery/resiliency models do not “banish” deficit as an organizing concept for the model, but rather rely on it as the point of departure for the individualizing work of recovery. In the process, their work helps to show how difference itself—difference *as* distance from the ordinary—becomes a liability as deficit is redirected back towards the norms of whiteness.⁹⁷

Furthermore, we can cull from the work of Harper and Speed a crucial critique of the recovery politics being deployed at FRC such that the endemic protection of ordinary whiteness becomes evident. Harper and Speed suggest that: “Recovery is thus framed as the need for the service user to acknowledge the inappropriateness of their negative beliefs, values, and behaviors and to rethink these ‘inappropriate’ cognitions and behaviors into a set of more satisfying, hopeful, and contributory values and behaviors. This model of recovery makes emotional distress an explicit problem of individualized identity, rather than for example, an effect of structural inequality.”⁹⁸ Here, we can begin to see some of the ways in which the ongoing need for replenished populations of harm begin to operate as the raw materials for the recovery factory. As a willing agent of the capitalist machine, Nurse Nancy no doubt models the “right” relations to behavior and comportment that are expected as she outlines the many punitive policies that would be put into place upon the recovery factory’s opening. In the process, we can begin to see how and why the middle-management agents of racial-capitalist extraction continue to act and operate much like the “petty bourgeoisie” that DuBois names in his critical “white worker” text.

In securitizing her own power in and through the tenor of tense, barely established control of the other, Nancy helps us to see that the values, ethics, and praxes of the recovery factory are not in fact so far from the values, ethics, and praxes of the silver factory. Further analyses of the alliances that are unfolding between agents of state power, servants of “civic” capitalism, and those who labor in direct service trenches with dreams of ascending the managerial ladder show us that the work of recovery-world making in the crucible of the opioid crisis is far from radical and far from transformative.

Rehabbing old industrial buildings means re-wealthing those who already got rich once on the promises of extractive capitalism, either as white workers or as white owners. The spoils of those promises don't always look like fat paychecks, but also incorporation into the many subltler structures of protection and alliance that are made possible by ordinary whiteness kept firmly in place. According to the District Court Logs from September 28 – October 3, 2017, Nancy Elmer herself was arrested and charged with operating a motor vehicle under the influence of alcohol. “Charge of operating under the influence of liquor or 0.08 percent was not prosecuted,” the publicly available Court Log reads, “as, according to a statement made by a counsel from the district attorney’s office, the Commonwealth can’t prosecute this case with the evidence available for trail.”⁹⁹ Instead of being arrested for a DUI that may have even mandated her to treatment at a facility like the one she currently reigns over, Elmer was charged with “miscellaneous municipal motor vehicle ordinance or bylaw, to writ, making an illegal U-tern. Fined \$25. Found responsible for number plate violation, fined \$35.”¹⁰⁰ Instead of incurring the major financial burden of a DUI, which also typically includes largely limited transportation access due to loss of license and possible mandated treatment, Nancy Elmer had to pay \$55 in fines to the state. In the process, she swiftly evaded entrance into the very same system for which she labors. These kinds of under-the-radar “fixes” to problems that would otherwise cause life-altering issues for those without access to resources or connections no doubt illustrate the rich returns that an investment in the boundaries of ordinary whiteness make possible.

IV: Conclusion: Cutting Otherwise

Daniel Dowd carried himself to the lobby of the old silverware factory and deposited his body there at its final resting place. Given the many challenges to the possibility of fostering true recovery worlds—recovery worlds in the image of radical freedom—at the Franklin Recovery Center, Dowd’s suicide no doubt demands a process of accounting—one that can clearly examine and respond to the limitations—and actual violences—contained in sites of treatment that are tasked with holding and caring for people situated at multiple intersections of harm. For Dowd, institutional trauma, military violence, and a troubled relationship with substances delivered him to the point of the cut—a self-inflicted gunshot wound that terminated the possibility of a different kind of future. His death was no doubt spectacular, attesting to the productivity of his own personal crisis. He went out in a clear, self-designed vision of protest, alerting all who connected with his self-narrated experiences of the wrongs that he felt were being personally inflected upon him.

The official response to Dowd’s suicide was varied. In the days immediately following his death, Robert Haigh, Greenfield’s chief of police highlighted the importance of right optics in a situation such as this: “When someone does something in this manner, in a very public manner, you certainly don’t want to ignore the situation... You don’t want to shortchange it,” Haigh said in one of only two local news articles published about the incident.¹⁰¹ In an effort towards that transparency—and to quell demands from the local public about the exact nature of admittance to this new beacon of hope—clinical staff at the FRC also attempted to clarify information about admissions policies and insurance practices with local media outlets. Administrators went

on record citing that less than 5 percent of prospective patients have insurances that do not contract with FRC, ostensibly framing Dowd as a rare exception.¹⁰² And, Behavioral Health Network, along with the Massachusetts Department of Public Health—the state Bureau that provides licensing for detox services in the state—both announced they would conduct internal probes into Dowd’s claims of neglect by FRC clinical staff.¹⁰³ However, in the almost two years since the incident, there have been zero attempts at public follow up by BHN or DPH on any of the promised investigations. In fact, Dowd’s suicide has been effectively swept under the rug by police and administrators alike. In the meantime, it seems that the FRC continues to facilitate its medically-assisted treatment and “recovery” programming by feeding and replicating the very same kinds of crises (contingent living arrangements, unsafe relationships to people in power, incumbering institutional red tape) that many people attempt to detach from by seeking support at the detox in the first place.

The absurdity of that paradox is not, it seems, totally lost on the higher ups at FRC. Dr. Ruth Potee, medical director of FRC, told the *Greenfield Recorder* shortly after Dowd’s death that some days, she walks into the FRC and sees, “homeless shelter, psych unit, detox....That’s what we’re running.”¹⁰⁴ Here, Potee highlights the stretched capacities of her staff—clinical and otherwise—to respond to the diverse demands for support that began pouring in as soon as the doors officially opened in May 2016. “I didn’t know that’s what it was going to be like,” Potee says, ultimately confirming that the demand for acute care is both overwhelming and unmanageable in a region that has felt the hit of opioid-related overdoses, addictions, and deaths hard over the past 5 years.¹⁰⁵ Much *has been* invested here in addressing complex iterations of bodily harm in

this de-industrial landscape that is animated by the vestiges of a turning economy. But, it seems that even more is being demanded by potential patients who seek not only to kick drugs, but also to make some kind of transformative shift in the actual conditions of their lives.

As the promise of recovery continues to be touted by the PR department of the FRC's parent organization, potential "clients" are still regularly turned away due to lack of an "open bed."¹⁰⁶ And when they do make it into an "open bed," and scrape by in a no doubt harrowing 3-day detox program *and* maybe even complete the 14-day stabilization option too, many are back through the doors again in no time. In addition to the increasingly high staff turnover, the many folks who cycle through the doors of the FRC are, it seems, living testaments to the "revolving door" concept of service delivery. Here, that revolving door is powered, as we've seen, by the deeply held systemic privileging of ordinary whiteness as capital and as capacity.

To this end, we must remember, too, that Dowd himself was as much *capacitated* by the systems he was enmeshed in as he was incapacitated by them. Dowd was an older, Franklin County-born white man who had some semblance of security in his small disability payments. He had an apartment to live in and a network of friends who supported him, even after his death.¹⁰⁷ He was in bands. Although he wasn't able to individually mobilize right payment at the right moment to individually assume the right role of recovering patient, by all accounts he *should* have fit the mold. His apparent shock at not being allowed—guaranteed, even—entrance into the detox factory shows the kinds of ongoing crises that are sparked as the gatekeeping mechanisms of ordinary whiteness and the continuous replenishment of populations of harm are continuously fortified by the

agents of non-profit administered recovery world-making. The unravelling of his *kind of body* should, as Dowd submits and as Facebook commenters confirm, rest in the capable hands of medical professionals. It's what we've been promised. It's what we've earned. It's our right. And yet, Keepers of the gate, as Dowd himself learned, can always already thwart the possibility of "recovering" that which has been lost, or, according to those facing the cut, that which has been taken away. Ordinary whiteness in crisis, indeed.

But what of the many bodies (of otherness, or un-whiteness) that likewise reach the door of the detox factory to be turned away for lack of something deemed crucial or necessary by staff? With the elaboration of a new "medically assisted" detox structure in Franklin County comes an influx of people outside of the narrow category of the "local" who likewise seek treatment and recovery from the grasps of opioid despair. These are folks who travel north in buses or overpriced taxis or borrowed cars to seek treatment in a place that is applauded as an regional advancement in addressing opioid despair. These are folks who often come from other places—Puerto Rico, Moldova, federal jails across Massachusetts—folks who move in complex networks of forced migration or carceral economies who are always already marked as outside of the possible bounds of the ordinary. When these folks are turned away from the doors at the FRC, they likely will never return in a blaze of glory to show the clinical administrators just what mistake they've made. Rather, these folks leave quietly, returning to the back seats of cars or to the woods to suffer with much less emergency or fanfare. These are the everyday crises that have always already underpinned the capacitation and re-capacitations of whiteness in Franklin County and everywhere else governed by those structuring logics.

Centering these experiences of despair—experiences of despair that are rarely ever pulled into the fold of the emergency—is necessarily crucial for imagining post-opioid recovery futures otherwise. Divestment from the clinical-curative structures of the factory in all areas of life is, quite plainly, an alternative investment in the potential for radical freedom for those who have been denied it as part of the structure of U.S. white supremacy. In such a future, the punitive recovery factory embodied by the FRC is no longer necessary or relevant as we abandon the logics of privation and accumulation that have made it what it is. Instead, we must re-learn to do care as part of the work of radical freedom, rather than to perform it as that which is antithetical to freedom. This requires, no doubt, listening to the many visions of radical care that have been articulated by black, queer, feminist, and anti-racist workers who constantly vision for us kinds of care that do not rely on or replicate the many seeds of institutional trauma that sprout when we are re-introduced to those environments as a precondition to our survival. It likewise requires attending and “rooting into” the unsanctioned networks and practices of care that have been assembled to meet the needs of drug habits and basic needs alike and have also thrived alongside sanctioned networks in Franklin County for centuries.

Notes to Chapter 3

¹ Soloman, “Suicide spotlights intersections between insurance and recovery.”

² The full text of Dowd’s suicide letter can be read at Cyndi Dodge’s Facebook post from February 2017. See Dodge, “How can ANY Detox turn a desperate veteran away.”

³ Reporting showed that the delays were largely due to ongoing concerns over the lingering toxicities in the building itself and the soil that it sits upon. See Walsh, “New treatment center offers 64 beds for addicts in Franklin County.”

⁴ Dodge, “How can ANY Detox turn a desperate veteran away.”

⁵ One commenter—whose comments on Dodge’s post have since disappeared—astutely pointed out that even if Dowd had MassHealth, the state subsidized health care plan in Massachusetts, he *still* wouldn’t have been able to access detox services covered by MassHealth at FRC if he was indeed a “fully service connected” vet. Full VA service connection, the commenter states, demands that veterans can *only* receive insured care from official VA sites. This paradox speaks to yet another institutional layer that must be negotiated in order to actually receive treatment where one can (or wants to) receive treatment. It likewise reveals the role that institutional affiliation with the agents of one’s trauma (here, the military) can play in re-traumatizing and re-isolating people as they seek different futures. A future line of this work likewise seeks to examine the complexities of clinical power, care, and trauma in the VA system. Zoë H. Wool’s work on U.S. soldiers, injury, and recovery processes at Walter Reed Army Medical Center is a relevant source on such investigations. See Wool, *After War*. Wool, who I knew during her time at Rutgers’ Institute for Health, Health Care Policy, and Aging when she audited Ed Cohen’s Foucault seminar, was also the recent recipient of an NSF CAREER Award. Wool will use the 5-year grant to conduct ethnographic research on informal and alternative models of caregiving for injured post-9/11 soldiers. Such a project—and its interdisciplinary methods—is an interesting model for collaboration and connection to my own work. See McCraig, Rice’s Zoë Wool wins NSF CAREER Award.”

⁶ Dodge, “How can ANY Detox turn a desperate veteran away.”

⁷ Dowd repeatedly refers to the head nurse as “that bitch Nancy,” revealing once again that the agents of care that operate at the level of direct service so often become the target of a kind of rage that is no doubt cumulative and systemic. Dodge, “How can ANY Detox turn a desperate veteran away.”

⁸ According to the most recent U.S. Census data, Franklin County’s racial demographics are 94.1% white; 1.6% black/African American; 0.5% American Indian; 1.7% Asian; 2.1% two or more races; and 4.0% Hispanic/Latino. U.S. Census Bureau, “Quick Facts: Franklin County, MA.”

⁹ Castillo, “The grand history of Lunt Silversmiths on display.”

¹⁰ Kinney, “Drug treatment centers to open at former Lunt property in Greenfield.”

¹¹ Goldstein, *Formations of United States Colonialism*, 3.

¹² For an overview of the major events and participants in the King Philip’s War, see Rebecca Beatriz Brooks’ blog post for HistoryofMassachusetts.org, “The History of King Philip’s War.”

¹³ Some biographical information on George C. Lunt comes from genealogy work posted to a Lunt family history blog. See Henry Lunt of Newbury, “George C. Lunt.” For a

complete history of the Lunt family, see the 1914 text compiled by Thomas Simpson Lunt, "Lunt: A History of the Lunt Family in America."

¹⁴ Newbury Historical Commission, "Early Settlement." For a genealogical history of A.F. Towle & Sons, see Voss, "American Silversmiths: Anthony Francis Towle."

¹⁵ Hobbs, "The Moulton and Towle Silversmiths."

¹⁶ Palache, "The Chipman Lead-Silver Mine in Newbury, Mass."

¹⁷ Bushman, "The Complexity of Silver," 12.

¹⁸ Bushman, "The Complexity of Silver," 5.

¹⁹ Bushman, "The Complexity of Silver," 14.

²⁰ In the surround, following Harney and Moten in *The Undercommons*.

²¹ Today, this historical event is also called the Peskeompscut Massacre or the Great Falls Massacre, gesturing towards contemporary attempts to reckon with the bloody legacy of this event and its ongoing misrepresentation in local history memory. I'll refer to it as the Battle of Turners Falls here as I unpack the ways in which nostalgic memories of this period—and this event in particular—continue to drive white entitlements to the land of Franklin County, as well as to the re-telling of its history. In 2004, Turner's Falls hosted a Reconciliation Ceremony which attempted to "begin to put the traumatic echoes of the past to rest." According to an account of the event by the Nolumbeka Project, "Lloyd 'Running Wolf' Wilcox, the chief medicine man of the Narragansetts, officiated at the ritual, which included an ancient pipe ceremony and a ceremonial fire of birch bark and cedar bows. Anemone Mars, granddaughter of the tribe's medicine woman, Ella Sekatau, was chosen to give the invocation, first in the Narragansett language, then in English. Following the ritual, gifts were presented to the Narragansetts, including tobacco grown in the Wissatinnewag garden." Nolumbeka Project, "Reconciliation Ceremony." A link to the full the Reconciliation Agreement is also available as a link at the source site. A more in-depth reading of this document is another line of potential investigation for this work.

²² Bodge, *Soldiers in King Philip's War*, 241-247.

²³ These descriptions of the Battle of Turners Falls are informed by Henry Kembold's narrative in the "Turner's Falls Fight," posted to the Miner Descent blog. Kembold's blog post synthesizes several 19th century local historical narratives of the event, including Sheldon, *The History of Deerfield*; Everts, *History of the Connecticut Valley in Massachusetts*; and the 1875 article "Peske-ompsk-ut; or, The Falls Fight" published in the *Turners Falls Reporter*. An immediate goal for the future of this project is to share the manuscript with local indigenous communities in order to further contextualize accuracy and bias and also to seek access to less institutionalized resources on and accounts of this historical event and its contemporary legacy from indigenous and Native perspectives. Another future goal is to return to these "local" history texts to more directly engage with the politics and praxes of indigeneity in "colonial" New England. Also relevant is the 2016 Technical Report, *Battle of Great Falls / Wissatinnewag-Peskeompskut (May 19, 1676)* published by the Mashantucket Pequot Museum & Research Center as part of their work on the historical and material history of this event per a grant from the U.S. Department of the Interior's National Parks Service. The investigation is the preliminary step in evaluating the site's potential for inclusion in the National Register of Historical Places's Battlefield category. Such inclusion may, it seems, be another interesting arm of state-sponsored re-membering in the region. See McBride, et al., "Technical Report."

²⁴ Kembold, "Turner's Falls Fight."

²⁵ See Scott, *Montague: Labor and Leisure* for a more in-depth history of the early settlement and manufacturing history of Turners Falls, which is officially a village of Montague, MA.

²⁶ For an overview of some of these tensions, see Demers, "Turners Falls dig into bloody history of American Indian massacre."

²⁷ According to a statement made by Turners Falls High School alum and Nolumbeka Project co-president David Brule, "Our position is that the tribes are the sole judges of what 'honors' them or what does not. We understand the non-tribal traditions and misplaced pride of sports teams using Indian symbols and mascots, but the time has come to let it go." Demers, "Turners Falls dig into bloody history of American Indian massacre."

²⁸ See Demers, "Residents vote four to one to keep Indian mascot at Turners Falls High School" for an account of the non-binding referendum vote and its aftermath in the community.

²⁹ Wolfe, "Settler Colonialism and the Elimination of the Native," 390. Also see J. Kēhaulani Kauanui's 2016 article "'A structure, not an event': Settler Colonialism and Enduring Indigeneity" for useful celebrations and critiques of the ways in which Wolfe's articulation of "structure not event" has been taken up in a variety of critical race and settler colonial studies projects.

³⁰ O'Brien, *Firsting and Lasting*, xii.

³¹ O'Brien, *Firsting and Lasting*, xxii.

³² Klein, *The Shock Doctrine*, 18.

³³ Klein, *The Shock Doctrine*, 19.

³⁴ Text adapted from Warner, "Picturesque Franklin" and archived at Museum of Our Industrial History, "A. F. Towle & Son Co."

³⁵ This history of Lunt Silversmith is from contextual / historical information included in the finding aid for the Lunt archives prepared by Marsha Mills in 2016 for the Manuscripts and Archives Department of UPenn's Hagley Museum and Library. Mills, "Lunt Silversmiths records."

³⁶ For an overview of the Free Silver movement and its relation to the gold standard and the financial crisis of 1893, see Reed, "The Silver Panic."

³⁷ Goldscheider, "At Sword's Point," 5.

³⁸ Goldscheider, "At Sword's Point," 4.

³⁹ Goldscheider, "At Sword's Point," 7.

⁴⁰ Goldscheider, "At Sword's Point," 7. Goldscheider does note, however, that despite investments in a local (clearly white) labor force, factory owners in this period did hire unskilled immigrants from Great Britain and Germany to undertake the most dangerous of the jobs in local works such as grinding and polishing metals (4). Those workers would later be replaced by immigrants from Ireland and Poland who began immigrating to the area in the late 19th and early 20th centuries.

⁴¹ Goldscheider, "At Sword's Point," 12.

⁴² Robinson, *Black Marxism*, 317.

⁴³ Castillo, "The grant history of Lunt Silversmiths on display."

⁴⁴ Kinney, "Lunt Silversmiths' decision to shut down operations."

⁴⁵ DuBois, *Black Reconstruction*, 17.

⁴⁶ Roediger, *Wages of Whiteness*, 13.

⁴⁷ Roediger, *Wages of Whiteness*, 14.

⁴⁸ Georgi, "Lunt Silversmiths."

⁴⁹ *New York Times*, "Gives Plan to Draft Industry in War."

⁵⁰ *New York Times*, "Gives Plan to Draft Industry in War."

⁵¹ Ledbetter, *Unwarranted Influence*, 6. The term "military-industrial complex" was first articulated in a speech given by Dwight D. Eisenhower in 1961 upon his exit from the Presidency. In the now-infamous speech, Eisenhower warned that, "In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the military-industrial complex." Quoted in Ledbetter, *Unwarranted Influence*, 3.

⁵² Raytheon's self-fashioned history is available on their website: "On July 7, 1922, a great American success story began: A few passionate visionaries created a high-tech venture in the shadow of a great university and developed a breakthrough product that transformed a nation." Raytheon, "History." This description is quite telling in its reliance once again on the trope of American Greatness to justify and re-contextualize the rise to power of one of the most violent collaborators of state-sponsored violence.

⁵³ Goldscheider, "At Sword's Point," 7.

⁵⁴ Goldscheider, "At Sword's Point," 8.

⁵⁵ *New York Times*, "F.H. Payne named as aide to Hurley."

⁵⁶ *New York Times*, "Gives Plan to Draft Industry in War."

⁵⁷ For biographical and genealogical information on Payne see the page managed by Nancy D. Coon on Geni.com, "Frederick Huff Payne." Coon, "Frederick Huff Payne."

⁵⁸ Although Raytheon is a major *international* defense contractor today, the company was founded in Cambridge, MA in 1922. It's proximity to Franklin County (located about 2 hours due west of Boston) and its founders' connections to MIT no doubt contributed to the early defense contract secured by Payne for Greenfield. Raytheon, "History."

⁵⁹ Description from Memorial Hall Museum, "Components of a Proximity Fuze made by Raytheon Manufacturing Company during WWII." See source for a short description of the mechanics of the proximity fuze.

⁶⁰ These technical descriptions are gathered from archival footage about the mechanics of the VT fuze and its military impact presented in the video, "The Proximity Fuze: Secret Weapon of World War 2," which is currently archived at Greenfield's Museum of Our Industrial Heritage and streaming on YouTube. Museum of Our Industrial Heritage, "The Proximity Fuze."

⁶¹ Strangely enough, when I was doing initial research on the VT fuze, the only other website that was currently hosting the video archived at Museum of Our Industrial Heritage was UATV, the public television station of the Ukraine. Upon return to investigate the connection later, I couldn't find any reference to the content on website I'd bookmarked to return. Something else worth noting is the name of the Museum of Our Industrial Heritage, particularly the strategic use of the words "our" and "heritage." These are both small nominations that reminds us that industrial history is not really for "everyone" but rather exists as an imaginative device for those who already fall inside as "us" and never outside as "them,"

⁶² Museum of Our Industrial Heritage, "The Proximity Fuze."

⁶³ The only other material related to the fuze in the permanent collections of Springfield's Memorial Hall Museum is a factory badge that belonged to "Constance Olszewski of Montague, Massachusetts, who worked at the plant as a teenager during the summer of 1945" and a brief note that suggests most workers at Greenfield's Raytheon plant were women. See Memorial Hall Museum, "Identification Badge of a Raytheon Manufacturing Company worker during WWII."

⁶⁴ Lloyd, "Peace is Our Only Shelter," 847.

⁶⁵ Lloyd, "Peace is Our Only Shelter," 847.

⁶⁶ Majumdar, "Raytheon Has a Genius Plan to Make the Stinger Missile a Drone-Killer."

⁶⁷ Norton, "Opiate epidemic leads Massachusetts Gov. Deval Patrick to declare public health emergency."

⁶⁸ Schoenberg, "Gov. Deval Patrick signs substance abuse law as national drug policy leaders gather in Boston."

⁶⁹ Norton, "Opiate epidemic leads Massachusetts Gov. Deval Patrick to declare public health emergency."

⁷⁰ According to a 2013 analysis of 2012 U.S. Census data undertaken by MassLive, Western Massachusetts demographics are increasingly diversifying. See Kinney, "Western Massachusetts population getting more diverse."

⁷¹ Kinney, "Lunt Silversmiths' decision to shut down operations."

⁷² Kinney, "Drug treatment centers to open at former Lunt property in Greenfield."

⁷³ Kinney, "Drug treatment centers to open at former Lunt property in Greenfield."

⁷⁴ For a bio, see Raipher, "Joseph A. Pellegrino."

⁷⁵ For a bio, see Raipher, "Raipher D. Pellegrino."

⁷⁶ Kinney, "Drug treatment centers to open at former Lunt property in Greenfield."

⁷⁷ According to BHN's 2017 Annual Report, they "served" a total of approximately 40,000 people in 2017. 42% of BHN clients identified as white, 40% as Hispanic, 7% as black, and 11% as Other/Undisclosed. Of the BHN workforce, approximately 20% identified as male and 80% identified as female, while approximately 50% identified as white, 20% identified as Latino, 14% identified as black, and 16% identified as Other/Undisclosed. See Behavioral Health Network, "BHN Annual Report 2017" for a complete account of BHN service population and employee demographics.

⁷⁸ Munshi and Willse, "Foreword," xiii.

⁷⁹ Rodríguez, "The Political Logic of the Non-Profit Industrial Complex," 22.

⁸⁰ Behavioral Health Network, "About."

⁸¹ The Taskforce's website states that their mission is: "To ensure that our rural region works collectively to help reduce opioid and heroin addiction, prevent overdose deaths, and improve the quality of life in our community." Opioid Task Force, "About Us."

⁸² Quoted in Rodríguez, "The Political Logic of the Non-Profit Industrial Complex," 22.

⁸³ Quoted in Rodríguez, "The Political Logic of the Non-Profit Industrial Complex," 21.

⁸⁴ Rodríguez, "The Political Logic of the Non-Profit Industrial Complex," 22.

⁸⁵ Rodríguez, "The Political Logic of the Non-Profit Industrial Complex," 22.

⁸⁶ Castillo, "Franklin County Sheriff: Detained immigrants treated on par with other inmates."

⁸⁷ My father spent several periods of time incarcerated at the Franklin County House of Corrections and one long-term effect of that incarceration was the rapid onset of

neuropathy in both of his feet due to the grossly inappropriate carbohydrate-filled meals he was fed as part of the jail's "special" diabetic meal option. My dad was someone who embodied many characteristics of ordinary whiteness and was often able to use those connections to formulate sometimes favorable relationships with guards, doctors, and other jail staff. When I think of the kinds of injuries he sustained in the care of the state, I can only imagine the extremes that many folks without such capital encounter when incarcerated in the same site.

⁸⁸ For particularly egregious abuses of such power, see the recent Massachusetts State Police overtime scandal. Six Mass State Troopers currently face charges in federal court and four have been arrested in connection with payroll fraud in seemingly coordinated efforts to misreport overtime hours, essentially embezzling funds directly from the State. Croteau, "Mass. State Police troopers charged in overtime investigation." Recent reporting suggests that MA state police knew as early as 2014 about the fraud but did little to address it. Bombard, "Mass. State Police knew about missed overtime shifts as early as 2014 and did little about it, records show." Now, taking advantage of an especially sweet loophole in the oversight of state power, several troopers under investigation have taken early retirement, cashing out accrued vacation and sick time. For one trooper under investigation, that amount totaled over to \$80,000. Kath, "Troopers Collect Huge Vacation and Sick Time Payouts While Under OT Investigation."

⁸⁹ Serreze, "Springfield nonprofit plans 64-bed detox center at former Lunt Silversmiths site in Greenfield." For a detailed summary of the Site Assessments and a detailed description of the Lunt property and surrounding area, see Town of Greenfield, "Former Lunt Silversmiths Redevelopment Project."

⁹⁰ Serreze, "Springfield nonprofit plans 64-bed detox center at former Lunt Silversmiths site in Greenfield." See Fritz, "Greenfield makes offer on Lunt Silversmith property" for a description of the proposed and eventually passed re-zoning of the area.

⁹¹ Town of Greenfield, "Former Lunt Silversmiths Redevelopment Project."

⁹² Chen, *Animacies*, 10.

⁹³ Chen, *Animacies*, 10.

⁹⁴ Kinney, "Drug treatment centers to open at former Lunt property in Greenfield."

⁹⁵ MassLive, "Lunt Silversmith's facility now home to Franklin Recovery Center and New Hope Center."

⁹⁶ All quotes from MassLive, "Lunt Silversmith's facility now home to Franklin Recovery Center and New Hope Center."

⁹⁷ Harper and Speed, "Uncovering Recovery."

⁹⁸ Harper and Speed, "Uncovering Recovery," 12.

⁹⁹ *Greenfield Recorder*, "District Court Logs."

¹⁰⁰ *Greenfield Recorder*, "District Court Logs."

¹⁰¹ Soloman, "Suicide spotlights intersection between insurance and recovery."

¹⁰² Soloman, "Suicide spotlights intersection between insurance and recovery."

¹⁰³ Broncaccio, "Vet dies in detox center lobby."

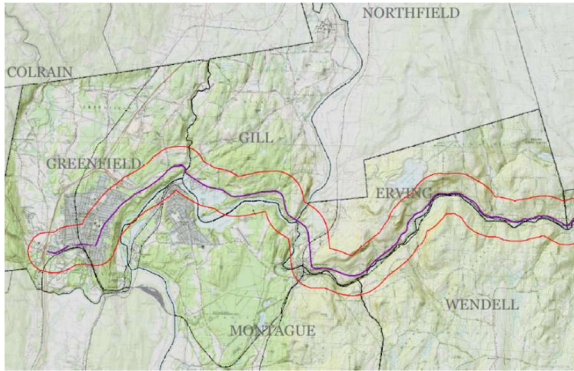
¹⁰⁴ Soloman, "Suicide spotlights intersection between insurance and recovery."

¹⁰⁵ Soloman, "Suicide spotlights intersection between insurance and recovery."

¹⁰⁶ "Open bed" is the phrase commonly used by clinical staff and potential patients to determine whether FRC and other detoxes have room to take on a new "case." Many times, people seeking detox spend 2-3 days on the phone with various programs in an

attempt to match up their need with an “open bed” to which they can actually acquire transportation.

¹⁰⁷ Interestingly, after Dowd’s death his friend Donald Brooks worked with another local woman to organize a peer support group for people who have lost a loved one to suicide. The group is a recent, Franklin County-specific example of a grassroots effort to initiate supports in the community based on shared lived experience and the desire to create connection rather than isolation in the process of coming to terms with loss. Soloman, “New Greenfield group provides support to those who lost a loved one.”

CODA:*Tapping Ecologies of Care in the Surround*

Topographic map of Greenfield and Turners Falls (Franklin Regional Council of Governments, "Mohawk Trail Scenic Byway Corridor Management Plan.")



Snapshot of abandoned mill building at the Connecticut River canals in Turner's Falls (Hedlund, "Turners Falls Massachusetts," Encyclopedia of Forlorn Places.)

In some senses, the soft impression that Greenfield leaves in the rocky topography of Franklin County makes it an easy landing spot for those who traverse rough landscapes—physical and psychic—and seek respite. Fed by the sustaining waters of three gushing rivers—the Connecticut River, the Green River, and the Deerfield River—Greenfield serves as a green-and-blue cradle of sorts for voyagers who follow the west/east trajectory of Route 2 out from the Berkshires and the West County hill towns or utilize the integral Interstate 91 corridor for north/south travel in the region. These roads, which have been carved out of limestone and marble and other bedrock deposits gleaned from what was once an ancient ocean's basin, facilitate the possibility of rapid, wide-scale movement in an area that has long served as a holding point—not quite "here" or "there."¹ The ancestors of these roads—the vast, interconnected networks of forest paths and trails sprawling across and through mountainous terrain, worked and worn by indigenous folks moving all manner of material and feeling—laid the groundwork for

long-standing linkages between the landscape of Franklin County and countless other far-off places. Greenfield, it seems, is a natural place to land.²

Today, long-running freight rails also intersect from all four cardinal directions in Greenfield, illuminating an aging network of transport infrastructure that no doubt contributes to ongoing influxes of “outsiders” who arrive to this town seeking some rest, some work, some community, or some combination of all three. Since the 17th century’s birth of industry in the region, this transportation infrastructure has continuously supported the movement and sheltering of indispensable, albeit often itinerant, temporary, or migrant, community members who may not be “from” here, but who find connection and respite here nonetheless. In the present moment, many of these community members—most often not white, most often un-resourced in the many kinds of capital it takes not just to get on but to thrive in a place where you have no roots—cycle in and out of the area due to an endless range of happenstances and circumstances. Sometimes, those include the labor demands of seasonal agricultural, marginally affordable housing and/or temporary shelter options, or incarceration within the Franklin County’s correctional facility, which houses overflow inmates from other states, in addition to international ICE detainees. The local hospital based in Greenfield likewise serves as a major regional hub for non-insured and/or subsidized access to primary and acute care through emergency room visits and the now in-town community health clinic.³ Combined, these dynamics generate a shifting lot of people who sometimes also bring with them chronic health issues, limitations in movement, or experiences with extreme states, in addition to the daily, grinding reality of finding enough to eat and a place to sleep.

Upon release from (or by evading) the many punitive institutions of Franklin County—the hospital, the jail, and now, Franklin Recovery Center—many folks often struggle to land in safe and stable living situations as they seek to re-root into a new place. Lack of available affordable housing, which may also look like the inability to successfully navigate subsidized housing systems and/or to “prove” one’s qualifications, means that folks do what they need to do to survive, often on their own or through strategic collaboration with others. Sometimes, this looks like the creation and inhabitation of short- and long-term encampments along the region’s vital rivers. The sloping forests that lead from Greenfield up to Turners Falls across the Connecticut River harbor creative possibilities for shelter at least and for sanctuary at most. The woods and rivers of Franklin County support those who cannot or will not access other forms of respite and offer something else to lay down with. If you look right, you may stumble across the kind of shelter constructed painstakingly from sticks and blankets and tarps. One where there might even be a bed with a clean comforter all set up. One where food storage is hard, but a makeshift kitchen complete with a counter helps. And it might even have a place to worship – a DIY church complete with seven seats. A RECOVER Project community member who often sleeps outside—especially when he is experiencing extreme states that get him kicked out of the local shelter—told me about his own encounters with such a setup in the forest between Turners Falls and Greenfield. “I went inside and there was a bed made up, so I moved in,” he told me nonchalantly. “Heard that others have stayed there too. Works okay except for when animals eat your food.”⁴

In these provisional spaces, life without full access to the sanctioned networks of clinical support offered by places like the Franklin Recovery Center might look and feel

different, but the land holds something useful, too.⁵ Those who occupy half-decayed mill buildings choked with supple saplings get up close and personal with what the combined forces of colonialism and capitalism have done to this land. They bear witness to it and live within it, dismantling arbitrary boundaries between the violence of the “forgotten” past and the violence of the “present moment.” In re-populating the often-disavowed spaces where industrial and natural ecologies converge, those existing in the unsanctioned holding spaces of Franklin County make those sites work not in the service of re-calibrated or “recovered” productivity and consumption, but rather towards different rhythms of precarity and reprieve that have been left in the wake. We can, it turns out, listen with great depth and learn much from Franklin County’s many “resistances” to the relentless hegemony of clinical power and ordinary whiteness as they are wielded (and have always been wielded) from sites that escape and/or exceed institutional boundaries.

Resistance is a sticky term—one that I am hesitant to ascribe to the many folks who traffic into and out of, around and through, Franklin County’s unsanctioned holding places, often without much choice in the manner. The messy work of getting on in the face of not enough is both political and not political—an attempt, perhaps concurrently, to appeal to and escape from what Stefano Harney and Fred Moten call “the enclosure” in *The Undercommons: Fugitive Planning and Black Study*. For Harney and Moten, the “enclosure” names false, hoarded, imaginative settler investments in the structural promises of protection—an investment that requires those who lived from *within* the walls of the fort to forget those who surround from without. The fort, they remind us, is always surrounded. “Our task,” Moten and Harney compellingly argue, “is the self-

defense of the surround in the face of repeated, targeted dispossessions through the settler's armed incursion. And while acquisitive violence occasions this self-defense, it is recourse to self-possession in the face of dispossession (recourse, in other words, to politics), that represent the real danger. Politics is an ongoing attack on the common—the general and the antagonism—from within the surround.”⁶ From within this geometry of domination we can clearly locate the enfolding work of the institution (institutions of whiteness, institutions of care, institutions of recognition and belonging) both here in Franklin County and in countless other places long marked and guarded by the protective arithmetic of settler colonialism. It is only by revealing the *falsity* of the enclosure—only by doing the work that Harney and Moten call “fugitive planning”—that we can touch and tap the power of the surround.

An ecology of care taps the surround. It is a tap root in the surround. It looks to the edges of the forest and to the shadowy outcroppings of the fort for guidance on how to take care and give care when the enclosure is burning or otherwise dying.⁷ It listens to the landscapes that have always held life and death—vivacity and violence—together, without demanding the extraction of value from either process. It knows there are other agents of healing that have been burned at the stake and executed by the state. An ecology of care is also necessarily post-opioid; post-synthetic; post-magic bullet; post-manufactured in a lab and sold by a sales agent; post-value-as-whiteness. An ecology of care asks those who surround what is left shaking, barely standing, to speak to each other, to share knowledges and histories and experiences that tell us how to live otherwise. An ecology of care doesn't ask us to reject medical intervention or even clinical diagnoses. Rather, it asks us to recognize that those who settled, those who designed intervention

and diagnosis in the image of white protection and white wealth, and white health are *still in charge*, making the same investments, generating the same profits, discarding the same refuse. An ecology of care amounts to a different structural and affective vision of care where we collectively turn towards what has been outside (sleeping there, fighting there, dreaming there) and, finally, finally, finally be quiet and listen.

And yet, the paradox of the state continues to loom over the emergence of an ecology of care, tempting us into its false lines of reasoning, its false promises of enclosure, and its false mechanisms of valuing what is other to and in excess of itself.

Again, Harney and Moten help us hold the work of resistance up to that lens:

In the clear, critical light of day, illusory administrators whisper of our need for institutions, and all institutions are political, and all politics is correctional, so it seems we need correctional institutions in the common, settling it, correcting us,” they suppose, before discharging such lines of reasoning with a call to what’s without: “But we won’t stand corrected. Moreover, incorrect as we are there’s nothing wrong with us. We don’t want to be correct and we won’t be corrected. Politics proposes to make us better, but we were good already in the mutual debt that can never be made good. We owe it to each other to falsify the institution, to make politics incorrect, to give the lie to our own determination. We owe each other the indeterminate. We owe each other everything.”⁸

The mutual debt that Harney and Moten speak of is fortified through our mutual self-determination, made manifest as we finally divest from that which hurts us, together.

That mutual debt—“*we owe each other everything*”—is shaped and forged in the spaces outside of the common, where we can be together honestly to do the messy work of care, which begets the messy work of becoming accountable to ourselves, to our histories, and to each other.

The lived sense of mutual debt, the shared work of accountability, and the primacy of the indeterminate lay at the center of the ethos and day-to-day life of the RECOVER Project.⁹ Every day except for Sunday, an ordinary storefront door is unlocked at 9 am and people pass through. Some are bone tired and on the verge of dissolution from the exhaustive work of negotiating boundaries that are not supposed to be crossed in properly contained life worlds: messy bottoms, lock ups, institutionalizations, coercive treatment systems. Some of these threshold-crossers may be residents at the recovery house up the street, others arrived in town on a bus at 7am, and some slept outside last night, arriving at the RP to use the bathroom or the phone and to find something to eat in the communal kitchen. Most (though not all) who cross teeter on some edge, often on the other side of what Rosi Braidotti calls a “‘lyrical lament’ – ‘I can’t take it anymore.’”¹⁰ The rippling effects of this lament can look like anything from a classic ‘spiritual awakening’ in the 12-step sense to smaller, almost indecipherable slinkings away from the systems and habits of enclosure that trap us. Regardless of the route, those who enter seek sustenance in the form of recognition, refuge, resource, or recourse. Clinical diagnoses or therapeutic mandates are for later in the day, located across other thresholds. First, someone must make the coffee. Someone must water the plants.

Depending on the day, crossing over and becoming together at the RP may look like 25 very different people assembled together in Community Meeting discussing the ethics and emotional nuances of making clean needle kits available in the bathroom. It may mean slipping into a circle of eight or nine people receiving acupuncture in their ears to help with stress and cravings or running into a veteran’s group that has just disbanded,

participants still raw from making hard connections between their experiences with the trauma of drugs and their experiences with the trauma of war. It may mean listening to the newest jam on your headphones or taking time for silent mediation. These days, you might also pick up some herbs or lay down for cranial-sacral massage thanks to the critical, radical work of the People's Medicine Clinic, a collective of natural healers and body workers who offer their services to RP community free of charge in the spirit of somatic liberation.¹¹ Sometimes, becoming-with at the RP means encountering a gaggle of kids in the space and the common room looks like a preschool; sometimes there's just a quiet assortment of silent folks sipping coffee, seeking refuge for an hour or for the day or for every day, three weeks in a row now. There will almost always be at least one or two long-time community members in the space, ready to receive new folks as they enter and do the nuanced, often draining work of meeting people where they are at. The fresh-from-detox, the just-curious, the court-mandated, and the seasoned 12-steppers are welcomed alike and offered some coffee and a tour. No need to identify with or be in "recovery" to belong here. The rest is up to what those who have just crossed over respond to and are drawn to in this contained experiment with care.

Challenging narratives and legacies of disposability, deficit, and danger, peer recovery communities like the RP offer us visions-in-practice of an ecology of care rooted in the simple idea that everyone who walks through the door already has something of value, something meaningful to contribute, and that can and should have space to make those contributions manifest. Carpenters build shelves to organize print resources. Guitarists offer impromptu afternoon concerts. Mechanically inclined folks organize bike maintenance clinics. Those who aren't sure what they're good can figure it

out. In the process, we collectively turn towards and attend to that which has been outside, in the surround, learning and living and getting on the whole while. Many folks here have been unharnessing from the institution in one way or another, bit by bit, whenever and wherever they can. Many of us know we are already good, despite what the cops or the doctors tell us. Now, the task at hand is to assemble and bless and fortify the undercommons—the networks and passages that make sure that knowledge sticks to the bones of all who have been told otherwise. Anarchist punk visionary Pat the Bunny has something to say about what divestment looks like as we do the concurrent work of building up the otherwise: “So I don’t want to kill a cop / what I want is neighborhoods where they don’t have to get called / When the shit goes down / ‘Cause our friends, they are enough, and our neighbors have enough / Finally we’re enough.”¹² How, I wonder, will the futures of care look when we have turned away from investments in the accumulation of clinical power and are, at last, tapped into and creating nets and networks and practices that implicitly know we are enough?

Notes to Coda

¹ See the chapter “Natural Resources” in the Franklin Regional Council of Government and the Berkshire Regional Planning Commission’s report on the Mohawk Trail Scenic Byway for more specific info on the natural history of the region. Franklin Regional Council of Governments, “Mohawk Trail Scenic Byway Corridor Management Plan.”

² In my own turn towards the ecology and geography of Franklin County in this section, I follow Kathrine McKittrick’s lead in *Demonic Grounds* to de-naturalize the seemingly “natural” connection between self-identity and space that has long cohered entitlement and access to lands in colonized spaces. McKittrick argues, “Geography’s discursive attachment to stasis and physicality, the idea that space ‘just is,’ and that space and place are merely containers for human complexities and social relations, is terribly seductive: that which ‘just is’ not only anchors our selfhood and feet to the ground, it seemingly calibrates and normalizes where, and therefore who, we are” (xi). In this work, I likewise attempt to challenge the subtle and explicit senses of “ownership” and “belonging” to place that no doubt strengthen the entitlements of and to ordinary whiteness in the region. By de-naturalizing the “natural history” of the area as that which belongs “naturally” to the dominant ordering of the community, I wonder what other kinds of belonging we might generate?

³ The Community Health Center of Franklin County is a generative potential ally in the work of reckoning with the many legacies of racial health disparity and clinical power in the region. Upon an initial explanation of my research at an RP Community Meeting in Summer 2016 where the Community Health Center’s Director was present, he expressed keen interest in collaborating on issues of power and justice in local health care. I look forward to connecting with the organization again, particularly now that they’ve moved from their hard-to-reach locale on the south road into Turners Falls to a storefront center on Main Street in Greenfield. See Community Health Center of Franklin County, “About Us” for an overview of the organization and its mission and goals.

⁴ Another friend from the RP community shared with me his experiences sleeping on the steps of a local church in town and befriending the mice that scurried around him at night, until he was eventually forcibly removed by the police and mandated to mental health treatment at Eastspoke, the locked psychiatric ward at Franklin Medical Center.

⁵ Also relevant to this conversation is the fact that many folks who move through liminal / “holding” spaces in Franklin County—the woods, but also the wealth of under-code, slum lord rental apartments and the many other ways to live without a lease—are also enmeshed in sanctioned systems, have been enmeshed there, or may return into those systems at various points. The boundaries between those systems and states of being are continuously in flux for many if not most of the community at the RECOVER Project.

⁶ Harney and Moten, *The Undercommons*, 17.

⁷ Relevant to the concept of care in the surround are recent (and ongoing) collective efforts to learn and practice methods of healing and caregiving that have been systematically disavowed and destroyed by historical and contemporary machinations of clinical power. Although there are no doubt problematic ways in which such “reclamations” are being commodified and stripped of their cultural contexts, examples abound of such re-figurations in the practices and ethics of care that are being directed by

and for indigenous people and folks of color. See in particular Harriet's Apothecary in Brooklyn, who describe themselves as "an intergenerational, healing village led by the brilliance and wisdom of Black Cis Women, Queer and Trans healers, artists, health professionals, magicians, activists and ancestors." Harriet's Apothecary, "Who We Are."

⁸ Harney and Moten, *The Undercommons*, 18.

⁹ I'm thinking here of my mentor Linda Sarage's assertion that in order to do peer recovery work, we must be willing to continuously "live in the question."

¹⁰ Braidotti, "The Ethics of Becoming Imperceptible," 140. This essay was formative to the proposal-stage of this project and has since fallen out of the main theory frame. In a future line of this work, I'd like to return to it again in order to think through some of the ways in which trauma—and in particular, trauma as Braidotti's concept of endurance—may serve as bases of healing connection in peer recovery models.

¹¹ Future lines in this work will likewise look at the People's Medicine Clinic as a rich site of intervention in care in Franklin County.

¹² Pat the Bunny, "My Kind of Fun."

Works Cited

- Ahmed, Sara. *The Cultural Politics of Emotion*. London: Routledge, 2004.
- Ahuja, Neel. *Bioinsecurities: Disease Interventions, Empire, and the Government of Species*. Durham, NC: Duke University Press, 2016.
- Alcoff, Linda Martín. *The Future of Whiteness*. Boston: Polity, 2015.
- Aubrey, Allison. "Tylenol May Help Ease the Pain Of Hurt Feelings." NPR, *Morning Edition*, December 4, 2017. Accessed July 8, 2018.
<https://www.npr.org/sections/health-shots/2017/12/04/567762087/tylenol-may-help-ease-the-pain-of-hurt-feelings>.
- BBC. "Donald Trump says U.S. is in 'moment of crisis.'" BBC Video, July 22, 2016. Accessed December 4, 2017. <https://www.bbc.com/news/av/election-us-2016-36852612/donald-trump-says-us-is-in-moment-of-crisis>.
- Barker, Kristin. *The Fibromyalgia Story: Medical Authority and Women's Worlds of Pain*. Philadelphia: Temple University Press, 2005.
- Behavioral Health Network. "About." BHN. Accessed November 22, 2018.
<https://bhninc.org/about/leadership/>.
- Behavioral Health Network. "BHN Annual Report 2017." BHN, 2017. Accessed November 20, 2018. <https://bhninc.org/2017-annual-report/>.
- Berlant, Lauren. *Cruel Optimism*. Durham, NC: Duke University Press, 2011.
- Bender, George A. *Great Moments in Medicine; the Stories and Paintings in the Series. a History of Medicine in Pictures*. Illustrations by Robert Thom. Midland, MI: Northwood Institute Press, 1966.
- Bennett, Kanya. "Say Her Name: Recognizing Police Brutality Against Black Women." ACLU, June 14, 2018. Accessed November 20, 2018.
<https://www.aclu.org/blog/criminal-law-reform/reforming-police-practices/say-her-name-recognizing-police-brutality>.
- Black Lives Matter. "Black Lives Matter Cambridge is Listening to Our Community." Black Lives Matter. Accessed November 8, 2017.
<https://blacklivesmatter.com/black-lives-matter-cambridge-is-listening-to-our-community>.
- Black Lives Matter. "Healing Justice." Black Lives Matter. Accessed November 2, 2018.
<https://blacklivesmatter.com/healing-justice>.
- Bodge, George M. *Soldiers in King Philip's War*. Leominster, Mass. Printed for Author, 1896.
- Bombard, Noah R. Mass. "State Police knew about missed overtime shifts as early as 2014 and did little about it, records show." MassLive, August 13, 2018. Accessed November 23, 2018.

https://www.masslive.com/news/index.ssf/2018/08/mass_state_police_knew_about_m.html.

Boston Globe Staff. "Read a transcript of Trump's remarks in N.H." *Boston Globe*, March 19, 2018. Accessed July 20, 2018.

<https://www.bostonglobe.com/news/politics/2018/03/19/read-transcript-trump-remarks/6lie27RlDkc1VgtlZvUBfL/story.html>.

Bowen, Eric Ph.D.; Christiadi, Ph.D., John Deskins, Ph.D., and Brian Lego. "An Overview of the Coal Economy in Appalachia." Commissioned by the Appalachian Regional Commission, January 2018. Accessed July 2, 2018. https://www.arc.gov/assets/research_reports/CIE1-OverviewofCoalEconomyinAppalachia.pdf.

Boyer, Dave. "Trump takes aim at Black Lives Matter, slams 'hostility and violence' against police." *The Washington Times*, May 15, 2017. Accessed July 8, 2018. <https://www.washingtontimes.com/news/2017/may/15/donald-trump-police-need-better-protection/>.

Braidotti, Rosi. "The Ethics of Becoming-Imperceptible." In *Deleuze and Philosophy*. Edited by Constantin V. Boundas. Edinburgh: Edinburg University Press: 133-159.

Briggs, Laura. "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology." *American Quarterly* 52.2 (2000): 246-273.

Broncaccio, Diane. "Vet dies in detox center lobby." *Greenfield Recorder*, February 13, 2017. Accessed June 29, 2017. <https://www.recorder.com/Greenfield-vet-ends-life-in-detox-center-lobby-8074983>.

Brooks, Rebecca Beatriz. "The History of King Philip's War." *HistoryofMassachusetts.org*, May 31, 2017. Accessed November 21, 2018. <http://historyofmassachusetts.org/what-was-king-philips-war/>.

brown, adrienne maree. *Emergent Strategy: Shaping Change, Changing Worlds*. Chico, CA: AK Press, 2017.

Bushman, Richard Lyman. "The Complexity of Silver." *Publications of Colonial Society of Massachusetts* 70 (2001): 1-15.

Butler, Octavia. *Parable of the Sower*. New York: Grand Central Publishing, 2000.

Butler, Octavia. *Parable of the Talents*. New York: Grand Central Publishing, 2000.

Care Ethics Research Consortium. Accessed November 14, 2018. <https://care-ethics.org>.

Case, Anne and Sir Angus Deaton. Mortality and morbidity in the 21st century. *Brookings*, March 23, 2017. Accessed July 7, 2018. <https://www.brookings.edu/bpea-articles/mortality-and-morbidity-in-the-21st-century/>.

- Castillo, Andy. "The grant history of Lunt Silversmiths on display." *The Greenfield Recorder*, August 28, 2017. Accessed August 26, 2018. <https://www.recorder.com/Lunt-Silver-display-12101537>.
- Castillo, Andy. "Franklin County Sheriff: Detained immigrants treated on par with other inmates." *The Greenfield Recorder*, August 14, 2017. Accessed November 23, 2018. <https://www.recorder.com/Sheriff-Human-Rights-Commission-11869518>.
- Centers for Disease Control. "Data Overview: Overview of the Drug Overdose Epidemic: Behind the Numbers." *CDC*, August 9, 2018. Accessed November 20, 2018. <https://www.cdc.gov/drugoverdose/data/index.html>.
- Centers for Disease Control. "Opioid Overdose: Understanding the Epidemic." *CDC*, August 30, 2017. Accessed November 20, 2018. <https://www.cdc.gov/drugoverdose/epidemic/index.html>.
- Centers for Medicare & Medicaid Services, "Promoting Interoperability (PI)." *Centers for Medicare & Medicaid Services*, November 16, 2018. Accessed November 20, 2018. <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms>.
- Chamberlin, Judi. *On Our Own: Patient Controlled Alternatives to the Mental Health System*. New York: Hawthorne Books, 1978.
- Chen, Mel Y. *Animacies: Biopolitics, Racial Mattering, and Queer Affect*. Durham, NC: Duke University Press, 2012.
- Childress, Sarah. "How the Heroin Epidemic Differs in Communities of Color." *PBS Frontline*, February 23, 2016. Accessed July 8, 2018. <https://www.pbs.org/wgbh/frontline/article/how-the-heroin-epidemic-differs-in-communities-of-color/>.
- Clare, Eli. "Stolen Bodies, Reclaimed Bodies: Disability and Queerness" *Public Culture* 13.3 (2001): 359-365.
- Clarke, Adele, Laura Mamo, Jennifer Ruth Fosket, Jennifer R. Fishman, and Janet K. Shim, eds. *Biomedicalization: Technoscience, Health, and Illness in the U.S.* Philadelphia: Temple University Press, 2010.
- Clough, Patricia Ticineto. "Rethinking Race, Calculation, Quantification, and Measure." *Cultural Studies, Critical Methodologies* 16.5 (2016): 435-441.
- Clough, Patricia Ticineto and Craig Willse. "Introduction: Beyond Biopolitics: The Governance of Life and Death." In *Beyond Biopolitics: Essays on the Governance of Life and Death*. Edited by Patricia Ticineto Clough and Craig Willse. Durham, NC: Duke University Press, 2011.
- Community Health Center of Franklin County. "About Us." Community Health Center of Franklin County. Accessed November 23, 2018. <http://www.chcfc.org/about-us.html>.

- Connelly, Andrew. "Should giant Charles Byrne be left to rest in peace?" *Al-Jazeera*, November 7, 2017. Accessed December 8, 2017.
<https://www.aljazeera.com/indepth/features/2017/09/giant-charles-byrne-left-rest-peace-170918135540891.html>.
- Coon, Nancy D. "Frederick Huff Payne." Geni, March 12, 2015. Accessed November 20, 2018. <https://www.geni.com/people/Frederick-Payne/6000000027755565619>.
- Cooper, Brittney C. *Beyond Respectability: The Intellectual Thought of Race Women*. Champaign, IL: University of Illinois Press, 2017.
- Cooper, Melinda. *Life as Surplus: Biotechnology & Capitalism in the Neoliberal Era*. Seattle: University of Washington Press, 2008.
- Croteau, Scott J. Mass. "State Police troopers charged in overtime investigation appear to be worst offenders for allegedly skipping shifts." *MassLive*, September 3, 2018. Accessed November 23, 2018.
https://www.masslive.com/news/index.ssf/2018/09/mass_state_police_troopers_cha.html.
- Crowe, Eyre. *Slave Auction at Richmond, Virginia (1856)*. 1856. Pen and ink. Garthewin Additional Collection, Department of Archives and Manuscripts, University of Wales, Bangor. Accessed December 4, 2017.
<https://eyrecrowe.com/pictures/1850s/slave-auction-at-richmond/>.
- Cvetkovich, Ann. *An Archive of Feelings: Trauma, Sexuality, and Lesbian Public Cultures*. Durham, NC: Duke University Press, 2003.
- Dahmer, David. "Town Hall Tonight Will Address Surging Opioid Crisis in Black Community." *Madison 360*, June 19, 2018. Accessed November 20, 2018.
<https://madison365.com/town-hall-tonight-will-address-surging-opioid-crisis-in-black-community/>.
- Deleuze, Gilles and Felix Guattari. *A Thousand Plateaus: Capitalism and Schizophrenia*. Minneapolis: University of Minnesota Press, 1987.
- Demers, Phil. "Residents vote four to one to keep Indian mascot at Turners Falls High School." *MassLive*, May 16, 2017. Accessed November 22, 2018.
https://www.masslive.com/news/index.ssf/2017/05/montague_residents_vote_four_t.html.
- Demers, Phil. "Turners Falls dig into bloody history of American Indian massacre helping spur move to change high school mascot. *MassLive*, October 26, 2016. Accessed November 22, 2018.
https://www.masslive.com/news/index.ssf/2016/09/in_turners_dig_into_bloody_mas.html
- DeWall, CN; G. Macdonald; GD Webster; CL Masten; RF Baumeister; C Powell; D Combs; DR Schurtz; TF Stillman; DM Tice; NI Eisenberger. Acetaminophen reduces social pain: behavioral and neural evidence. *Psychological Science* 21.7 (2014): 931-937.

- DiAngelo, Robin. "White Fragility." *International Journal of Critical Pedagogy* 3.3 (2011): 54-70.
- Diedrich, Lisa. "Que(e)rying the Clinic Before AIDS: Practicing Self-Help and Transversality in the 1970s." *Journal of Medical Humanities* 34 (2013): 123-138.
- Dodge, Cyndi. "How can ANY Detox turn a desperate veteran away - twice !!!!!!" Facebook, February 14, 2017. Accessed June 28, 2017. <https://www.facebook.com/cyndi.dodge/posts/1671475152868186>.
- Dowell, Deborah M.D., MPH; Elizabeth Arias, PhD; Kenneth Kochanek, MA; Robert Anderson, PhD; Gery P. Guy Jr, PhD, MPH; Jan L. Losby, PhD, MSW; Grant Baldwin, PhD, MPH. "Contribution of Opioid-Involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015." *JAMA* 318.11 (2017): 1065–1067
- Dtouch, "History Of Medicine: All 45 Paintings By Robert Thom." *Imgur*, June 11, 2014. Accessed November 2, 2017. <https://imgur.com/gallery/qXSrn>.
- DuBois, W.E.B. *Black Reconstruction*. New York: Harcourt, Brace and Company, 1935.
- Duffin, Jacalyn and Alison Li. "Great Moments: Parke, Davis and Company and the Creation of Medical Art." *The History of Science Society* 86.1 (1995): 1-29.
- Eveleth, Rose. "Why No One Can Design a Better Speculum." *The Atlantic*, November 17, 2014. Accessed December 3, 2017. <https://www.theatlantic.com/health/archive/2014/11/why-no-one-can-design-a-better-speculum/382534/>.
- Everett, C.S. "Melungeon History and Myth." *Appalachian Journal* 26.4 (1999): 358-409.
- Everts, L.H., *History of the Connecticut Valley in Massachusetts, with illustrations and biographical sketches of some of its prominent men and pioneers*. Philadelphia: Louis H. Everts, 1879.
- Eyre, Eric. "Opioid crisis drives a grim business in WV: body transport." *Charleston Gazette-Mail*, September 27, 2017. Accessed December 4, 2017. https://www.wvgazettemail.com/news/opioid-crisis-drives-a-grim-business-in-wv-body-transport/article_66740a51-3672-5c18-b1ed-63a89cc99fe6.html.
- Eyre, Eric. "780M pills, 1,728 deaths." *Charleston Gazette-Mail*, December 18, 2016. Published by The Pulitzer Prizes, 2017. Accessed November 3, 2017. <https://www.pulitzer.org/winners/eric-eyre>.
- Eyre, Eric. "Pill rules not enforced." *Charleston Gazette-Mail*, December 19, 2016. Published by The Pulitzer Prizes, 2017. Accessed November 3, 2017. <https://www.pulitzer.org/winners/eric-eyre>.

- Eyre, Eric. "Drug firms fueled 'pill mills' in rural W.Va." *Charleston Gazette-Mail*, May 23, 2016. Published by The Pulitzer Prizes, 2017. Accessed November 3, 2017. <https://www.pulitzer.org/winners/eric-eyre>.
- Fanon, Frantz. *Black Skin, White Masks*. Translated by Charles Lam Markmann. London: Pluto Press, 1986.
- Ferguson, Roderick A. *The Reorder of Things: The University and Its Pedagogies of Minority Difference*. Minneapolis: University of Minnesota Press, 2012.
- Foucault, Michel. *Society Must Be Defended: Lectures at the Collège de France, 1975-1976*. London: Picador, 2003.
- Foucault, Michel. *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage Books, 1994.
- Foucault, Michel. "Truth and Power." In *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*. Edited by Colin Gordon. Translated by Colin Gordon, Leo Marshall, John Mepham, and Kate Soper. New York: Pantheon Books, 1980.
- Foucault, Michel. *The History of Sexuality, Volume 1: An Introduction*. Translated by Robert Hurley. New York: Pantheon Books, 1978.
- Franklin Regional Council of Governments and Berkshire County Regional Planning Commission. "Mohawk Trail Scenic Byway Corridor Management Plan." Franklin Regional Council of Governments, June 2002. Accessed November 23, 2018. <https://frcog.org/publication/mohawk-trail-west-scenic-byway-corridor-management-plan/>.
- Frey, William H. "The US will become 'minority white' in 2045, Census projects." *Brookings*, March 14, 2018. Accessed June 20, 2018. <https://www.brookings.edu/blog/the-avenue/2018/03/14/the-us-will-become-minority-white-in-2045-census-projects/>.
- Freydl, Kathleen. "The Oxy Electorate: A Scourge of Addiction and Death Siloed in Fly-Over Country." *Medium*, November 16, 2016. Accessed July 2, 2018. <https://medium.com/@kfrydl/the-oxy-electorate-3fa62765f837>.
- Freyer, Felice J. "Is the opioid epidemic easing in Mass.?" *Boston Globe*, August 22, 2017. Accessed December 3, 2017. <https://www.bostonglobe.com/metro/2017/08/22/opioid-related-deaths-decline-mass/58Ya97almjKLaqtcLwl6VJ/story.html>.
- Fritz, Anita. "Greenfield makes offer on Lunt Silversmith property." *The Daily Hampshire Gazette*, December 18, 2012. Accessed November 23, 2018. <https://www.gazettenet.com/Archives/2012/12/GRLuntpropertyRECO-hg-120512>.
- Gamble, Vanessa Northington. "Remembering Anarcha, Lucy, and Betsey: The Mothers of Modern Gynecology." Interview by Shankar Vedantam. *National Public Radio, Hidden Brain*, February 16, 2016. Accessed December 1, 2017. <https://www.npr.org/templates/transcript/transcript.php?storyId=466942135>.

- Geo Wyeth. *Quartered*. 2014. *Vimeo*. <https://vimeo.com/89525432>
- Georgi B. "Lunt Silversmiths: Rogers, Lunt & Bowlen Company." *A Small Collection of Antique Silver and Objects of Vertu*. Accessed November 22, 2018. <http://www.silvercollection.it/usasillunt.html>
- Gilligan, Carol. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, MA: Harvard University Press, 1982.
- Gilmore, Ruth Wilson. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California*. Berkeley, CA: University of California Press, 2007.
- Gilmore, Ruth Wilson. "Fatal Couplings of Power and Difference: Notes on Racism and Geography." *The Professional Geographer* 54.1 (2002): 15-24.
- Glod, Susan A., M.D. "The Other Victims of the Opioid Epidemic." *The New England Journal of Medicine* 376 (2017): 2101-2102.
- Goldberg, David Theo. *The Threat of Race: Reflections on Racial Neoliberalism*. Malden, MA: Wiley-Blackwell, 2009.
- Goldscheider, Tom. "At Swords Point – an Organized Labor History of Greenfield." Museum of Our Industrial Heritage, November 2017. Accessed November 22, 2018. <http://industrialhistory.org/wp-content/uploads/2017/08/At-Swords-Point-Article.pdf>.
- Goldstein, Alyosha, ed. *Formations of United States Colonialism*. Durham, NC: Duke University Press, 2014.
- Greenfield Recorder*. "District Court Logs, Sept. 28 to Oct. 3, 2017." *Greenfield Recorder*, October 5, 2017. Accessed November 23, 2018. <https://www.recorder.com/The-latest-distrrict-court-logs-from-Franklin-County-12909258>.
- Guattari, Emmanuelle. *I, Little Asylum*. Translated by E.C. Belli. Boston: MIT Press, 2014.
- Guo, Jeff. "The disease killing white Americans goes way deeper than opioids." *The Washington Post*, March 17, 2017. Accessed October 19, 2017. https://www.washingtonpost.com/news/wonk/wp/2017/03/24/the-disease-killing-white-americans-goes-way-deeper-than-opioids/?noredirect=on&utm_term=.e45e0b8f3720.
- Hansen, M.B.N. *Feed-forward: On the Future of Twenty-First Century Media*. Chicago, IL: University of Chicago Press, 2015.
- Harney, Stefano and Fred Moten. *The Undercommons: Fugitive Planning & Black Study*. New York: Minor Compositions, 2013.
- Harper, David and Ewen Speed. "Uncovering Recovery: The Resistable Rise of Recovery and Resilience." *Studies in Social Justice* 6.1 (2012): 9-25.

- Harriet's Apothecary, "Who We Are." Harriet's Apothecary. Accessed November 23, 2018. <http://www.harrietsapothecary.com/who-we-are/>.
- Hartman, Saidiya. *Lose Your Mother: A Journey Along the Atlantic Slave Route*. New York: Farrar, Strauss and Giroux, 2008.
- Hedlund, Mark. "Turner's Falls, Massachusetts." Encyclopedia of Forlorn Places, October 20, 2013. Accessed November 23, 2018. <http://cofp.net/turnersfalls.html>.
- Hennessy-Fiske, Molly. "Trump administration transfers hundreds of migrant children to border tent camp." *Los Angeles Times*, October 3, 2018. Accessed November 20, 2018. <https://www.latimes.com/nation/la-na-texas-tornillo-20181003-story.html>.
- Henning, Kelly J. "Overview of Syndromic Surveillance: What is Syndromic Surveillance?" New York City Department of Health and Mental Hygiene, September 24, 2004. Accessed November 2, 2017. <https://www.cdc.gov/mmwr/preview/mmwrhtml/su5301a3.htm>.
- Henry Lunt of Newbury. "George C. Lunt (Silversmith)." Henry Lunt of Newbury: Sponsored by Descendants of Henry Lunt, March 22, 2011. Accessed September 2, 2018. <http://henryluntofnewbury.blogspot.com/2011/03/george-c-lunt.html>.
- Heroin(e)*. Directed by Elaine Mcmillion. Center for Investigative Reporting & Requisite Media, 2017. <https://www.netflix.com/mx-en/title/80192445>.
- Higginbotham, Evelyn Brooks. *Righteous Discontent: The Women's Movement in the Black Baptist Church, 1880-1920*. Cambridge, MA: Harvard University Press, 1993.
- Historical Society of Pennsylvania. "What the Doctor Ordered: Dr. Benjamin Rush Responds to Yellow Fever." Accessed February 3, 2018. <https://hsp.org/education/unit-plans/diagnosing-and-treating-yellow-fever-in-philadelphia-1793/what-the-doctor-ordered-dr-benjamin-rush-responds-to-yellow-fever>.
- Hobbs, Stillman M. "The Moulton and Towle Silversmiths." In *Hampton's 1962 "Old Home Day" Program*, Lane Memorial Library. Accessed November 20, 2018. <http://www.hampton.lib.nh.us/hampton/history/1988/silversmiths.htm>.
- Hoefle, Milton, L. "The Early History of Parke-Davis and Company." *Bulletin for the History of Chemistry* 25.1 (2000): 28-34.
- Hong, Grace Kyungwon. "Neoliberalism." *Critical Ethnic Studies* 1.1 (201 5): 56-67.
- Institute for Contemporary Art: Boston. *When the Stars Begin to Fall: Imagination and the*

American South. February 4 – May 10, 2015. Accessed December 3, 2017.
<https://www.icaboston.org/exhibitions/when-stars-begin-fall-imagination-and-american-south>.

International Society for Disease Surveillance. “Electronic Syndromic Surveillance Using Hospital Inpatient and Ambulatory Clinical Care Electronic Health Record Data: Recommendations from the ISDS Meaningful Use Workgroup.” International Society for Disease Surveillance, November 2012. Accessed November 8, 2018.
https://knowledge-repository.s3.amazonaws.com/recommendations/Recommendations_2012_11_MU_Recommendations.pdf.

Jaggar, Alison M. “Caring as a Feminist Practice of Moral Reason.” In *Justice and Care: Essential Readings in Feminist Ethics*, edited by Virginia Held. Boulder, CO: Westview Press, 1995: 179-202.

James, Keturah and Ayana Jordan. “The Opioid Crisis in Black Communities.” *Journal of Law, Medicine, and Ethics* 46 (2018): 404-421.

Kapsalis, Terri. *Public Privates: Performing Gynecology from Both Ends of the Speculum*. Durham, NC: Duke University Press, 1997.

Kath, Ryan. “Troopers Collect Huge Vacation and Sick Time Payouts While Under OT Investigation.” NECN, October 25, 2018. Accessed on November 23, 2018.
<https://www.necn.com/news/new-england/Troopers-Collect-Huge-Vacation-and-Sick-Time-Payouts-While-Under-Investigation-498579611.html>.

Katz, Josh. “Drug Deaths in America Are Rising Faster Than Ever.” *The New York Times*, June 5, 2017. Accessed December 4, 2017.
<https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html>.

Kauanui, J. Kēhaulani. “‘A structure, not an event’: Settler Colonialism and Enduring Indigeneity.” *Lateral: Journal of the Cultural Studies Association* 5.1 (2016):
<https://doi.org/10.25158/L5.1.7>.

Kembold, Henry. “Turner’s Falls Fight.” *Miner Descent* blog, April 2, 2012. Accessed July 3, 2018. <https://minerdescent.com/2012/04/01/turners-falls-fight/>.

Kinney, Jim. “Drug treatment centers to open at former Lunt property in Greenfield.” MassLive, July 11, 2016. Accessed July 23, 2018.
https://www.masslive.com/business-news/index.ssf/2016/07/drug_treatment_centers_to_open_at_former.html.

Kinney, Jim. “Western Massachusetts population getting more diverse.” MassLive, June 13, 2013. Accessed November 22, 2018. https://www.masslive.com/business-news/index.ssf/2013/06/western_massachusetts_population_getting.html.

Kinney, Jim. “Lunt Silversmiths' decision to shut down operations, prompts Greenfield to seek ways to reuse property.” MassLive, November 19, 2009. Accessed

- November 22, 2018.
https://www.masslive.com/news/index.ssf/2009/11/lunt_silversmiths_decision_to.html
- Klein, Naomi. *The Shock Doctrine: The Rise of Disaster Capitalism*. New York: Metropolitan Books, 2007.
- Kliff, Sarah. "The opioid crisis changed how doctors think about pain." *Vox*, June 5, 2017. Accessed July 3, 2018. <https://www.vox.com/2017/6/5/15111936/opioid-crisis-pain-west-virginia>.
- Kosten, Thomas R., M.D. and Tony P. George, M.D. "The Neurobiology of Opioid Dependence: Implications for Treatment." *Science & Practice Perspectives* 1.1 (2002): 13-20.
- Ledbetter, James. *Unwarranted Influence: Dwight D. Eisenhower and the Military-Industrial Complex*. New Haven: Yale University Press, 2011.
- Lenz, W. "A Short History of Thalidomide Embryopathy." *Teratology* 38.3 (1988): 203-215.
- Lockhart, P.R., "New York just removed a statue of a surgeon who experimented on enslaved women." *Vox*, April 18, 2018. Accessed July 1, 2018.
<https://www.vox.com/identities/2018/4/18/17254234/j-marion-sims-experiments-slaves-women-gynecology-statue-removal>
<https://www.vox.com/identities/2018/4/18/17254234/j-marion-sims-experiments-slaves-women-gynecology-statue-removal>.
- Lipsitz, George. "The Possessive Investment in Whiteness: Racialized Social Democracy and the 'White Problem' in American Studies." *American Quarterly* 47.3 (1995): 369-387.
- Livingston, Julie. *Debility and the Moral Imagination in Botswana*. Bloomington: Indiana University Press, 2005.
- Lloyd, Jenna M. "'Peace is Our Only Shelter': Questioning Domesticities of Militarization and White Privilege." *Antipode: A Radical Journal of Geography* 43.3 (2011): 845-873.
- Lorde, Audre. *The Cancer Journals*. San Francisco: Aunt Lute Books, 2006.
- Lunt, Thomas Simpson. *Lunt: A History of the Lunt Family in America*. Salem, MA: Salem Press Co., 1914. Accessed November 22, 2018.
<https://ia800207.us.archive.org/28/items/lunthistoryoflun00lunt/lunthistoryoflun00lunt.pdf>.
- Majumdar, Dave. "Raytheon Has a Genius Plan to Make the Stinger Missile a Drone-Killer." *The National Interest*, June 4, 2017. Accessed November 3, 2018.
<https://nationalinterest.org/blog/the-buzz/raytheon-has-genius-plan-make-the-stinger-missile-drone-20995>.

- Marez, Curtis. *Drug Wars: The Political Economy of Narcotics*. Minneapolis: University of Minnesota Press, 2004.
- MassLive, "Lunt Silversmith's facility now home to Franklin Recovery Center and New Hope Center." MassLive Video <https://www.youtube.com/watch?v=eMiKyjOjuo0>, YouTube, July 8, 2016. Accessed November 23, 2018 <https://www.youtube.com/watch?v=eMiKyjOjuo0>.
- Mathis-Lilley, Ben. "Huckabee Claims Black People Aren't Technically Citizens During Critique of Unjust Laws." *Slate*, September 11, 2015. Accessed December 5, 2017. <https://slate.com/news-and-politics/2015/09/mike-huckabee-dred-scott-black-people-arent-fully-human-under-law-he-erroneously-claims.html>.
- Metzel, Jonathan M. and Joel D. Howell. "Great Moments: Authenticity, Ideology, and the Telling of Medical 'History.'" *Literature and Medicine* 25.2 (2006): 502-521.
- McBride, Kevin, David Naumec, Ashley Bissonnette, and Noah Fellman. "Technical Report: Battle of Great Falls / Wissatinnewag-Peskeompskut (May 19, 1676): Pre-Inventory Research and Documentation Plan." Mashantucket Pequot Museum & Research Center, April 2016. Accessed November 22, 2018. https://www.montague-ma.gov/files/Battle_of_Great_Falls_Phase_I_Final_Technical_Report.pdf.
- McCraig, Amy. "Rice's Zoë Wool wins NSF CAREER Award." *TMC News*, April 5, 2018. Accessed November 21, 2018. <http://www.tmc.edu/news/2018/04/rices-zoe-wool-wins-nsf-career-award/>.
- McGauley, Joe. "13 Items You Never Knew Were Made By Prisoners." *Thrillist*, May 20, 2015. Accessed November 1, 2018. <https://www.thrillist.com/gear/products-made-by-prisoners-clothing-furniture-electronics#>.
- McHenry, Leemon. "Biomedical Research and Corporate Interests: A Question of Academic Freedom." *Mens Sana Monographs* 6.1 (2008): 146-156
- McKittrick, Katherine. *Demonic Grounds: Black Women And The Cartographies Of Struggle*. Minneapolis: University of Minnesota Press, 2006.
- McRuer, Robert. *Crip Theory: Cultural Signs of Queerness and Disability*. New York: NYU Press, 2006.
- Melamed, Jodi. "The Spirit of Neoliberalism: From Racial Liberalism to Neoliberal Multiculturalism." *Social Text* 89.24.4 (2006): 1-24.
- Melamed, Jodi. "Racial Capitalism." *Critical Ethnic Studies* 1.1 (2015): 76-85.
- Memorial Hall Museum. "Components of a Proximity Fuze made by Raytheon Manufacturing Company during WWII." Memorial Hall Museum Online Collection. Accessed November 20, 2018. <http://www.memorialhall.mass.edu/collection/itempage.jsp?itemid=18397>.
- Memorial Hall Museum. "Identification Badge of a Raytheon Manufacturing Company worker during WWII." Memorial Hall Museum Online Collection. Accessed

- November 20, 2018.
<http://www.memorialhall.mass.edu/collection/itempage.jsp?itemid=18396>
- Miller, Greg, Julie Vitkovskaya, and Reuben Fischer-Baum. “‘This deal will make me look terrible’: Full transcripts of Trump’s calls with Mexico and Australia.” *The Washington Post*, August 3, 2017. Accessed October 4, 2017.
https://www.washingtonpost.com/graphics/2017/politics/australia-mexico-transcripts/?utm_term=.66d3c9639701.
- Mills, Marcia. “Lunt Silversmiths Records: 2544.” Manuscripts and Archives Department, Museum and Library, University of Pennsylvania. October 25, 2017. Accessed November 22, 2018.
http://dla.library.upenn.edu/cocoon/dla/pacscl/ead.pdf?sort=date_added_sort%20desc&fq=top_repository_facet%3A%22Hagley%20Museum%20and%20Library%22&id=PACSCL_HML_2544&.
- Mol, Annemarie. *The Body Multiple: Ontology in Medical Practice*. Durham, NC: Duke University Press, 2003.
- Muñoz, José Esteban. “Feeling Brown, Feeling Down: Latina Affect, the Performativity of Race, and the Depressive Position.” *Signs* 31.3 (2006): 675-688.
- Munshi, Soniya and Craig Willse. “Foreword.” *The Revolution Will Not Be Funded: Beyond the Non-Profit Industrial Complex*. Edited by INCITE! Durham, NC: Duke University Press, 2007: xiv-xxii.
- Museum of Our Industrial Heritage. “A. F. Towle & Son Co., Greenfield MA.” Museum of Our Industrial Heritage. Accessed November 22, 2018.
<http://industrialhistory.org/histories/a-f-towle-son-co-greenfield-ma/>.
- Museum of Our Industrial Heritage. “The Proximity Fuze: Secret Weapon of World War 2.” YouTube, October 15, 2012. Accessed November 2, 2018.
<https://www.youtube.com/watch?v=6-D592VR4RU>.
- National Institute on Drug Abuse. “Overdose Death Rates.” *National Institute on Drug Abuse*. August 2018. Accessed November 20, 2018.
<https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.
- Nelson, Alonda. *Body and Soul: The Black Panther Party and the Fight Against Medical Apartheid*. Minneapolis: University of Minnesota Press, 2013.
- Neuman, William. “City Orders Sims Statue Removed From Central Park.” *The New York Times*, April 16, 2018. Accessed July 2, 2018.
<https://www.nytimes.com/2018/04/16/nyregion/nyc-sims-statue-central-park-monument.html>.
- Newbury Historical Commission. “Early Settlement.” Newbury Historical Commission. Accessed July 2, 2018. <http://newbury1635.org/early-settlement.html>.
- Newkirk, Vann R. II. “What the ‘Crack Baby’ Panic Reveals About The Opioid Epidemic.” *The Atlantic*, July 16, 2017. Accessed October 22, 2017.

<https://www.theatlantic.com/politics/archive/2017/07/what-the-crack-baby-panic-reveals-about-the-opioid-epidemic/533763/>

The New York Times Staff, "Gives Plan to Draft Industry in War: Assistant Secretary F.H. Payne Says Production Burden Will Be Appropriated." Special to the *The New York Times*, October 23, 1930, 21.

The New York Times Staff, "F.H. Payne Named as Aide to Hurley: Hoover Picks Massachusetts Industrial Leader as Assistant Secretary of War." Special to the *The New York Times*, April 23, 1930, 4.

Ngai, Sianne. *Ugly Feelings*. Cambridge, MA: Harvard University Press, 2007.

Noddings, Nel. *Caring: A Feminine Approach to Ethics & Moral Education*. Berkeley: University of California Press, 1984.

Nolan, Dan and Chris Amico. "How Bad is the Opioid Epidemic?" *PBS Frontline*, February 23, 2016. Accessed December 3, 2017.
<https://www.pbs.org/wgbh/frontline/article/how-bad-is-the-opioid-epidemic/>.

Nolumbeka Project, "Reconciliation Ceremony." Nolumbeka Project, May 19, 2004. Accessed November 22, 2018.
<http://nolumbekaproject.blogspot.com/p/reconciliation-ceremony-2004.html>.

Norton, Michael. "Opiate epidemic leads Massachusetts Gov. Deval Patrick to declare public health emergency." *MassLive*, March 27, 2014. Accessed November 2, 2018.
https://www.masslive.com/politics/index.ssf/2014/03/opiate_epidemic_leads_mas_sachu.html.

O'Brien, Jean M. *Firsting and Lasting: Writing Indians out of Existence in New England*. Minneapolis: University of Minnesota Press, 2010.

Ojanuga, D. "The medical ethics of the 'father of gynaecology', Dr. J. Marion Sims." *Journal of Medical Ethics* 19.1 (1993): 28-31.

Omi, Michael and Howard Winant. *Racial Formation in the United States: From the 1960s to 1990s*. New York: Routledge, 1994.

Opioid Task Force. "About Us." Opioid Task Force, 2018. Accessed November 23, 2018.
<http://opioidtaskforce.org/about-us/>.

Page, Cara. "Reflections from Detroit: Transforming Wellness & Wholeness." INCITE! Blog, August 5, 2010. Accessed November 1, 2018. <https://incite-national.org/2010/08/05/reflections-from-detroit-transforming-wellness-wholeness>.

Palache, Charles. "The Chipman Lead-Silver Mine in Newbury, Mass." *Rocks & Minerals* 25.5-6 (1950): 247-249.

- Park, Alice. "The Story Behind the Viral Photo of an Opioid Overdose." *Time*, January 24, 2017. Accessed October 18, 2018. <http://time.com/4634809/photo-opioid-addiction>.
- Parts Unknown*. "Massachusetts." Season 4, Episode 7. Directed by Toby Oppenheimer. CNN, November 9, 2014.
- Pat the Bunny. "My Idea of Fun." Wingnut Dishwasher's Union, *Burn the Earth! Leave it Behind!*. Audio Recording. Seattle, WA: Crafty Records, 2010.
- Piepzna-Samarasinha, Leah Lakshmi. "A Not-So-Brief Personal History of the Healing Justice Movement, 2010-2016." *Mice Magazine*, Fall 2016. Accessed November 2, 2018. <http://micemagazine.ca/issue-two/not-so-brief-personal-history-healing-justice-movement-2010%E2%80%932016>
- Plows, Alexandra, ed. *Messy Ethnographies in Action*. Wilmington, DE: Vernon Press, 2018.
- Puar, Jasbir K. *The Right to Maim: Debility, Capacity, Disability*. Durham, NC: Duke University Press, 2017.
- Puckett, Anita. "The Melungeon Identity Movement and the Construction of Appalachian Whiteness." *Linguistic Anthropology* 11.1 (2001): 131-146.
- Raipher for the Win. "Joseph A. Pellegrino." Raipher for the Win. "Accessed November 23, 2018. <https://raipher.com/attorneys/joseph-a-pellegrino/>.
- Raipher for the Win. "Raipher D. Pellegrino." Raipher for the Win. "Accessed November 23, 2018. <https://raipher.com/attorneys/raipher-d-pellegrino/>.
- Rajan, Kaushik Sunder. *Pharmocracy: Value, Politics, and Knowledge in Global Biomedicine*. Durham, NC: Duke University Press, 2017.
- Raytheon. "History: Who We Are." Raytheon, 2018. Accessed November 22, 2018. <https://www.raytheon.com/ourcompany/history>.
- Reddy, Chandan. *Freedom with Violence: Race, Sexuality, and the U.S. State*. Durham, NC: Duke University Press, 2011.
- Reed, Lawrence W. "The Silver Panic." FEE: Foundation for Economic Education, June 1, 1978. Accessed November 22, 2018. <https://fee.org/articles/the-silver-panic/>.
- Reinarman, Craig and Harry G. Levine. "Crack in the Rearview Mirror: Deconstructing Drug War Mythology." *Social Justice* 31.1-2 (2004): 182-199.
- Rihter, Ivana. "It's Time to Talk About the Opioid Crisis as a Women's Health Issue." *Vogue*, March 6, 2018. Accessed November 1, 2018. <https://www.vogue.com/article/opioid-crisis-womens-health-heroin-oscar-nominated-documentary-addiction-recovery>.
- Roberts, Dorothy. *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-first Century*. New York: The New Press, 2012.

- Robinson, Cedric J. *Black Marxism: The Making of the Black Radical Tradition*. Chapel Hill, NC: The University of North Carolina Press, 2000.
- Rodríguez, Dylan. "The Political Logic of the Non-Profit Industrial Complex." *The Revolution Will Not Be Funded: Beyond the Non-Profit Industrial Complex*. Edited by INCITE! Durham, NC: Duke University Press, 2007: 21-40.
- Roediger, David R. *The Wages of Whiteness: Race and the Making of the American Working Class*. New York: Verso Books, 2007.
- Rose, Nikolas. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, NJ: Princeton University Press, 2006.
- Rowse, Tim and Tiffany Shellam. "The colonial emergence of a statistical imaginary." *Comparative Studies in Society and History* 55.4 (2013): 922-954.
- Sarage, Linda, Jacob Powers, and Lindsey Whitmore. *From the Ground Up: How to Build Your Own Peer-to-Peer Recovery Center*. The RECOVER Project, 2013. Accessed November 2, 2018. <http://recoverproject.org/wp-content/uploads/2016/05/RECOVER-Project-From-the-Ground-Up.pdf>.
- Schoenberg, Shira. "Gov. Deval Patrick signs substance abuse law as national drug policy leaders gather in Boston." MassLive, August 6, 2014. Accessed November 2, 2018. https://www.masslive.com/politics/index.ssf/2014/08/gov_deval_patrick_signs_substa.html.
- Schuller, Kyla. *The Biopolitics of Feeling: Race, Sex, and Science in the Nineteenth Century*. Durham, NC: Duke University Press, 2017.
- Scott, Eugene. "Native Americans, among the most harmed by the opioid epidemic, are often left out of conversation." *The Washington Post*, October 30, 2017. Accessed November 20, 2018. <https://www.washingtonpost.com/news/the-fix/wp/2017/10/30/native-americans-among-the-most-harmed-by-the-opioid-epidemic-are-often-left-out-of-conversation/>.
- Scott, Kyle J. *Montague: Labor and Leisure*. Chicago: Arcadia Publishing, 2005.
- Serreze, Mary C. "Springfield nonprofit plans 64-bed detox center at former Lunt Silversmiths site in Greenfield, pending environmental cleanup." MassLive, June 9, 2015. Accessed November 23, 2018. https://www.masslive.com/news/index.ssf/2015/06/64-bed_detox_center_planned_at.html.
- Sharpe, Christina. *In the Wake: On Blackness and Being*. Durham, NC: Duke University Press, 2016.
- Sheldon, George. *A History of Deerfield, Massachusetts: the times when the people by whom it was settled, unsettled and resettled*. Greenfield, MA: Press of E.A. Hall & Co., 1895-1896.

- Smith, Barbara Ellen. "De-Gradations of Whiteness: Appalachia and the Complexities of Race." *Journal of Appalachian Studies* 10.1-2 (2004): 38-57.
- Soloman, Joshua. "New Greenfield group provides support to those who lost a loved one." *Greenfield Recorder*, June 8, 2018. Accessed August 11, 2018. <https://www.recorder.com/New-Greenfield-group-provides-support-to-those-who-lost-a-loved-one-to-suicide-17831792>.
- Soloman, Joshua. "Suicide spotlights intersections between insurance and recovery." *The Greenfield Recorder*, February 17, 2017. Accessed June 29, 2017. <https://www.recorder.com/Franklin-Recovery-Center-suicide-case-comes-to-a-close-8166171>.
- Spade, Dean. "Intersectional Resistance and Law Reform." *Signs* 38.4 (2013): 1031-1055.
- Spettel, Sara and Mark Donald White. "The Portrayal of J. Marion Sims' Controversial Surgical Legacy." *The Journal of Urology* 185 (2011): 2424-2427.
- Spillers, Hortense J. *Black, White, and in Color: Essays on American Literature and Culture*. Chicago: University of Chicago Press, 2003.
- Spillers, Hortense J. "Mama's Baby, Papa's Maybe: An American Grammar Book." *Diacritics* 17.2 (1987): 64-81.
- Stewart, Kathleen. *Ordinary Affects*. Durham, NC: Duke University Press, 2007.
- Stoll, Steven. *Ramp Hollow: The Ordeal of Appalachia*. New York: Hill & Wang, 2017.
- Szasz, Thomas. *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*. Syracuse, NY: Syracuse University Press, 1997.
- Time Staff. "Here's Donald Trump's Presidential Announcement Speech." *Time*, June 16, 2015. Accessed December 4, 2017. <http://time.com/3923128/donald-trump-announcement-speech>.
- Town of Greenfield. "Former Lunt Silversmiths Redevelopment Project." Town of Greenfield, Massachusetts, Mayor's Office, 2018. Accessed November 23, 2018. <https://greenfield-ma.gov/p/329/Former-Lunt-Silversmiths-Redevelopment-Project>.
- TriageMD, "Paintings Capture 'Great Moments in Medicine.'" *TriageMD: Wealth Planning & Education for Physicians*, June 16, 2015. Accessed December 4, 2017. <https://www.triage-md.com/posts/paintings-capture-great-moments-medicine>.
- TriageMD, "'Great Moments in Medicine' Part 2." *TriageMD: Wealth Planning & Education for Physicians*, August 2, 2015. Accessed December 4, 2017. <https://www.triage-md.com/posts/great-moments-medicine-part-2>.

- Turners Falls Reporter Staff, "Peske-ompsk-ut; or, The Falls Fight." *Turners Falls Reporter*, 1875. Pocumtuck Valley Memorial Association, Memorial Hall Museum. Accessed November 20, 2018.
<http://www.memorialhall.mass.edu/collection/itempage.jsp?itemid=5729&level=beginner&transcription=1&img=14>.
- Unknown. *Les Curieux en extase, ou les cordons de souliers*. 1815. Print. Printed by Louis François Charon. The British Museum. Accessed December 3, 2017.
https://www.britishmuseum.org/research/collection_online/collection_object_details.aspx?objectId=691448&partId=1&images=true.
- U.S. Census Bureau. "Quick Facts: Franklin County, MA." 2010 Census. Accessed November 22, 2018.
<https://www.census.gov/quickfacts/franklincountymassachusetts>.
- U.S. Census Bureau. "Quick Facts: Greenfield, MA." 2010 Census. Accessed November 20, 2018. <https://www.census.gov/quickfacts/greenfieldtowncitymassachusetts>.
- U.S. Census Bureau. "Quick Facts: New Hampshire." 2010 Census. Accessed November 20, 2018. <https://www.census.gov/quickfacts/nh>.
- Vestal, Christine. "Fighting Opioid Abuse in Indian Country." PEW, December 6, 2016. Accessed July 1, 2018. <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/12/06/fighting-opioid-abuse-in-indian-country>.
- Voss, William Erik. "American Silversmiths: Anthony Francis Towle." *Silversmiths & Related Craftsman*, 2005. Accessed September 2, 2018.
<http://freepages.rootsweb.com/~silversmiths/genealogy/makers/silversmiths/83638.htm>
- Wailoo, Keith. "Historical Aspects of Race and Medicine: The Case of J. Marion Sims." *JAMA* 320.15 (2018): 1529-1530.
- Wall, L.L. "The Medical Ethics of Dr. J. Marion Sims: A Fresh Look at the Historical Record." *Journal of Medical Ethics* 32.6 (2006): 346-350.
- Wallace, R. Stuart. "New Hampshire History in Brief." New Hampshire Division of Historical Resources, 2007. Accessed July 20, 2018.
<https://www.nh.gov/nhdhr/markers/brief.html>.
- Walsh, Kait. "New treatment center offers 64 beds for addicts in Franklin County." WWLP-22 News, July 14, 2016. Accessed November 21, 2018.
<https://www.wwlp.com/news/local-news/franklin-county/new-treatment-center-offers-64-beds-for-addicts-in-franklin-county/1043873414>.
- Warner, Charles F. "Picturesque Franklin [Mass.] 1891." Northampton, MA: Wade, Warner & co., 1891. Hathi Trust Digital Archive. Accessed November 22, 2018.
<https://babel.hathitrust.org/cgi/pt?id=mdp.39015025108070;view=1up;seq=3>.
- Washington, Harriet A. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Anchor Books, 2008.

- Weheliye, Alexander. *Habeas Viscus: Racializing Assemblages, Biopolitics, and Black Feminist Theories of the Human*. Durham, NC: Duke University Press, 2014.
- White, Deborah Gray. *Too Heavy a Load: Black Women in Defense of Themselves, 1894-1994*. New York: W.W. Norton & Co., 1999.
- White, William L. "Recovery Rising: Radical Recovery in America." *William White Papers*, October 1, 2004. Accessed November 15, 2018.
<http://www.williamwhitepapers.com/pr/2004RadicalRecovery.pdf>
- Whitesell, Nancy Rumbaugh, Ph.D.; Janette Beals, Ph.D.; Cecelia Big Crow, B.A; Christina M. Mitchell, Ph.D; and Douglas K. Novins, M.D. "Epidemiology and Etiology of Substance Use among American Indians and Alaska Natives: Risk, Protection, and Implications for Prevention." *American Journal of Drug and Alcohol Abuse* 38.5 (2012): 376-382.
- Wolfe, Patrick. "Settler Colonialism and the Elimination of the Native." *Journal of Genocide Research* 8.4 (2006): 387–409.
- WSAZ News Staff. "Manchin beats Morrissey to keep U.S. Senate seat." WSAZ News Channel 3, November 7, 2018. Accessed November 20, 2018.
<https://www.wsaz.com/content/news/Manchin-projected-to-beat-Morrissey-to-keep-US-Senate-seat-499890582.html>.
- Wynter, Sylvia. "Unsettling the Coloniality of Being/Power/Truth/Freedom: Towards the Human, After Man, Its Overrepresentation—An Argument." *CR: The New Centennial Review*. 3.3 (2003): 257-337.
- Zuckerman, Jake. "Pharma industry fueling Morrissey's US Senate campaign." *Charleston Gazette-Mail*, November 4, 2017. Accessed November 20, 2018.
https://www.wvgazettemail.com/news/politics/pharma-industry-fueling-morrissey-s-us-senate-campaign/article_fdb411b9-2a2f-5936-8f95-6ae1d2b6d4cd.html.