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Trick(y): The production of evidence and the reproduction of social death among pregnant addicts in California

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Trick(y): The production of evidence and the reproduction of social death among pregnancy addicts in California

by

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DISSERTATION

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[redacted]

This dissertation is dedicated to Marti and Jonah. Even though you are both gone, you are present on every page.

There are so many people who supported me throughout this project. First, I would like to thank the women of the daily-rent hotels in the Mission District who shared so much with me. I would especially like to acknowledge Lexi, Ramona, Anita, and Monica. These four women literally took me under their wings while I conducted my field work, and gracefully accepted my presence, my questions, my tape-recorder with wit, grace, tears, and irritability (to name just a few of the emotions we shared). As I hung out in the hotels or on the street many, many women went out of their way to make sure none of the dealers thought I was an undercover cop, which kept me safe. They teased me when I got propositioned for dates, tried to borrow money, cried on my shoulder, asked about my kids, laughed with me and at me during our three years together. I could not have done it without them. I hope my rendering of their stories can live up to the trust they placed in me.

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and continued to support my work while also working along side me in the hotels. From the Ladies Night program I would like to acknowledge the support of Laura Guzman, Vero Majano, Mary Howe, Laura Enteen, and Emalie Huriaux.

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Trick(y): The production of evidence and the reproduction of social death among pregnant addicts in California

Kelly Ray Knight, PhD

This dissertation is focused around a singular ethnographic question which engages both science studies and critical medical anthropology: What happens when the socially dead reproduce?

Homeless, pregnant, drug-addicted women embody a specific form of social death in the urban American landscape. Their interactions with institutions, everyday lives and drug use foreclose future possibilities; their unborn children represent a site of critical intervention to ensure the production of a healthy life from a diseased one. The irrationality of the pregnant addict is re-interpolated through emergent scientific claims about addiction as a "brain disease" and the increasing diagnosis of bi-polar disorder to contain both the mania and depression of traumatized homeless women. Epidemiologists and clinicians – "category makers" – must document behavior, blood and urine to substantiate diagnoses that count, those which translate into monetary and social capital. Mental health bureaucrats – "neurocrats" – are charged with processing pregnant addicts' claims for social legibility, tapping institutions to gain access to public dollars and a room inside. Women who cannot, or refuse to, meet diagnostic criteria are left to circulate in predatory and violent drug-sex economies. Without social legibility, these pregnant addicts negotiate daily life and income generation with the "proto-capitalists", hotel manager pimps to whom women become indebted for shelter. The medical anthropologist – an "info-vulture" – struggles to make sense of it all by self-reflectively analyzing the logics of science, bureaucracy, and the streets.

How these key figures – the pregnant addict, the category maker, the neurocrat, the protocapitalist, and the info-vulture - position their narratives relative to the reproduction of social death becomes a question of evidence. As the story of the pregnant, homeless, drug-addicted woman travels from the street - to the lab - to the policy maker's desk, she is reconstituted. When the socially dead reproduce we are all morally implicated. We seek to produce and digest evidence that explains *both* the death *and* its reproduction.

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Chapter 1 The Reproduction of Social Death

I. Introduction

In this dissertation I hope to accomplish three things. First, I would like to chase down an ethnographic question, demonstrating the benefits and challenges of following that question wherever it might lead. Second, I hope to place my project at the intersection of ethnographies of addiction, homeless and mental illness. Many anthropological engagements with homelessness and/or mental illness neglect to engage with the everyday reality of drug use and addiction with adequate seriousness. On the other hand, ethnographies of addiction and homelessness can adopt a dismissive stance toward the scientific and clinical challenges presented by mental illness, however defined and experienced. I offer this dissertation as a humble corrective to these gaps as I perceive them.

Third, this project is a methodological entreaty to both science studies and critical medical anthropology. By demonstrating the everyday stakes – the physical and emotional fallout that occurs when contested biomedicalized categories such as addiction, pregnancy, bipolar disorder, and PTSD hit the streets – I argue that it is not enough to critique categories without addressing consequences. By engaging in a critique of all forms of evidence production – including that of the medical anthropologist – I hope to level the intellectual playing field upon which critical analyses of knowledge production can take place.

II. The reproduction of social death

My dissertation is focused around a singular ethnographic question which engages both science studies and critical medical anthropology: What happens when the socially dead reproduce?

Homeless, pregnant, drug-addicted women embody a specific form of social death in the urban American landscape. Their interactions with institutions, everyday lives and drug use foreclose future possibilities; their unborn children represent a site of critical intervention to ensure the production of a healthy life from a diseased one. The pregnant addicts I studied in this ethnographic project were socially dead because their claims to citizenship were dependent upon their recognition by state apparatuses of biomedical control; their lesser social status was determined by dual biologically-manifesting constraints: first addiction, then pregnancy. They were also socially dead by measure of geography - living chaotic, dangerous and stressful lives in the daily rent hotels, engaging in on-going drug-sex economy hustles to avoid homelessness, feed their addictions, and deaden their rage.

The irrationality of the pregnant addict is re-interpolated through emergent scientific claims about addiction as a "brain disease" and the increasing diagnosis of bi-polar disorder to contain both the mania and depression of traumatized homeless women. Epidemiologists and clinicians – "category makers" – must document behavior, blood and urine to substantiate diagnoses that count, those which translate into monetary and social capital. Mental health bureaucrats – "neurocrats" – are charged with processing pregnant addicts' claims for social legibility, tapping institutions to gain access to public dollars and a room inside. Women who cannot, or refuse to, meet diagnostic criteria are left to circulate in predatory and violent drug-sex economies. Without social legibility, these pregnant addicts negotiate daily life and income generation with "the proto-capitalists", hotel manager pimps to whom women become indebted for shelter. The medical anthropologist – an "info-vulture" – struggles to make sense of it all by self-reflectively analyzing the logics of science, bureaucracy and the streets.

How these key figures – the pregnant addict, the category maker, the neurocrat, the protocapitalist, and the info-vulture - position their narratives relative to the reproduction of social death becomes a question of evidence. Whose narrative is most believable and why? As the story of the pregnant, homeless, drug-addicted woman travels from the street - to the lab - to the policy maker's desk, she is reconstituted. Social institutions seek to make rational the irrationality of her history, her present and her future. When the socially dead reproduce we are all morally implicated. We seek to produce and digest evidence that explains *both* the death *and* its reproduction.

III. Key figures

> The contemporary moral landscape is heterogeneous. One observes a proliferation of types and figures of moral discourse – held to be incompatible by first-order observers – both within collectivities and even within individuals: divergent ethical and epistemological discourses multiply; actors frequently, perhaps always, employ more than one. This state of affairs frequently troubles those in search of consistency understood as internal logical rigor, one aspect of the process Max Weber referred to as 'rationalization.' In their trouble, however, such actors often contribute to the process of rationalization. However, others active in the same systematization process but producing systems based in different ethical substances will not be convinced by logical rigor alone.
>
> The way that the moral landscape is inhabited in daily life (including moments of crisis or rupture) is logically disjunctive from the moral landscape as reflected upon by those authorized to pronounce prescriptive speech acts about it. Thus, while many serious speech acts about the moral landscape are produced by actors who are reflective about their positions, the anthropologist can approach their discourses and practices like those of any other. Theorists, philosophers, ethicists, scientists, and the like can thus qualify for inclusion in the category that used to be called 'natives.' No contemporary moral debates of any import have been resolved through disputation and argumentation alone. Although this observation should probably be troubling to a philosopher in search of universals without which a grounded moral life is held to be impossible, to an anthropologist the lack of consensus and/or resolution does not mean that nothing of significance is happening or that people are not leading ethical lives.[1]

This chapter describes the main actors in this ethnography, those who are producing evidence which constitutes and responds to the social environment of US urban poverty. It is perhaps analytically necessary to reduce the complexity of a picture such as this. Addiction, violence, sex, poverty, babies, bureaucrats, social workers, scientists, politicians…

1 Paul Rabinow (2008) *Marking Time: On the Anthropology of the Contemporary*. Princeton University Press. Page 79.

There is a need to have representatives, figures made recognizable through their evidentiary claims. I seek to define and explore these figures and their interactions while making sense of the complex terrain of pregnancy and addiction in this time and place. Paul Rabinow's provocative assertions provide an anthropological license to recognize all the players who construct and perform evidence about pregnancy and addiction in this "moral landscape." They also form a demand for the author and the reader - to explore both openly and critically the ways in which multiple actors, ethnographically captured, eek out their ethical lives. But first the figures, writ large.

The pregnant addict[2] – a social constructed category of person with diagnoses to explain the irrationality of her existence, and a diverse lived identity and embodied experience.

The category maker – the epidemiologist-clinician who extracts and surveilles the behaviors, blood and urine which quantify diagnoses and predict risk.

The neurocrat – the social worker, entitlements counselor who legitimizes drug-using women based on health and mental illness diagnoses to garner material benefits.

The protocapitalist– the "hotel-pimp" brothel manager who runs private, daily-rent hotels and influences the physical and emotional experiences of pregnant addicts in the everyday.

The info-vulture – the medical anthropologist who performs the roles of researcher, story recorder, confidant, food buyer, chauffeur, medic, outreach worker and friend. The info-

2 I use the term "addict" purposefully. "Drug user" is a more politically correct term, and for some persons a more behaviorally accurate one. "Addict" is a term applied to persons experiencing physical and emotional states of dependence on a controlled substance. I use it because it is how most of the women referred to themselves, which highlights important linguistic and political distinctions between how persons are named and how they name themselves. I use it also because part of the goal of this ethnographic endeavor is to desanitize certain discourses about drugs and drug use, and I find "drug user" to be a lightweight term for the suffering that many of the women were experiencing as a result of substances in their life – as a result of their addictions- in all their complex manifestations. I also use the term to link political and epidemiological discourses of addiction with emergent neurological debates that align addiction as a brain disease akin to other forms of mental illness. Needless to say my use of the term "addict" does not mean that I am aligning myself with punitive rhetoric and policies toward persons with drug addiction, such as mass imprisonment and other efforts spurned on by the failed, yet inexplicably continuing, US War on Drugs. But if "addict" is a slur, a defaminatory term because of these associations, then please view my use of it throughout as a provocation to reexamine the term and its utility.

vulture's main task is "sense-making", the imposition of rational frames and theories upon the apparent irrationality of this social world.

In describing these key figures as "figures" I point toward ways in which assumptions about their legitimacy and expertise can create limitation. It is more interesting, I argue, to examine how they interact and *co-depend* upon each other to produce knowledge about pregnancy, addiction, and poverty. The interactions between these key figures in the everyday - with their many unintended and unexpected consequences - have real effects in the world. Some of these figures appear to, and do, enjoy taken-for-granted social legitimacy; others appear to be socially illegitimate, at first blush. Critically, and ethnographically, exploring the diverse logics of knowledge production that each figure deploys is key to understanding their roles in the reproduction of social death. (Chapter 2).

The interactions of these figures weave themselves into a "successor" narrative, borrowing from Donna Haraway's concept of a "successor science" which calls for "a feminist version of objectivity" – one embedded in both science studies and social critique.[3] The "situated knowledges"[4] which produce the successor narrative here are the result of the comparative and collapsed story of overlapping forms of evidence. Participant observation generates documentation of pain, irrationality and violence, on the part of pregnant addicts and info-vultures alike. Statistics provide a broader picture of mental illness, drug use, risky sex, and homelessness. By design, they stabilize time and experience, sanitizing suffering in the creation of categories. Neurocrats need diagnoses. The categorical logic which these diagnoses compel initiates the presumed

3 Donna Haraway calls for "a feminist version of objectivity." Borrowing from Harding, she agrees it should take the form of a "successor science": "Feminists have stakes in a successor science project that offers a more adequate, richer, better account of a world, in order to live in it well and in critical, reflexive relation to our own as well as others' practices of domination and the unequal parts of privilege and oppression that make up all positions." Haraway, Donna. (1991) Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Simians, Cyborgs, and Women: The Reinvention of Natur*e. New York: Routledge. Page 187.

4 . Haraway offers "situated knowledges" as an "alternative to relativism." Situated knowledges are "partial, locatable, and critical knowledges sustaining the possibility of webs of connections called solidarity in politics and shared conversations in epistemology." Haraway, (1991) Page 191.

social safety net so pregnant addicts do not get caught short – indebted to the hotel managers. The capitalist logic that governs this particular form of housing instability is both vigilant and arbitrary. The cost of rent ($35-60/day) and the threat of debt are vigilant. The punishment meted out for non-payment is unpredictable - sometimes extended with a soft hand and sometimes with an iron fist. The goal of the info-vulture, me, the medical anthropologist, in this setting, is to collect information – to record stories and witness events - and to make sense of it and to be a friend. This witnessing and its transition into text can compel a moral narrative, while it simultaneously relies upon the normativity and accessibility of social suffering and social death in this ethnographic "scene". The info-vulture feeds off the logics of both science and the streets.

IV. Critique-Evidence-Authority

In a critique of ethnographies conducted on drug using women, Nancy Campbell took a shot at the "rhetorical figure" of the "hypotyposis" – a graphically descriptive introduction into an ethnographic social world which is meant to reify the ethnographer's "authenticity" through the narrative negotiation of a binding "ethnographic contract." She writes:

> Ethnographic texts tend to display their subjects when the author is establishing the warrant for the project, a process crucial to the narrative contact. Agreement is often achieved through the use a rhetorical figure called 'hypotyposis': '…a highly graphic passage of descriptive writing, which portrays a scene or action in a vivid and arresting manner. It is used to conjure up the setting and its actors, and to 'place' the implied reader as a firsthand witness.' Authors convey authority, credibility, and the sense of having been there through the use of intense imaginary that arouses empathy or outrage. Readers who enter into an ethnographic contract are asked to accept this fiction of authenticity.[5]

The methodological focus of my project is to place all forms of evidence production – whether they are epidemiological statistics, ethnographic narratives, mediated statements, or provider and policy-maker discourse – under critical examination. The

5 Nancy Campbell (2000) *Using Women: Gender, Drug Policy, and Social Justice.* New York: Routledge. Page 203. Quoting Paul Aktinson (1990) *The Ethnographic Imagination*. New York: Routledge. Page 71.

goal is to see what can be learned about the complex social conditions under which the socially dead reproduce by examining evidence produced about them. Campbell critiqued, but did not conduct, ethnographic participant observation among drug using women, choosing instead to examine state-produced documents and media. I argue for, and have done, both. Moving from the streets, to the public health institutions, to the labs, to the halls of government has allowed for a science studies critique of evidence production that does not sacrifice attendance to the social suffering in the liminal realties of pregnant addicts' lives. Rather than settle for arousing either "empathy *or* outrage," as if those emotions are diametrically opposed, by sharing ethnographic encounters I hope to provoke the reader instead to occupy the contested moral terrain that encompasses *both* empathy and outrage, the space that lies between them. This is the space in which I found most of my ethnographic participants – be they pregnant addicts, category markers, neurocrats, clinicians, or myself. With that in mind, I offer a hypotyposis of my own:

Chandra Hotel Mission district, San Francisco November, 2009
As I walk down the hallway, it is completely silent. This isn't unexpected. It is about 1 o'clock in the afternoon and most of renters in this privately owned, $50 a night, hotel are either out for the day trying to make rent for another night inside, or they might be sleeping off the crack and alcohol excesses from the night before, if management hasn't forced them out, yet.

I notice that the window that you climb out of to reach the fire escape at the end of the hallway is open, but there is no breeze. The hotel smells like stale cigarettes, garbage, and Indian food (prepared by the management, who have access to the only kitchen in their apartment on the first floor[6]). Last night when we saw Ramona on an outreach shift, she had requested a lot of gauze and bandages. The night before Ramona had cut open and drained two large abscesses on Amy's butt, in the shower down the hall. Amy and Ramona are sharing a room here and both pulling dates out of it for rent and drug money. We talked briefly, Ramona was irritable and short with me. I asked if I could return today to go get something to eat with her, she said, "I don't care." Pause, then, "OK, sure." At eight months pregnant she looked uncomfortable, and hassled. Her trick was waiting patiently for her to finish up with us. Her face was set in an angry grimace.

I reach Ramona's room, end of the hallway on the right, #26. I knock on the door. "Ramona, it's Kelly." Thud and a groan. Silence. I knock again. "Ramona, open the door, it's Kelly. Let's go get something to eat." It sounds like someone is crawling on the floor. Then I hear a sound that is difficult to describe. It is a grunt, several grunts actually, followed by a low moan. It is deep,

6 The vast majority of the hotel managers that I interacted with during my field work were from the Gujarat region of western India. See Chapter 4.

animal sounding, but it also sounds almost muffled. More grunts. It sounds like she is trying to talk to me, to respond, but she can't.

Several things flash through my mind at once. First thought: stroke? Possible. She smokes a lot of cigarettes and a lot of crack, on top of her large heroin habit. She could have had a stoke and not be able to communicate. Second thought: Is she tied up? It sounds like she can't move very easily. She has a lot of regular tricks, but often needs quick money to make rent if they don't come through. Over the years I have heard more stories of sex workers being kidnapped and tied up in hotel rooms than I care to count. Tied-up is possible. The morning trick could have gone very badly.

I knock again, in a soft but urgent tone I plead, "Ramona the door is locked, I am worried about you. Can you reach the door to let me in?" More groans, a bit longer. Third thought: labor! Shit, maybe she is in labor. I lean closer to the door to listen. The water is running. "Ramona why is the water running?" No answer. "Ramona?" No answer.

I look at the fire escape. I know this room, room #26. Plenty of folks who haven't paid rent or who are banned from this hotel sneak in through the window off the fire escape. Hopeful, I tell Ramona, "I am going out on the fire escape to see if I get in through the window." No answer. I walk the short distance from the door to the window and climb out. On the fire escape I lean over, the windows are locked, the curtains drawn. I can't see in at all. Shit.

I return to the door. "Ramona, can you open the door? I am worried that you are not OK. I don't want to get the manager." No answer. Now my heart is beating out of my chest. I am starting to panic. How long have I been at the door? Five minutes? Ten minutes? Maybe she already had the baby and is bleeding in there. That might explain the water running. Maybe she has OD'd. I really don't know what to do. I can't break the door down. If I call an ambulance without seeing her first, chances are likely she will be arrested 5150, and held for 72-hour lock down at the San Francisco General Hospital Psych Ward. She will lose her housing and most of her stuff if she is gone that long. What if the manager kicks her out because of the problems I am causing? What if she is already dead? I can't leave without knowing what is going on, yet I am paralyzed by the unintended consequences any of my actions might cause. Weighing bad choice against bad choice, I decide.

"Ramona, I am going to get the manager to let me in. I will be right back." Back down the hallway, down the stairs. At the landing of the second floor about 30 parts to a broken vacumn cleaner are laid out on the ground. The manager, a South Asian woman in her early 50's is bent over trying to reassemble the machine. The manager has the desk guy, her assistant who runs the front window – looking over her shoulder. They are responsible for keeping things running for the owners of the hotel. They gain little from it, and tolerate little. They have heard it all before, and want the rent. Today. They both look up. "I am worried about Ramona, she won't answer her door. I am not sure she is OK. "She is OK." The manager assures me dismissively, "I saw her this morning. She had a visitor." "Visitor" is private hotel code for a trick. Ramona was up working for her rent already. The manager turns back to the broken machine.

I go back to #26. Knock on the door again. Louder now: "Ramona!! Ramona!! You need to open the door for me." There is no answer. I feel panicked and stuck. I can't leave and I can't see if she is alright. I walk back to the manager.

"Listen, I am really not sure if she is OK. And the water is running in her room." I say.

"You know I can't open the door. I am not allowed to." The manager retorts.

"The water is running. It might be overflowing, I can't tell." This is a last ditch effort on my part.

I walk back up. Still knocking. A small groan, but nothing else. I hear the sound of the manager coming, keys jingling. The water was running. That either gave her the excuse – water damage in the hotel is a huge deal. The manager is clearly annoyed with me. She sighs. With a high pitched, very stern voice and rap of the back of her knuckles, she says “Ramona!!!” No answer, but some movement maybe. The manager slips the key in the lock. As the door opens it is immediately kicked back by Ramona who is on the floor half hidden behind it. “No,” Ramona yells. Then Ramona looks up and sees me. She takes her foot off the door. I wedge myself through the half open doorway. “Ramona, it’s Kelly. Are you OK?” The manager is already out of sight, half way down the hallway, by the time I close the door. The manager doesn’t care, or perhaps more accurately, she isn’t paid to.

Ramona gets up on her feet, ackwardly. I quickly scan the room and her body for blood. She is naked from the waist down with a short t-shirt on. Her legs are scarred, but I notice no bruises or blood. I walk two steps over to the faucet and turn off the water in her sink. Turning around to face her again, she falls into my arms. Exhausted howls and screams come out of her. Her body heaves and shakes as she sobs in my arms. I hold her like a child, stroking her back, letting her cry on me. She sobs for full minute. “It’s OK,” I keep repeating.

Then she looks up, and appears to recognize her own vulnerability on my face. She separates from me and leans over the bed. Her swollen belly carries her forward so she needs to bend her knees. “I’m tired. I can’t keep going on like this.” She wails. “I feel like I am done.”

I notice syringes on the bed and a bunch of other paraphrenalia from last night’s outreach strewn around. Condoms, gauze 4-by-4s, medical tape, prenatal vitamins, an empty sandwich wrapper. She manages – barely - to get some underwear on and turn off the porn that is still playing on the suspended TV across from the bed. She isn’t in labor, no stroke, to kidnapping. She is just really high.

She wants to show me something. In a moment of lucidity she asks me if I have seen the mouse. “What mouse?” I ask. “The dead mouse. The baby. There.” She is pointing under the bed. “I had to kill it. It wanted to sleep with me. It was crawling right in next to me on the bed. It had to go.” Her face is plaintive. She is upset about killing the mouse and needs me to see it. I bend over and see a baby mouse dead on a sticky trap. “I have more”, she says pointing to the remaining sticky traps on the low table near the door.

Ramona’s high is coming back and she starts to phase out, meaning she is no longer talking to me. Trance like her body starts to gyrate. Arms lift in stilted, choppy movements that don’t seem intentional or connected to the rest of her body. Her eyes roll back in her head; she starts to sway on her feet, grunting again. I have seen Ramona a mess before, lots of times. Almost pissing in her own pants on the street, cursing the staff at the homeless shelter when the bathroom was closed. Yelling and running down the street chasing a high, with fiending eyes. Yet, this is as high as I have ever seen her. I contemplate the fact that I am witnessing a nightmare and I wonder if it is mine, or hers, or shared. She keeps bending over, low to the ground in a birthing pose, but she isn’t in labor.

In a freaky ironic twist “Outbreak” that Dustin Hoffman movie about epidemiologist and scientists chasing the “host” of a deadly monkey disease is now playing on the TV. Not knowing how long this will last, and not knowing quite what to do as Ramona fades in and out of her high, I decide I have to wait it out. She is very fucked up, and keeps getting to close to the wall and hitting her head and her arms against it. 45 minutes of grunting and swaying later she finds her flip-flops and heads to the door. I had suggested I get food and come back to her room because I thought she was too fucked up to walk down the stairs, but she insisted on leaving. “I am starving.” She says. “And I need to get out of here.”

Down the stairs, stepping carefully over the vacuum parts, she says “I’m coming back OK?” She is trying to sound mean and strong. The manager has her key and could easily lock her out, if she hasn’t made rent yet.

She stumbles with me to the Taquaria two doors down where she attempts to eat her enchiladas two fork-fulls at a time. There are four men in the restaurant, two working and two eating at separate tables. They are all are staring, with a mixture of disgust and pity as Ramona repeatedly drops her plastic forks and keeps trying to get up and get new ones. Her jeans are falling almost off her slender frame, so that her butt is exposed. She wears them below her protruding belly, and she doesn’t seem to notice that they are falling down. I ask if she has been eating, lately. “You look thin.” I say. “That’s mean,” she replys.

“I am ready to go in (to treatment).” Ramona says between spoonfulls. The food seems to be sobering enough to stop her fading out and grunting. “What did First Steps say to you when you left?” I ask. Ramona was in First Steps, a program for pregnant women, one where you give birth and keep your baby if you stay and follow the rules. She left in August when she was 5.5 months, after only two days. “They said they would always have a bed for me.” Ramona comments.
“When do you want to go?” I ask. “Tomorrow, morning.” I have heard this before. Yet I still want to get her there. Is this really what she wants this time, or is this what she thinks I want to hear right, now? “Call me if you want me to go tomorrow. I will come down.” I say.

I leave her to go pick up my daughter at school. I am terrified about what will happen to her next and hugely relieved to get away from her. I wonder what reception she will get back at the Chandra Hotel. The manager will probably kick her out because of me being such a pain in the ass.

Two weeks later, Ramona and I are riding in my car returning from the methadone clinic. She has had her baby, and he is still being held at the hospital while she decides whether and when she will enter drug treatment at First Steps. Getting on methadone through the pregnancy and postpartum program is a move toward that.
I ask her “Did I get you in trouble when I had the manager open your door?” She looks kind of blankly at me. “You were groaning and grunting and I thought you were hurt.” I apologize, unsure if she will see my intervention as a breach of her privacy.
“I was grunting? What do you mean?” “You sounded like this.” I imitate the sound to the best of my ability. She laughs a bit awkwardly. “Do you remember when we were together? And we went to eat.” I ask.
“Yeah, I remember eating. Yeah. I was grunting?” “Yeah, and banging your head against the wall, and flailing your arms like this (I imitate as best I can while driving). I thought you were totally tweaking on speed.”
“I don’t do speed.” She responds shortly.
“I know.” I say. “I have never seen anything like it, though. You were all over the place.
“Huh.” She says, pensively.
She doesn’t remember it.
“You should have taken some pictures.” She says.
“I did.” I reply, and we both laugh.

V. "Addiction is a disease, let's treat it that way!"

> To begin, statists [later called statisticians] familiarized the scientific world and the educated public with the use of aggregate numbers and mean values for studying an inherently variable object.[7]
>
> -Thomas M. Porter

> Individuals are classified as having SMI (Serious Mental Illness) if at some time during the past year they had a mental, behavioral, or emotional disorder that met criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV), and that resulted in functional impairment that substantially interfered with or limited one or more major life activities. Individuals with either alcohol or drug dependence or abuse are said to have a substance use disorder. Individuals with both SMI and a substance use disorder are said to have co-occurring SMI and a substance use disorder.
>
> Based on SAMHSA' s (Substance Abuse and Mental Health Services Administration) National Survey on Drug Use and Health, in 2002, nearly 2 million women aged 18 or older were estimated to have both serious mental illness (SMI) and a substance use disorder during the past year.[8]

In October, 2009 a conference was held on Addiction Health Services at the Sr. Francis Drake Hotel in downtown San Francisco. The audience for the conference was clinician-epidemiologists. The focus of the conference is to discuss the implementation and ramifications of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act which was subtly attached to the $700 billion bank bailout legislation, the Troubled Assets Recovery Program (TARP). H.R.1424 was signed in to law by President George W. Bush October 3, 2008. Mental health care parity may have been voted in under the radar of public debate but its implications for the health care treatment of millions of Americans with substance use disorders are potentially profound. The parity law mandates that insurance companies – private and public – which provide mental health and substance abuse services must compensate treatment plans for mental health and substance abuse conditions on par with physical health conditions. In short, treatment for alcohol dependence = pace maker.

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7 Thomas M. Porter (1986) *The Rise of Statistical Thinking 1820-1900*. Princeton University Press, Page 5.

8 The NSDUH (National Survey on Drug Use and Health) Report: Women with Co-Occurring Serious Mental Illness and a Substance Use Disorder. Retrieved December 2009. http:///www.oas.samsha.gov

What is contextually important about mental health parity and addiction equity from the perspective of the institutional interactions with pregnant addicts is that it represents additional ammunition in the public domain for the biomedicalization of addiction. Perhaps more importantly than scans showing the addicted brain on the cover of Time magazine[9] or exponentially increasing public testimonial about substance use and abuse, H.R. 1424 is in fact the policy instantiation of the biomedicalization of addiction. Insurance money is finally attached to addiction health services and legal muscle to protect it. While the fiscal life of this policy is still in its infancy – the law enacted has been delayed to January, 2010 due to regulatory battles - the conversation among health care providers and researchers in San Francisco was already lively by 2009.

I highlight this story of federal policy change as a way to underscore the seething conflicts between multiple opposing discourses of addiction in US society. The social suffering embodied in Ramona's wails actively competes with accusations of moral failure and public resource exploitation. Neither of these "addiction stories" can be easily squared with the insistence that because addiction is a "brain disease," locating and intervening at the neurological level is the key priority. The debate opposing the disease model and the moral failure model can easily reduce to only to political angling over resource allocations unless you try and examine, as this project does, the everyday collision of biomedicalization with the experience of suffering. The conference tag line, aptly geared toward a room full of "category-makers", reads: "Addiction is a disease, let's treat it that way!" This is an easy mantra of humanistic social responsibility that unfortunately sanitizes Ramona's social reality – her poverty, her sex work, her self-described irrational use of crack when she could "quit anytime she wanted to," her baby, the fact she had to kill the baby mouse.

9 Nash, M.J. (1997) Addicted. *Time Magazine*, May 05, 1997.

VI. Mediated confessions: USA

We can pull back from the scene of Ramona - a vision of drug-addled frenzy, banging her head and hands over and over again against the dirty walls of her hotel room - to examine the wider American landscape of addiction discourse. Caroline Jean Acker argues that "drugs, licit and illicit, have been the objects of moral panics in the United States since the rise of temperance movements in the nineteenth century, but most especially since the Progressive Era."[10] These moral panics which have attached themselves to various drugs overtime – heroin, then crack, now methamphetamine – have also historically identified specific villains and victims. In very recent US history the field appears to be widening. Urban poor scapegoats who make "the choice" to ruin their lives with drugs and alcohol are being unwittingly aligned with a more "general public," people who were not raised in poverty and deprivation yet still struggle with "addiction". This does not override the vast stratification persons in these relative social positions experience as addicts, but it does demonstrate how scientific understandings of addiction are potentially leveling an etiological playing field. Public perceptions of "addiction" – to drugs, food, sex, whatever – are increasingly viewed as perhaps more influenced by brain chemistry than moral flaws or failures of willpower alone. Public figures coming forward and admitting to stigmatizing conditions, such as Magic Johnson discussing his HIV positive status and numerous celebrities discussing battles with depression does not displace all stigma associated with conditions. Yet, celebrity addicts move addiction out of ghetto and into the more public domain. Pharmaceutical resources are geared toward large, profitable markets, which highlights the potential financial windfall embedded in the convergence of the biomedicalization of mental illness and addiction which serves as a backdrop in this emergent conversation.

10 Caroline Jean Acker. (2002) *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control.* John Hopkins University Press. Page 6.

The mediated spectacle of the public confession of drug and alcohol addiction is now commonplace in the United States. From politicians, to writers, to entertainers, and reality show guests, everyone appears to have an addiction struggle to share with the American public. They offer their "stories" up for public consumption with the implicit understanding that both blame – for personal failures - and sympathy – for the fact that they are "diseased"- will be on offer. A local example comes from San Francisco Mayor Gavin Newsom's public admission of alcoholism and rehabilitation.[11] A website listing hundreds of celebrity addicts, whose names include J. Paul Getty, Jr., Eminem, Daryl Strawberry, Prince Harry, Mary Tyler Moore, and Tonya Harding, are circulating in the public domain because "drug and alcohol addiction knows no boundaries when it comes to social classes, wealth, ethnicity or status. Addiction is a part of every group of people everywhere."[12]

There is the hugely popular a reality TV program, *Intervention*, on the A&E cable network which won the 2009 Emmy for Outstanding Reality Series. It charts the personal and family lives of everyday Americans who are struggling with drug and alcohol addiction, as well as "other compulsive disorders". The biomedicalization of addiction intersecting with the socio-behavioral is made manifest on the website for *Intervention* which is littered with counseling and treatment linkages, while also featuring direct to consumer advertising by a pharmaceutical sponsor. Reckitt Benckiser Pharmaceuticals Inc., it states, is "a specialty pharmaceutical company that manufactures and markets SUBOXONE (buprenorphine)…and is committed to supporting community-based programs and expanding access to medical therapies for

11 Heather Knight, Cecilia M. Vega and Phillip Matier, Chronicle Staff Writers (2007) Newsom seeks treatment for alcohol abuse. *San Francisco Chronicle.* February 05, 2007.

12 http://www.drugalcohol-rehab.com/famous-addicts.htm

patients suffering from the chronic, relapsing *brain* disease of opioid dependence."[13] The multiply referential messages of personal responsibility, social support and altered brain chemistry as the keys to unlocking addiction's grip pervade all aspects of the website and its associated links.[14] The public perception appears to be that addiction can affect anyone's brain and ruin anyone's life.

VII. The pregnant addict as exception

The proliferation of confessional, addiction imaginary and text – in memoirs[15], talk shows, reality shows, endless blog entries - can transform addiction into a mainstream and accessible phenomenon – almost a tragicomedy. Yet the poor "pregnant addict" still stands in exception to this neutral American "anyone." She represents a less empathetic embodiment of human suffering; a greater social failure. The pregnant addict. What imagines does this appellation conger in your head? She is, at once, everything we pity and everything we condemn. She is hard to look upon without recognizing that she is the embodiment of social failure. She should not be stuck here, doing that, we think as pass her on the street noticing her (sex) work clothing and her scarred skin. She is hard not to judge. We ask ourselves: Who, regardless of their hardships, would not get themselves out that situation for the sake of their unborn child?

The pregnant addict is the copy and the original. She is perceived to be the copy of her own flawed genetics, made crazy and addicted through her own social abandonment when parents, families, and institutions failed her throughout her own girlhood and beyond. She fills the slot of the originator of future suffering, literally

13 "Special advertising section from our sponsor" link; http://www.aetv.com/opioid-dependence/#Whydependenceneedstreatment, emphasis mine.
14 "Special advertising section from our sponsor" link; http://www.aetv.com/opioid-dependence/#Whydependenceneedstreatment
15 See NY Times Bestseller, *Lit: A Memior* by Mary Karr (Harper Collins, 2009) The prologue is entitled "An Open Letter to My Son," in which Karr admits that her alcoholism and mental health hospitalizations have hurt her now 20 year old son. Interestingly, the first line begins "Any way I tell this story is a lie…"

producing the next generation of unparented (unparentable, the media would have us think) addicts whose neurological disadvantages are multiply imprinted through their lineage and through their mothers actions while they were in the womb. Or at least this is the fear. A fear shared sometimes by her, sometimes by her health care providers, and often by most of society. How have we come to hold these visions of pregnancy, addiction and its consequences? What is the historic construction of drug use and social reproduction that lends to these competing attributions of individual and societal blame for pregnant addicts? More importantly, what might be changing in these visions as new emergent discourses unevenly replace those of their past? Ludwig Fleck argued that syphilis remained a stigmatized "devil's disease" even after its viral origins were biological evidenced, demonstrating that when etiologies of disease change throughout history, remnants of old thought styles do not completely disappear but often get covered up or distorted.[16] So, too is the etiology of addiction, and thus pregnancy and addiction, undergoing a make-over crafted by one part techno-science, one part public consumption, and one part business-as-usual governmentality. (Chapter 3)

Back at the conference, I eat my complimentary stuffed chicken and asparagus lunch that came with the $375 conference registration fee while straining to hear the speaker, the talk I actually came for. The lunch key note speaker is Mitch Katz, San Francisco's Director of Public Health appointed by Mayor Gavin Newsom. After apologizing for disturbing our lunch and promising to be brief, Katz begins his talk. He flatters addiction researchers, recognizes their "pivotal role." More interesting is when he attempts to speak both a political figure – a health policy maker and adjudicator – and

16 Fleck writes that older, historic etiological explanations never completely disappear. There are remnants, sometime thinly veiled, that point to older scientific truth claims even when contradictory and more modern explanations of disease have been adopted. This is useful for an examination of mental health diagnosis because of the socially embedded nature of the diagnosis, and its relation to larger social ills that often invoke religious or magical themes. For example, historical understandings of "madness" as devil possession help to lend clarity to the social anxieties that portray mentally ill persons as morally dangerous as opposed to only as psychosocially disabled or suffering from a brain disorder. Ludwik Fleck (1935) *Genesis and Development of a Scientific Fact*, University of Chicago Press. Page 64.

as a clinician. Like most category-makers in San Francisco, Katz' background is grounded in providing clinical care and in epidemiological research on San Franciscans' health problems, really the health problems of the urban poor. Why the urban poor? Because they are the most expensive patients to treat.[17] The urban poor are the high utilizers – or "frequent flyers" as they are called by doctors in the city's public hospital – of the emergency room, of 911 emergency calls for expensive police and EMT escorted visits to the hospital and of primary care because poor people carry the lion's share of the disease burden in the United States.[18] Mitch Katz describes his own patients: "My patients don't live in the "narrow box," very few have health issues without also having mental health issues, especially substance use and abuse." Housing and health measure sin the city of San Francisco, under the guises of Dr. Katz, work actively to house those who are chronically homeless and facing multiple health and mental health problems. But for those who are not swept up in the progressive housing futures that are designed to capture "the lowest hanging fruit" – the physically sickest and most mentally ill in supportive housing, are left to fend for their housing and basic needs in the daily-rate, privately-owed hotels where I spent three years conducting ethnographic field work (Chapter 4).

VIII. Getting inside

"Never trust a bitch with your life story, because some day she might end up as an eyewitness."
- Graffiti inside Marta's room at the Daya Hotel, September 2007

My long history as a public health researcher and service advocate for drug-using women influenced my choice of field site focus. While I began my participant observation at the homeless drop-in center's *Women's Space* program which was held

17 Agency for Health Care Research and Quality. HCUP Fact Book 8: Serving the Uninsured: Safety-Net Hospitals, 2003. Rockville, MD: Agency for Health Care Research and Quality; 2007.

18 Shumway M, Boccellari A, O'Brien K, Okin RL. (2008) Cost-effectiveness of clinical case management for ED frequent users: results of a randomized trial. *Am J Emerg Med.* 6(2):155-64.

weekly for two hours in the evening, I did not remain there. I was much more interested in observing the hotels where women lived and so began to volunteer for a weekly outreach program which served women, the majority of whom paid daily for hotel rooms. The way that I initially gained entree to the daily-rent hotels is through working with an outreach program run by a feminist, leftist free reproductive health care clinic in San Francisco. I first began field work in the daily rent hotels in June 2007, after several months of participant observation at a drop in center for homeless women a half a block away from the intersection of 16th and Mission Streets. I began working a Tuesday night shift which conducts outreach in four SRO hotels, and later shifted to Monday evening to work in five other hotels, and then back to Tuesday nights again. The hotels in which I conduct participant observation are not large, often they average about 20-50 rooms, on two floors. See Table 1.

Table 1 Hotel details

Hotel Pseudonym	Street Location	Private/Public owned	Outreach site	Number of rooms
Nimish	16th	Private	Yes	25
Marque	Mission	Public	Yes	30
Daya	Mission	Private	Yes	25
Kennedy	16th	Public	No	100
Metropica	Valencia	Private	No	100
Daly	Mission	Private	Yes	20
Roberts	Mission	Private	No	30
Raman	Mission	Private	Yes	50
European	Mission	Private	No	--
Grey	Mission	Private	Yes	40
Bridgit	Mission	Private	Yes	85
Chandra	Mission	Private	Yes	25
Visha	Mission	Private	Yes	20
Hotel 66	16th	Private	No	100
Globe	16th	Private	No	50

The private hotels are almost exclusively owned by the same family which runs them like a cartel. There are specific forms of gendered political economic exploitation that take place in private hotels that are systematic - even as they are arbitrarily applied according the whim of the management. These include forced monthly evictions to deny women tenancy rights, extracting “visiting fees” from paying sex customers to improve

the profitability of the hotel as a brothel, and creating on-going indebted relationships with women while charging exorbitant daily rental fees.

Trina's Room , Daya Hotel, Cost $600/month, November 2007

Every Monday or Tuesday night the outreach team, usually two or three of us, troll through the hallway of the SRO hotels announcing "condom ladies!!" We gave safer sex and injection supplies to women who open their doors or who happen to be around. We would talk and laugh in the hallways, catch up, assess, refer, and share stories. We were often called upon to doctor wounds, assess the need for hospitalization (most often due to abscesses), gave pregnancy tests and prenatal vitamins, in addition to the free food and the supplies we offered (shampoo, tampons, soap, etc.) Through this initial interaction, I came to identify women for ethnographic follow-up based their social

interactions, housing situation, health needs, and willingness to talk. I also was able to document the living conditions and social worlds in the hotels first hand.

Women's Community Clinic Outreach Coordinator (left) and me (right) in front of daily-rent hotel on an outreach shift, February 2008.

I sometimes approached women in the hotels, sometimes later on the street, and described my dissertation project to them. Those willing to provide inform consent became a part of my core cohort. Overall, both the larger, and the core, cohort of women mirror the demographics of women in private hotels. Women who rent rooms in the 16th/Mission Street Corridor are ethnically diverse, with about one-third being African-American, one third White and one-third Latina. I have encountered very few Asian women or women who identify themselves as Native American. Only a handful (5) of all women (about 70) I have encountered doing participant observation in hotels are monolingual Spanish-speakers (unlike many of the younger men), although many women I know are bilingual Spanish and English-speaking.

When conducting participant observation with women I used a variety of data collection techniques, including participant observation where women live and work;

one-to-one taped interviews; walking tours of neighborhood and housing environments narrated by women; accompanying women, with their permission, to health and social service appointments, documenting interactions with other institutional bodies (police, parole, eviction court), observation of drug and sex work venues, documenting women's participation in activist, community, political and other public activities, and photoethnography.

Although I did not compensate women for participant observation activities, I was above to reimburse a handful of women (12) for longer, qualitative interviews. Women whom I selected for longer qualitative interviews ranged through out the three years of my project. Initially I interviewed a couple of women in 2007 and then stopped, focusing on participant observation instead. Through this participant observation, I discovered what seemed to me to be a high number of pregnancies occur among women in daily-rent hotels. As my project shifted to focus on the experience of pregnancy, and the ways in which it highlighted evidence production in relation to mental illness and addiction among homeless women, I focused the longer qualitative interviews on pregnant or recently post partum women. Women who participated in these interviews were compensated $20 for their time, consistent with the political economy of on-going public health studies that take place among urban poor, homeless populations on San Francisco.[19]

Initially I informed the women I spoke with that I was an anthropologist working on "a book" about their experiences living in daily rent hotels. I explained that I was a student, getting my doctorate in medical anthropology. Consistent with the Internal Review Board (IRB) procedures of the Committee of Human Research (CHR) that I was mandated to follow as part of the state and federally funded research studies, and as a

19 More information about the political economy of health and addiction research in San Francisco and my role in it and outside of it during my fieldwork is described in Chapter 7.

student at University of California San Francisco, I was authorized to use an information sheet explaining my project and a longer consent form for those women I selected for the longer qualitative interviews. Most women responded favorably to being informed about my project, many neutrally dismissed the information. Other women sometimes questioned "What does an anthropologist do?" or "Don't you study bones?" I would reply that I study everyday life, and women's experiences living in the hotels. Regardless of my continual restatement of my role, many women interpolated me as a case manager – or social worker - type, both because this is a more recognizable role, especially for a white woman who takes a keen interest in their everyday lives, and because "anthropology" was often too esoteric.

There is no question that my dual attribution, whether real or imagined, potentially created multiple social positions for me. This may have played a role in how women reacted to me and the information they shared. What isn't clear to me is how and in what way. I offer one early example, to explore the ways in which perceived role might simultaneously appear to matter and to not matter. Alexandra, a woman I came to know well during my three years of ethnography, said something ironic to me the day after I had been introduced by the drop-in center staff as "a researcher," with the statement that "we value evaluation, it improves our programs," in 2007. At the time I stated unequivocally that my project was not evaluative, but it didn't matter. In some sense all research conducted in service settings, especially critical medical anthropology one might argue, is evaluative. The following conversation indicates Alexandria's astute observation about my multiple roles, and also how her housing concerns – and how my inability to really address her needs (housing) rendered my info-vulturing, in whatever form, largely irrelevant.

Women's Space **Drop-in Center** **February, 2007**

I sit at the second table and see Alexandra. Alexandra is a large (300 pounds probably) and tall African-American woman with a wide face and a vacant look about her. Her eyes seem overly

open wide most of the time. She often sits but doesn't engage much and stares ahead of her. Many of the women come into the site like a hurricane and create a lot of energy and sometimes disruption. They announce themselves. Not Alexandra. My impression is that she is largely unnoticed, despite her size. I have taking a liking to her, partly because of her easy smile and gentle manner at the site. She doesn't intimidate me like some of the other women do. Alexandra was selected to be part of the women's group, eight women names were chosen out of hat to be paid to participate in a women's group were they helped plan the activities of the site and took more of a leadership role. It was also focused on HIV prevention. Many women wanted to be picked, thus the random selection. I haven't been able to sit in on the Monday groups but hope to catch the next one and stay for the whole 8 weeks. Anyway Alexandra, as part of this group, joined the retreat on Sunday for the latter half, along with the five other women. They helped us plan activities and think about fund raising. At this retreat – much to my chagrin - I was introduced as a "researcher" and that researchers "help us evaluative our programs."

When I see Alexandra, I say hi, and she says "You know you look just like the woman from the other day. The researcher."
"Oh. That was me. You mean at the retreat on Sunday."
"Yeah, you look just like her. I was thinking."
"Yeah. I am Kelly."
"Yeah. Alexandra. What are doing here?"
"Well, I volunteer here."
"How can you volunteer and do research?"
"Hm. That's a good question. Well, I am interested in how women are managing their housing and deal with their health stuff so that is what my research is about, and I thought *Women's Space* is a good place to talk to women who are concerned about that."
"Oh. Can you get me some new housing because I have got to make a change?"
"Oh. No. Unfortunately I don't have access to any rooms. I am interested in talking to folks about their housing situations but I am not a case manager. I can't get people housing. Have you talked with Sophia? She might be able to help you. Where are you at now?"
"I am at the Omaha."
"Right on Mission?"
"No, Valencia."
"Oh, right. I haven't been there."
"It's awful. I got a room. See I hear voices. And when I am in my room, I hear them outside and it makes me scared. And Michael, he's next store. He hears them too. We protect each other. But my worker at hospital said 'maybe they are real'.
"Hm. Was he a psychiatrist?"
"Yes, a psychiatrist case worker. He said 'well, maybe there are people outside.'"
"What do you think?" I ask.
"I don't know. I don't like it. I feel scared when I close my door."
"That isn't a good feeling. Where would you like to be?"
"Get back on Section 8. Get something better for myself. I would like for Michael and I to go together, because he is sacred too. Oh. Foods up." Alexandra got up immediately to get a tray of food before it is all gone.

These sets of concerns had a specific effect on my fieldwork, in that I focused on leaving the drop-in center as site of participant observation, and only attending the center in the company of a woman with whom I was ethnographically engaged or to attend a policy or procedural training relevant to my topic. I do not discontinue my role with the outreach program, because it gave my access to the daily-rent hotels. Because

I was known to the hotel management as someone who had some form of institutionalized sanction to interact regularly with women, I was give basically unrestricted access to the daily hotels at any time of day or night, without having to rent a room or pay a visitor's fee. As I describe below, the daily-rent hotels were privately owned sites of rampant illegal activity on the part of hotel renters and of the management . Without this sanctioned entree, I felt I would not have been able to document the realities of the lives of women in the hotels. Even with the sanction, hotel managers sometimes viewed me with suspicion or annoyance. My presence and interactions with women in these settings, caused concern for me because I worried that I might jeopardize women's ability to stave off evictions. That said, my general experience with managers was one of tolerance and not open hostility.

IX. The variability of time

Ramona, like all the other pregnant addicts who reside in the hotels, operates in multiple, different "time zones", everyday. She is on addict time, searching and satiating her addiction to crack and heroin. Her expanding womb provides a ticking time bomb, with only four weeks before her due date when I encounter her at the Chandra in November 2009. She is on "SRO time" in which she needs to hustle up her rent – about $35-50 dollars a night, depending on if she is "doubling-up" with someone to lower the rent – everyday through sex work. She is on treatment time: When will she go back? Is it too late? Can the baby be born clean if she stops today? – these are question she asks of herself and that are being asked of her. And she is on "lifetime," recalling a life of addiction and involvement with institutions which have adjudicated her income generating strategies and her drug use, most relevantly through Ramona's loss of the custody of her most recent child prior to this pregnancy, now age 3 in foster care. It is difficult to hold the "whole story," even as an ethnographic narrative, when I am

interacting with the stresses and pressures each of these temporalities place upon her. She appears to be emotionally, physically, and structurally bound in a limbo state betwixt and between these temporal demands – negotiating the liminality of everyday through both time and space.

Anita's room the day of her child custody court date Chandra Hotel March 2010 Graffiti reads: "GOD hates sin, but LOVES the sinner"; "Check out Time!"; "you pay Now!!!"

Health and housing policies for the urban poor are built upon numbers – health statistics about disease and heath service utilization outcomes, as well as those about health economics and cost savings are the "facts" that justify the policy decisions. These facts are reified by stabilizing time, creating categories from measurable behaviors. If Ramona's "behaviors" are driven my five different temporal demands, what sort of health and housing policy could aptly respond? When I discuss this phenomenon of multiple time frames with a San Francisco housing policy maker, he replies: "Exactly. That is why words like "lying" and "knowing" don't apply here – not to these patients. I see my pregnant patients smoking crack, do all kinds of craziness.

And when they lose the kid, they are *devastated*. I am mean really traumatized, *retraumatized*. And I want say, "Wait a minute, *come on*. You must have seen this coming?" But she didn't. She didn't see it coming. She didn't, really, *know* it was going to happen. Not before it did. I don't know if it is holding on to hope, or just the ability to compartmentalize the addiction from everything else that is going on." (Chapter 5)

X. Neurocratic possibilities

It is not a coincidence that the law lumped mental health parity with "addition equity." The frequent co-occurrance, or co-morbidity in the biomedical language, of substance use disorder and severe mental health conditions is widely documented in the public health and clinical literature[20]. Teasing out the causal relationship between mental illness symptoms and substance abuse behaviors is much more complex on the ground. Enter the "neurocrat," whose responsibility it is to advocate and attest to the presence of a mental illness which can produce social legibility. For persons seeking disability benefits who are not struggling with co-morbid substance abuse disorder, this is fairly straight forward. They need a qualifying health diagnosis to be approved, for example medically disabling Human Immunodeficiency Virus (HIV) or AIDS. For those who do have co-morbid substance use and mental illness diagnosis and treatment is easy to get wrong. Due to the linkage of disease documentation to welfare entitlement, diagnosis and treatment sometimes have little to do with each other. Arguably, the neurocrats job is to diagnose mental illness in order to treat poverty.

Homeless drop in Mission district, San Francisco February, 2004

I am on site to recruit women and men into a small qualitative study about the impact of Care Not Cash [San Francisco welfare deferral and housing policy][21] on HIV risk behaviors. I meet an African-American woman, about my age, mid 30s. She is very eager to be interviewed. I ask if

20 The NSDUH (National Survey on Drug Use and Health) Report: Women with Co-Occurring Serious Mental Illness and a Substance Use Disorder. Retrieved December 2009. http:///www.oas.samsha.gov

21 See Chapters 2 and 4.

she is on GA (general assistance) and she says "Not anymore." We go upstairs to the room the drop-in center is loaning me for interviews near the clinic and talk for several hours. Lexi is homeless, sleeping with her husband, off and on in the parking lot of a bread factory three blocks away. The bread factory tolerates the homeless as long as they clean up and disperse when the morning shift starts. Lexi has a tent and everything, she says it is pretty OK, as gone as the men don't get too drunk and start to hassle when her old man is gone.

We talk welfare, drug use, housing, and family. These are all connected to a recent painful experience for Lexi: she lost a baby in October. She describes her confusion about why the hospital couldn't save her daughter, born at 6.5 months when Lexi's cervix opened prematurely. "When they handed her to me I thought she would just be a…I don't know I didn't think she would be a *baby*. A full baby, with hands and feet and…" She starts to cry.

Lexi's access to methadone maintenance treatment was linked to her pregnancy through a special program seeking to expedite pregnant women into drug treatment for opioid addiction immediately upon request. When she left the hospital after her daughter died, she was detoxed and had to scramble to find another funding stream to pay for her methadone. As her health status changed, from pregnant addict to just addict, so did her ability to makes claims on the state for drug treatment access. She was put in touch with a social worker who could process her needs, and immediately the social worker encouraged her toward SSI [Social Security Income]. "The case worker said, 'You have PTSD…you haven't dealt with the death, you are in trauma, and you can't work.' 'I said, no.' Because, I have always worked. I came to this life late, to drug use late. I used to work. I didn't want to give up like that. But that was it. I had PTSD. And you know I did [have PTSD]. I mean of course I did. But I just didn't want it to mean something for the welfare."

The emergence of neurocratic possibilities represents an interesting twist stemming from the accusation that drug addicts were using federal welfare dollars to support their addictions which changed entitlement disability policy in the mid 1990s. When substance use dependence was discontinued as a legitimate claim to health disability by the federal government January 1, 1996, so too was the mandate that those receiving disability benefits be actively enrolled in some form of drug/alcohol treatment. Several things occurred as a result. The neurocrat was substantiated as the most likely means to reclaiming benefits for the 100,000s of drug users who were now ineligible; and epidemiological research on drug users began to pay closer attention to mental health diagnoses. (Chapter 6).

XI. (Re)cycling through the daily hotels, pregnant again

There is no straight road to housing stability even for those women who gain the social legibility offered by SSI entitlement. Many may be eligible for SSI but still actively

circulating in the private daily-pay hotels, turning tricks, hustling, and using various substances. Women in these situations find themselves indebted to the protocapitalists – the "hotel-pimp" brothel managers who run private hotels. Always focused on the daily rent – they are paid to do so by the hotel owners – the protocapitalists adjudicate the everyday, controlling who has access to women, forcing women (and other renters) to move out every 21-days to deny them tenancy rights, charging extra fees for their "visitors" (tricks). As exploitative as these relationships are on first observation, they are also complex in their co-dependency. Protocapitalist operate on and benefit by the profit-driven world of the drug sex economy. In this sense, everyone is "playing by the same rules" – money talks and bullshit walks. Many women are afraid to make claims against the hotel, for poor maintenance, unfair rental practices, health or legal violations because they are indebted to managers, they fear burning bridges may mean they can't accrue debt later when they might need to, and homelessness is worse. If crisis in health or family arise, if a women needs to "mother," there is literally no space for that in this world – as the private hotels frown upon and actively discourage women from having their children there. Pregnant addicts – using drugs or not - are routinely told they will need to move out of the hotels once the baby arrives.

And pregnancy does offer a way out. As a woman addict's biological status transform her into a pregnant addict, she becomes eligible for a placement in residential treatment if she is willing to follow all the rules. The she can escape the daily rent hotels, at least for a period of time. But if a pregnancy ends or is terminated, the tenuous state of the social safety net for women drug users becomes apparent. As Lexi's experience demonstrates the convergence of pregnancy, drug use, family, and debt is constant and overwhelming in this social world.

Homeless drop in Mission district, San Francisco August, 2007
The clinic was going on tonight and the first conversation that I had was with Kitt, who told me she was gonna go have an abortion tomorrow. I gave her a pregnancy test a couple of week of ago on outreach, and she said that was how that she had tested herself. She's twenty weeks pregnant, now. She's missed the appointment [for the abortion] a couple of times and I'm wondering if she's not sure if she really wants to go. It seemed like it. "If I don't do it now, it is going to be too late." She sighs. I haven't seen her this down in a while. She had gone to the General {San Francisco General Hospital] today to get the shot…I guess, the preparatory shot for the abortion tomorrow at 10 am.

We didn't have a lot of time to talk. She wanted to go up to the clinic, because she said she thinks she has Gardnerella, she thinks she has a yeast infection. She said she was kind of smelling down there, so I was wondering about that, on top of dealing with the abortion. I'm gonna check in with her on Tuesday [night on the outreach shift]. I asked her if she had somebody to go with her tomorrow to the [abortion] clinic, and she said that, "I have a couple of girlfriends who'd said they would go, but you never know"…I said, "Yeah, you know, that can be a hard thing to do on your own", and she said, "Yeah, I think that they're gonna come with me tomorrow." I felt better about that - it was hard to see her so sad. She went up to the medical clinic. I went to go find her later and she was already gone.

One week later
I just ran into Kitt and she had lost her place to stay – that's one of the reasons why we didn't see her on outreach. It sounds like she came into some money, somehow – her husband's in jail…and his dad just passed away. So, because there was a settlement there, Kitt came into seven thousand dollars, somehow, through her husband's father, and she gave the money – five thousand dollars of it – to her mom, 'cause her mom's raising two of her kids, and then her sister's got another one of her kids. So she had called her mom the night of her abortion and found out that her son, Daniel, who's seven was in the hospital [getting a minor operation]. So she went out there to see him. Well, she was on her twenty-one day at the Nimish [hotel] and she said she had fifteen dollars credit with them. She told me they agreed to hold her room, but when she got back, the management said they packed up her stuff. She went to go get it back and she saw somebody at the hotel selling it out on the street. Kitt freaked out and got into a fight with the hotel manager and the manager called the police…Kitt threatened the manager saying that "something bad was gonna happen" and the hotel manager called her a bitch and it sounds like it was a huge incident.

Kitt's really upset and, and really high and spinning. She went outside and took a hit of crack before she could come back in and relax, so she's really charged up. She also said, "I took care of that problem"…so she had the abortion and she looked really upset about it, still. She didn't have a place to stay in the Mission, but she said she needed out here, this is where she cops [drugs] and works [does sex work]. This is probably where she's gonna be. She looked really upset. She said was still going through a lot and she just really wanted to talk to me – she was talking a mile a minute, about everything. She showed me a picture on her cell phone of her son when he was in the hospital after his operation. She's just seems really overwhelmed after having the abortion, seeing her son in the hospital, and then having lost her place on the twenty-one day. She has to move every twenty-one days when she is in the hotels.

The info-vulture surveys the scene. In this ethnography of urban poverty, gender, science and the state the infovulture is the medical anthropologist who occupies multiple social roles while also witnessing the social suffering of the reproduction of social death.

"That is why I am trying to get myself together" **November 2009**

I almost trip over Anita on my way to meet Cupcake for an interview. Cupcake is staying at on of the nicer SRO hotels a bit off the main drag of 16th and Mission Streets. I ring the bell, and the gatekeeper at the front desk doesn't understand who I want to see. He gets the manager, who comes out for the living quarters just adjacent to the glassed off front check-in. He won't let me up without a room number. He pretends he doesn't know who I am talking about when I describe Cupcake – even when I give many of her aliases. It's a wash, no interview today. I am pissed because Cupcake has been gone for 18 months, I don't know where, and now she is back, and she thinks she is pregnant again.

Back on the street, I walk by Anita once. Thinking I don't know her I turn around to introduce myself. "Hey, I'm Kelly. I don't know if have we met before?" I say to the slumping figure. Anita lifts her head and we recognize each other. She has lost all of her pregnancy weight that she had in September when we spent time together. I didn't recognize her. She is wearing fishnet stockings and a skirt, which is dropped around her mid thigh. Maybe it is too big for her now that she is so thin. Her butt is showing through the stockings, no underwear. She is sitting on a small roller suitcase with a plastic bag next to her. She just woke up and she is looking around at her stuff and trying to get her things sorted out. "I fell asleep right here." she says kind of surprised. I ask if I can sit next to her and grab a spot on the sidewalk.
"You might want to move away because I am going to smoke." She says pulling out her crack pipe. "I don't mind, if you don't" I say. She shrugs and lights up. "There," she sighs. But she is still constantly, but somewhat unobtrusively, looking for something in her stuff.

"Where have you been? I haven't seen you around." I ask

"I went to the Tenderloin to buy some crack and stayed there for a while," she says smiling.

None of the people who walk by seem to notice her hitting her pipe - not the yuppies or the hipsters shopping in the Mission. One woman my age makes eye contact with me questioningly. I get this a lot, folks trying to place me. I am actually the same age as most of the women out here so get mistaken for someone doing sex work. Usually it is by men who are looking for a date. An African-American women - skinny with no shoes on – saunters by and looks at Anita. "Why you think you can act 39? You ain't 39! I am!" yells the woman. The woman walks on. Anita looks at me, she says "That was weird because I am 39 – I lie to everyone about that – If you hadn't been here to witness that, I never would have told *you* my real age." Young Latinas in Catholic school uniforms walk by and barely register her or me, even though we are taking up a fair part of the sidewalk at this point. Anita is still fishing through her stuff.

A guy – older white guy, pretty nondescript, stops to proposition Anita on his way to hotel where Cupcake is staying. "I know. I know." She says to him dismissively. He wants to have sex and smoke crack with her to give her a place to stay. She says he keeps checking in with her.

Anita is freezing. It is very cold even for November in San Francisco. About 40 degrees. I am freezing sitting on the cold ground and I have a lot more clothes on than Anita. Anita is still rifling through her stuff. "I can't find my pill." she says. "And a rock."

When she stands up again, I find her morphine pill on the sidewalk and give it to her. "I need some water." she says.

Neither of us can spot the rock she is looking for. She starts doing the search on the ground thing that crack smokers do, picking up bits of dusk and looking at them up close. Then she comments "Oh here I go doing the fiend thing." She stops, giving up on the rock. We walk to get the water in my car two blocks away. I don't understand why she needs the water until she explains that she is going to crush and shoot [inject] the pill. "There is no way I would get well [stop withdrawal symptoms] if I swallowed it. Takes too long." Getting the two blocks is tough she keeps repeating "I am soooo dope sick." She is sweaty and pale and her nose is running

continuously. She is looking down and stops every couple of feet searching for used cigarettes that have some tobacco left in them. She finds one that is half smoked and goes into a convenience store for some matches.

We finally reach my car. I am parked right in front of the weekly women's drop-in and there are women already lined up to get in, about 20 of them. I recognize many of them and we catch-up. Anita leaves her suitcase in my car and disappears for about an hour. I walk into the shelter with Ramona who has showed up with her $200 trick, a white computer-nerd looking guy who waits outside the drop-in for her.

Later when I am giving her back her suitcase I ask Anita about her daughter who was born in July. The baby's tox screen was positive [for drug exposure] and Anita lost custody immediately upon her birth. In September, Anita wasn't sure if her aunt would be willing to adopt the baby this time – her aunt has her other daughter in her custody. The baby was in limbo, not Anita's, not quite the state's, and not under her aunt's custody.

"I haven't seen her [the baby]." She says. With her loss of all parental rights Anita can't legally see her daughter, even if her aunt had custody. "I don't know [what is happening with her]. But that is why I am trying to get myself together." She smiles optimistically, "So it will work out."

Two weeks later
Anita asks me for a pregnancy test while I am on an outreach shift.

Pregnancy is the quintessential, embodied intersection between bioclinical scientific theories of addiction, mental illness and the on-the-ground ethnographic engagement with the mental and physical anguish that pregnant addicts endure when carrying, delivering, and - more often that not - loosing their children. In this ethnographic milieu there are multiple opportunities for failure. Public health failure becomes the domain of the infovulture, perhaps more so than the pregnant addict. Viability is at stake for her and her child. Viability for the socially dead: what forms can life take here? Ways out - of the maze of evidentiary speech acts, practices, and facts that combine with the everyday suffering produced in this place - are negotiated and uncertain. (Chapters 7 and 8)

Examining evidence produced about pregnant addicts helps to frame the critique of the reproduction of social death in the private, daily-rent hotels. A categorical convergence in the biomedicalization of mental illness and addiction may point toward a widening of the stigmatized boundaries of drug use outside of the moral domain of failed willpower. Yet, pregnant addicts still mark an exception. The exception that pregnant

addicts embody is a space of both outrage and empathy, and they are joined there by other figures in this ethnography – the info-vulture, the category maker, the neurocrat, and the proto-capitalist – who each in there own way seek to respond to and control the tricky problem of pregnancy and addiction.

Chapter 2 Pregnancy (conception), theory (concept)

Main Entry: **con·cep·tion**

Pronunciation: \kən-'sep-shən\

Function: *noun*

Etymology: Middle English *concepcioun,* from Anglo-French *concepcion,* from Latin *conception-, conceptio,* from *concipere*

Date: 14th century

1 a (1) **:** the process of becoming pregnant involving fertilization or implantation or both (2) **:** EMBRYO, FETUS **b :** BEGINNING <joy had the like conception in our eyes — Shakespeare>
2 a : the capacity, function, or process of forming or understanding ideas or abstractions or their symbols **b :** a general idea **:** CONCEPT **c :** a complex product of abstract or reflective thinking **d :** the sum of a person's ideas and beliefs **concerning** something
3 : the originating of something in the mind
synonyms see IDEA[22]

I think my problem and 'our' problem is how to have *simultaneously* an account of radical historical contingency for all knowledge claims and knowing subjects, a critical practice for recognizing our own 'semiotic technologies' for making meanings, *and* a no-nonsense commitment to faithful accounts of a 'real' world, one that can be partially shared and friendly to earth-wide projects of finite freedom, adequate material abundance, modest meaning in suffering, and limited happiness.[23]

- Donna Haraway

I. Pregnancy Diagnosis

Contingency and radical uncertainty. These two concepts, which frequently appear in theoretical discussions about the production of knowledge, were echoing in my brain as Lexi described her process of deducing that she was pregnant for the third time. Contingency references the social and historical. Critical medical anthropology hinges its allegiance to the ethnographic methods and its commitment to "local knowledge" as a construct of practices to this concept. Radical uncertainty – while sometimes leveraged in discussions of faith and meaning – haunts debates of science, technology, and

22 Merriam Webster, Online dictionary, Accessed March, 2010.

23 Haraway, D. (1991) Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Simians, Cyborgs, and Women: The Reinvention of Nature*, New York: Routledge. Page 187.

expertise. The stubborn adherence to claims of objectivity and the desperation with which slippery bio-psycho-social categories are bounded in clinical and epidemiological work speaks volumes to the threat and perceived consequences of uncertainty. Even so, as Donna Haraway points out so eloquently, "our" problem is that we seek to live in both the worlds of contingency and that of the "real." Pregnancy diagnosis embodies these theoretical dilemmas: it is contingent on the local social world for its meanings and manifestations, it is proximal and very real - literally in the women's body, part of her. The radical uncertainty of pregnancy's outcome is mediated by both the everyday and techno-scientific.

As we sat in McDonald's one spring morning in 2009, Lexi and I discussed the multiple ways she "knew," and yet was perhaps still unsure about, the "fact" she was pregnant. We talked her own embodied expertise, her mistrust but ultimate acquiescence to the pregnancy testing technologies available to her. We discussed her family's religious background and how it weighed heavily on her decision not to terminate her pregnancy. She expressed risks about the institutionalization of her pregnancy relative to her past forced detoxification from methadone maintenance treatment slot. She held fast to her decision not to disclose her pregnancy to Pano, the baby's father.

This chapter will weave broader theoretical concepts underpinning evidence production through a metaphorical and a concrete engagement with pregnancy. I introduce anthropological evidence – the conversation between myself and Lexi - at the start of this chapter because the conversation alludes to the theoretical constructs that I bring to bear when understanding evidence production about pregnant addicts. Each of the figures in this ethnography "know" about pregnancy and addiction. This knowledge is contingent upon the stability of the categories most relevant to their areas of expertise.

Ethical stances which motivate interventions - be they personal or institutional – are derived from these theoretical underpinnings upon which the knowledge is based. Interventions in their design, by their logic, in their use, and despite some of their intentions, frame the experience of the pregnant addict and the other figures making sense of this world. But first a conversation about knowledge: embodied knowledge, social knowledge and the shared construction of limited expertise.

McDonald's Mission District San Francisco March, 2009

Lexi and I are eating breakfast at McDonald's. About 10 am, it is crowded and loud. Young mothers from El Salvador and Guatemala attend to their children, fetching ketchups and straws. Muni bus drivers wait impatiently in line. Older Mexican men sit with coffee in the corner swapping stories. Drug dealers, sex workers, and other street folks move in and out constantly, often stopping to chat with us, or waving. Everyone knows Lexi. She has been staying in the hotels and on the streets down here for more than a decade.

The day before today I was contacted by an outreach worker, Tamika, who said Lexi wanted to talk to me because she thought she was pregnant. I go to see her in her hotel, and she has been up all night turning tricks to pay for her rent. She was sick the week before and is several hundreds of dollars in debt to the hotel manager. We talk for over an hour without her mentioning her pregnancy to me. After a long discussion about her going to the hospital for another girl's (Dylan's) delivery and subsequent abandonment of her son, I ask Lexi directly.

K: So what about you? Tamika told me that you were worried about being pregnant.

L: Oh yeah. I took that damn test thing and it came out positive.

K: When?

L: Both of them.

K: Both of them.

L: I'm shocked. I'm hoping it's just one of those – this was the third one I took.

K: And they're all three positive?

L: Um-hum.

K: Umm, what you gonna do?

L: The way I look at it…I mean I don't believe in abortions. I got two of them [kids] and I can't take care of them right now. I'm saying to myself I thought I had a period twice, two months in a row. But I had a period before so then you can't count on that with me.

K: Oh really?

L: I have periods up until I'm like six months [pregnant].

K: Really?

L: Always have.

K: That's fucked up.

L: Very.

K: So how can you tell then?

L: It gets kind of…well when I'm not pregnant it gets real heavy. But other than that when I'm pregnant it gets not real heavy, it spots but I still have a period.

K: So it's hard to tell.

L: Um-hum. And I didn't went to a clinic yet because if I do that they're going to put me on PPMT [Prenatal and Post partum Methadone Treatment, the methadone program specifically funded for pregnant women] again and I don't want to do that.

K: Why don't you want to be on PPMT?

L: Because I hate [the Director]…That bitch.

K: Would you have to go on PPMT?

L: Yes, I think so.

K: But then if you decide not to have the baby then you'll get knocked back off [the methadone program], right? So that's the – cause that's what happened before.

L: Exactly, that's right.

K: I remember when we first met like four years ago…you got fucked behind that because you lost all your methadone [after your baby died].

L: That was messed up. When I lost the baby that was fucked up…My locker got taken and they kicked me off the methadone. That was so bad. Ugh!

K: Did you talk to Pano about it?

L: You know what, we have never really still to this day actually really mourned that [the death of their baby] and came to terms with it. I mean I have but it's something that…I start to get emotional and then I try to blank it out. What made me feel a little better was when my mom told me and I never knew that. She told me that – she said that she had one too [a baby die due to premature opening of the cervix]. She was pregnant and she was not on drugs…So when she told me that I felt a little relieved. Cause I was doing my best to try to stay clean.

K: Yeah, you were.

L: And I was outside [homeless] too, living outside in a tent back here.

K: You were behind the bakery, right?

L: Sure was. It was devastating. And then when they explained it to me, see that nurse practitioner or so-called doctor…Cause it was like she didn't want me to have a baby. She didn't,

she was against me from the beginning. And I don't know if it was because it was Chili's baby. It was just weird. And then they told me her baby, that other junkie's baby, her baby lived, and she was like four months [pregnant]. She's [that baby's] fine.

K: I remember that. You felt like they [the hospital] didn't do everything they should have?

L: No, they didn't. And I felt like it was like because I was black. The way they said it to me. "Would you like to see your baby?"

Lexi and I have discussed the loss of her baby many, many times since we first met in 2004. Feeling my time is short, I switch the conversation back to her current pregnancy.

K: How far along do you think you are?

L: I don't know.

K: A month or something like that?

L: Damn. I'm serious. This time you know I do not want him to know nothing.

K: You don't want Pano to know?

L: Nope. I don't want anything to do with him period.

K: Why don't you want to tell him?

L: He's an asshole. I don't want to talk to him.

K: Listen, if you want some help to get some care or anything I can go with you.

L: Thank you. I'm going to try to get my shit together this week…You see I got this thing about – I'm not a practicing Jehovah's Witness but it's entirely against my religion.

K: Have you ever had an abortion?

Lexi shakes her head.

L: I had a miscarriage.

K: Oh, you did? When? After your son was born [in 2002]?

L: I had a miscarriage, yeah, after Lionel was born I had a miscarriage like a few years after that, 2-1/2 years. So that's not an abortion, that's a miscarriage.

K: No, it's not [an abortion].

L: I just you know it's like every time I get even more stressed something else pops up. And I keep looking at - and there's no way I…or anything else.

K: No way you what, hon?

L: Missed, you know that I'm misreading three different tests? I don't think so. But then one of those tests were expired.

K: Are they all the ones from us [from the outreach program] or did you buy one?

L: No, I got them from you guys.

K: Do you want to have a blood test so you know?

L: Yeah, I think I should.

K: Which clinic you going to?

L: Not to the methadone clinic, I don't want to tell no one…Where can we go?

K: Maybe [the agency] Housing for Mothers and Children?

L: Oh yeah there's free confidential tests there. What are you doing tomorrow?

K: Let me find out if they do it.

L: Yeah, cause you can come with me. I would like you to.

K: I definitely want to come with you. I might not be able to come tomorrow. I could probably come on Monday.

L: Whenever you can. That's fine. I have to do something [about the pregnancy]…I pretty much know that I am [pregnant]. You know why?

K: Are you sick?

L: Throwing up every morning. I pretty much know I am. I can't drink liquor like I used to.

K: It doesn't taste good?

L: It don't taste good. I throw up soon as I taste it. I mean I'm craving sugar I have to have it and it's all through the night. Like ice. I got the symptoms, I know.

K: Seems like it.

L: And they're [placing her hands on her breasts] tender and they hurt. And then I see some milk…I thought women's milk dried up after you had your baby. Do it ever dry up?

K: I think it depends on woman to woman. I know that they can get it –

L: I'm talking about shhh [makes the sound of water flowing].

K: Really?

L: I swear to God! (laughs)

K: I hadn't heard about that but you know what –

L: I never nursed.

K: But the milk was there so it had to dry out even if you didn't nurse?

L: Um-hum.

K: I don't know.

L: But you're not supposed to start getting milk glands until you're like --?

K: It think it depends.

L: Does it really?

K: I don't know.

L: We're going to have to check this out for sure cause I pretty much know I am. I'm just trying to face it.

K: Yeah, you gotta, cause it's not gonna change.

L: It ain't gonna go away, exactly. And you know what? It could be another sign like God gave me 7 years ago when I had [my son] Lionel to get my butt out of here, be clean and stay gone. I mean I can look at it like that.

K: It's the main way out [pregnancy because of unquestioned access to services].

L: Exactly.

K: You see that Dylan and other folks - and it doesn't work that way for everybody.

L: It sure don't. And that's just sad. Ugh!

K: I mean maybe that's an extreme case 'cause I know Benz is trying to keep her baby.

L: Is she?

K: She went into a treatment program.

L: She did? Benz went into a treatment program?

K: As far as I know.

L: Where's her baby?

K: With her I think.

L: She had it?

K: She had the baby yeah in January.

L: Cause I never seen that. I haven't seen the baby. Her stomach was fat and all of a sudden she got skinny.

K: No, I saw her, after we talked about that [Lexi seeing her skinny, Lexi had thought Benz had lost her baby]…She got a residential [treatment slot]. And I don't know if her baby's out of the hospital yet but I know you know she's – so you know I mean it's hard. It's hard - always this hard. You should get some sleep.

L: Okay. I'll have to go hit the streets [go back to sex work for her rent].

Lexi and I part ways. She is unable to get a blood test at the local agency. Eventually she sought out a sonogram at the hospital, but never entered formal or consistent prenatal care.

While Lexi experiences many of the biological "signs" of pregnancy, her traumatic pregnancy history, indebtedness, drug use, alcoholism and social vulnerability exert contingencies on her knowledge, and the bring to light the uncertainty to her future. During this conversation she expresses fear, ambivalence, and hope that reflect the structured choices and limits framing her sense of potential optimism about the future of her pregnancy. Juxtapose my conversation with Lexi about the multiple ways a woman "knows" about a pregnancy with the authorative informational education available to women who subscribe to the weekly blog from *What To Expect When You Are Expecting.com* created by the authors of the book *What to Expect When You Are Expecting* which has spent 351 consecutive weeks on the New York Times Best seller list[24].

> **Email Subject Line: Proof Positive—You're Pregnant!!**
> **Week 5 of Pregnancy: Pregnancy Hormones Kick In**
> Whip out that pregnancy test — it's time to pee (which is a good thing because at 5 weeks pregnant, you probably need to go more often). The level of hCG (the pregnancy announcer hormone) in your urine is high enough to be detected by a home pregnancy test, so you'll be able to confirm what you probably already suspect: you're expecting! By now you'll have missed your period — one of the more obvious indications that you're pregnant. But there'll be other signs too. Like that sense of exhaustion that's likely washed over you (or, more likely, hit you like a tidal wave). And those tender breasts. Or that slight wave of nausea you might have felt when you walked by your spouse's plate of scrambled eggs. Growing a baby — even one no larger than a small apple seed — is hard work, and your body is responding in kind.
>
> Large amounts of hormones — chemical signals that circulate in your body and cause physical changes in you — are being mass-produced: estrogen to maintain the levels of progesterone and hCG; progesterone to maintain the function of the placenta, to keep the smooth muscles of the uterus (and other places) from contracting, and to stimulate the growth of breast tissue; and hCG to support the corpus luteum and keep progesterone at its appropriate level. Watch out — these hormones are going to take over your life!
>
> How did you know you were pregnant? Ask other pregnant moms-to-be here.

24 From the web advertising for the 4th edition: "The latest information, a friendlier-than-ever voice, a new look -- it's a brand-new, cover-to-cover revision of What to Expect When You're Expecting—the book that's been a New York Times bestseller for 351 weeks and counting, and is read by over 90 percent of pregnant women who read a pregnancy book. More comprehensive, reassuring, and empathetic than ever, the fourth edition covers everything an expectant mom (and dad) needs to know, from preparing for pregnancy to birth to those first miraculous (and exhausting) weeks with a new baby. It is overflowing with tips, helpful hints, and humor, making it even more accessible and easier to use than ever before." Accessed December, 2009.

I argue that pregnancy is like theory: productive, reproductive, organic, and derivative. Concepts require conception, a gestational period in which a range of emotional and intellectual responses need to be "tried on," experienced in order to be absorbed, worked through, and/or discarded. Pregnancy is an ontological experience which points to untold futures, and raises a multitude of questions. The old joke about the impossibility of being "sort of" pregnant hints at the fact that pregnancy is experienced as an authoritative shift. Yet it is also marked - both emotionally and physically - with radical uncertainty. And of course these generalizations don't apply to everyone, everywhere. Theory too, occupies a place in the past, future, and present of thinking about lived experience and the production of truth. Theory is produced from the materials of the past, fused to form something else – in this way theories are always historically bound. At worst theory can appear oppressively distal from our lives as we understand them to be. At best, theories about knowledge production can expand our understanding of the breadth of sociality in its macro and micro operations, and the depth of the human condition as locally articulated. Some theories grow and develop as we might expect them to; others are stillborn.

The theory that I am intent on producing in this ethnographic work borrows from critical medical anthropology studies which deconstruct the nature of evidence and those which attend to the organic experience of everyday lives. An anthropological stance which debunks the stability of scientific categorization and positivism is extremely useful. It is also limited in its ability to address the blood and guts resulting from the power differentials, contradictions, and irrationality of everyday life. A social suffering perspective emanates from the everyday. Yet, if this ethnographic engagement does not include a reflective anthropological critique of the production of evidence, it is also short sided.

This chapter is organized around three broad theoretical issues in science studies and critical medical anthropology which are most relevant to questions of pregnancy and addiction. First, I introduce a broad discussion of social construction, knowledge and power, offering theoretical insights from Hacking, Canguilhem and Foucault to ground an analytics of evidence production. Second, I return to the figures of this ethnographic analysis and interrogate how "knowledge" as a social construction becomes valid evidence for each. I ask: How does the production of evidence interact theoretically with bioclinical facts and critical medical anthropology's proximal witnessing of social suffering?

Pregnant drug addicts are categorically unstable constructs, socio-biological moving targets. They are also real women struggling, suffering, and making the apparently irrational "choice" to continue drug use throughout their pregnancy. I posit that studying evidence-making about pregnant addicts requires a multi-sighted approach in which pregnant addicts, government officials, scientists, and myself - as a de facto sense-maker - are all ethnographically examined. To explore the evidence constructed and leveraged, one must examine the metrics by which evidence is judged factual, true, and worthy of note.

II. Social construction, knowledge and intervention

Ian Hacking has written extensively on the tension between scientific claims for objective knowledge and arguments for social constructionism.[25] In his famous work, *The Social Construction of What?*, Hacking argues that to understand the "sticking points" between these apparently opposing camps, one must look at their sources of evidence, either internally or externally located:

25 See Ian Hacking: (2000) *The Social Construction of What?* Harvard University Press, (1990) *The Taming of Chance.* Cambridge University Press, (2006) Making People Up. *London Review of Books.* 28(16):23-26.

> The constructionist holds that explanations for the stability of scientific belief involve, at least in part, elements that are external to the professed content of the science. These elements typically include social factors, interests, networks, or however they be described. Opponents hold that whatever be the context of discovery, the explanation of stability is internal to the science itself.[26]

Distinctions between "internal and external explanations of stability"[27] are thought provoking because stability invokes credibility. In scientific discourse credibility often hinges on the scientist's ability to control bias, and reduce the complexity introduced by multiple perspectives. Kuhn discussed scientific knowledge production in terms of the nature and logic of what is deemed scientific as well as the "techniques of persuasive argument"[28] offered by scientist. However, Kuhn was ultimately unwilling to question scientific rationality, a skepticism that underpins constructionist claims.

Hacking argues that people and their behavior are *interactive kinds*, capable of looping effects which change them, individually and as a group, as a result of classification. They can potentially destabilize knowledge categories that are meant to be stable. On the other hand, *indifferent kinds* according to Hacking are those objects of classification which do not change in response to their classification, such as quarks in physics. The difference in the perceived stability of the objects makes some objects associated with disciplinary engagements: "The targets of the natural sciences are stationary. Because of looping effects, the targets of the social sciences are on the move."[29]

Hacking refers to the classifications within the category of mental illness as "transient" to capture their historical contingency: mental illnesses "show up only at some times and some places."[30] This is conceptually and methodologically useful to questions of evidence about the addiction and mental illness because it forces one to ask: Why

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26 Hacking, I. (2000) *The Social Construction of What?* Page 92.

27 Hacking, I. (2000) *The Social Construction of What?* Page 33.

28 Kuhn, T. 1996 [1962]. *The Structure of Scientific Revolutions.* University of Chicago Press.

29 Hacking, I. (2000) *The Social Construction of What?* Page 108.

30 Hacking, I. (2000) *The Social Construction of What?* Page 100.

these set of [mental health] conditions? Why now? Indeed, this strain of constructionist thinking has led to widely contested views of "mental illness" itself as having no biological basis[31] nor requiring any form of institutionalized response outside of community settings. For example, Franco Basaglia, the Italian psychiatrist and pioneer of the global movement to deinstitutionalize mental health care, has argued that it is how society's professionals (psychiatrists) see and listen to schizophrenics that construct their illness.[32] These divergent viewpoints foreground current policy debates in San Francisco that rage on about housing unstably housed, urban poor people diagnosed with substance use problems and mental illness, including pregnant addicts.[33] It also impacts our understanding of how women might experience their own experience of mental illness as socially constructed and organic, a product of their familial and social experience and residing in their brain. Kitt offered an example of this discursive description when she discussed her social and organic experiences of rage and violence:

> I think the other girls are dealing [drugs]. It's like I feel a little intimidated because I don't have that same 'fuck it' [disregard for risk]. Cause I'm a little scared of the way I feel right now cause I have a lot of animosity with myself cause I go to extremes in my brain you know. And that's particularly why I don't like to fight anymore cause I will really hurt someone you know.

Lexi also offered a similar nuanced perspective when she initially questioned a PTSD diagnosis encouraged upon her by a neurocratic social worker after the death of her daughter in 2004. Lexi was resisting a "disabled" social label by linking her "mental condition" to experiences of childhood sexual abuse and her mother encouraged Lexi to accept the associated benefits along with the diagnosis.

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31 See Horowitz, A.V. (2002). *Creating Mental Illness*. Chicago: University of Chicago Press; Caplan, P. (2002). Expert decries diagnosis for pathologizing women. *Journal of Addiction and Mental Health*. September/October 2001; Caplan, P. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who's normal*. New York: Addison-Wesley.

32 See Basaglia, F. (1969). Silence in the dialogue with the psychotic. *Journal of Existentialism* 37:99-101.

33 Current San Francisco housing debates, policies and their effects on women substance users (pregnant and not pregnant) are discussed in greater detail in Chapter 7.

Lexi: But the thing is with SSI…I have put it off. Maybe I can work. Because once you, this is my viewpoint…SSI is like…I have been putting it off because I really don't want to be disabled. This is where I am at and I might be able to get a job…And my mom says that I am just in denial, because she says, 'You do have a mental condition. I am not saying your crazy. But you have been through a lot of stuff and drug use it has an effect too'. I say, 'I know that'. And she said 'You had issues prior to being a drug addict you had issues since you were a child.' And I did, I mean, but then lot things happened to me in my past. I was molested with her second husband. I mean. All that kind of stuff happened in our family and being a Jehovah's Witness and loosing my baby. I mean tried to kill myself three times when I was younger.

Kelly: When you were younger, like as a teenager?

Lexi: I was nine years old the first time. I was thirteen the second time. And I was 22 the third time. I tried seeing a psychiatrist but I never followed up…I have been anti-depressants but I quit that because I didn't want to be 'crazy'. Didn't want to be on SSI.

In order to further explore theoretical connections between the biological origins of the pathological and the social environment, we now turn to Canguilhem.

The pathological and the social

I would like to borrow two observations from Canguilhem to help frame the overall discussion of pregnancy, theory, evidence, and validity. First, is Canguilhem's discussion of the construction of the "normal" and the "pathological" – in biology. Second, is Canguilhem's argument that "each society has a mortality that suits it."[34] Both ideas originate from Canguilhem's famous and widely cited work, *The Normal and Pathological*. He argues that biology and environment interact within a social milieu in such a manner that examining health reveals the "socially normative" – the stratified values of lives in the local context.

A physician and philosopher who directly influenced Foucault and Derrida as well as Lacan and Althusser, Canguilhem offers important insights into the relationship between what is considered normal and pathological in relationship to a given environment.[35] Canguilhem argued that the normal state of an organism is not in binary

34 Canguilhem, G. (1966) *The Normal and the Pathological*. Zone Books. Page 161.

35 Canguilhem, G. (1989) [1966] *The Normal and the Pathological*. Canguilhem writes: "If the normal does not have the rigidity of a fact or collective constraint but rather the flexibility of a norm which is transformed in its relation to individual conditions, it is clear that the boundary between the normal and the pathological becomes imprecise." Page 182.

opposition to the pathological state. Rather, both are states of life; states of life in which the normal and pathological were continually displaced. In this rendering of vitalism, disease is not understood as a lack, but rather a new set of inputs into the environment of the organism.

> Disease is a positive, innovative experience in the living being and not a fact of decrease or increase. The content of the pathological state cannot be deduced, save for a difference in format, from the content of health; disease is not a variation on the dimension of health; it is a new dimension of life.[36]

By introducing an alternative categorization for pathological states, Canguilhem also laid claim to a set of behavioral politics which bear upon the discussion of evidence production about the pregnancy and addiction. Canguilhem not only defined pathology environmentally, but also defined health in terms of the ability to respond to and overcome new environmental challenges.

> The healthy organism tries less to maintain itself in its present state and environment than to realize its nature. This requires that the organism, in facing risks, accepts the eventuality of catastrophic reactions. The healthy man does not flee before the problems posed by sometimes sudden disruptions of his habits, even physiologically speaking; he measures his health in terms of his capacity to overcome organic crises in order to establish a new order.[37]

Canguilhem presents the co-production of pathology and health as that which is the result of responses – successes and failures - to the experience of external pressure. Such pressure can, and is, multiply construed for pregnant addicts. There is the pressure of the pregnancy on her body, on her baby's development, the pressure exerted by chemicals – nicotine, cocaine, alcohol – exerted on the mother's body and the body of her fetus. The pressure to acquire food; the pressure of no sleep; the pressure of multiple sexual encounters; the pressure of drug withdrawal. At the level of the biological, a "normal" pregnancy is quantified and qualified with rapid efficiency in the United States, but the interaction between normal signs and symptoms and those which indicate pathology. The observation of one medical description of what pregnancy

36 Canguilhem, G. (1989) [1966] *The Normal and the Pathological.* Page 186.

37 Canguilhem, G. (1989) [1966] *The Normal and the Pathological.* Page 200.

diagnosis is echoes Canguilhem's observations: "The diagnosis of pregnancy is dependent upon the ruling out of other pathologies."[38]

Canguilhem's carries his argument out of petri dish and into broader society, making a second intervention which is of particular interest here. He claims:

> Everything happens as if a society had 'the mortality that suits it', the number of the dead and their distribution into different groups expressing the importance which society does or does not give to the protraction of life.[39]

One might be tempted, when examining the evidence that circulates about pregnancy and addiction to wonder if a society also has a *maternity* that suits it?

> Maternity: (1) pregnancy: the state of being pregnant; the period from conception to birth when a woman carries a developing fetus in her uterus (2) motherhood: the kinship relation between an offspring and the mother (3) motherliness: the quality of having or showing the tenderness and warmth and affection of or befitting a mother[40]

If we agree to this tri-referential conceptualization of "maternity," we can then appreciate further the way Canguilhem propels our analysis to be inclusive of biology, environment, and the social in our assessment of whom society deems appropriate for vital endorsement and support. The ways in which pregnant addicts are implicated in the vital politics of the State is through interventionist means. The interactions with and management of pregnant addicted women tells us a great deal about social value practices, and allowable social death.

The move from "normal" to "necessary"

Pregnancy and addiction provide an interventionist landscape. The pregnant addict rises immediately above other addicts – male or female – for access to drug treatment and housing. Specifically, there are funded "slots" for methadone treatment for women who are pregnant and addicted to opioids, and for residential drug treatment

38 http://emedicine.medscape.com/article/262591-overview

39 Canguilhem, G. (1989) [1966]*The Normal and the Pathological.* Page 161.

40 http://www.wordnetweb.princeton.edu Accessed December 2009.

which women can join either pregnant (once detoxed off illegal substances and alcohol) or post partum with her child when she has earned custody through the clean (drug-free) urine toxicology screens. That is to say in San Francisco, if the pregnant addict is willing to enter the "system," then it is a more a question of *when*[41] rather than *if* she will be absorbed within it. However, she is not absorbed without a necessary reconstruction of her identity relative to "responsibility."

Foucault took Canguilhem's interpretation of the pathological to his understanding of the construction of subjectivity and to his interpretation of the role of institutions in creating environmental breeding grounds for mental pathology. To Foucault the choice to categorize and confine those deemed "mad" is a direct result of governmental social and political control over persons with transgressive behaviors whom are also failed participants in the labor market. This categorization of the "mad," formed a "strangely mixed and confused group," who shared the common feature of failed social productivity, rather than the physical mark of disease.

> There must have formed, silently and doubtless over the course of many years, a social sensibility, common to European culture, that suddenly began to manifest itself in the second half of the seventeen century; it was this sensibility that suddenly isolated the category destined to populate places of confinement. To inhabit the reaches long since abandoned by the lepers, they chose a group that to our eyes is strangely mixed and confused….From the beginning, the institution set itself the task of preventing 'mendicancy and idleness as the source of all disorders'. In fact, this was the last of the great measures that had been taken since the Renaissance to put an end to unemployment or at least to begging.[42]

Foucault connects the practices of earlier doctors and 19th century psychiatrists with cruelty and punishment toward patients that were deemed mad.[43] Patients were deemed mad because they were given a pathological label – even if not biological or organic. With the birth of the asylum, however, the relationship shifts from systemized cruelty to coercion and fear within institutions of confinement. Consistent with Foucault's

41 The significance of time, in all its existential forms, is addressed in detail in Chapter 5.

42 Foucault, M. 1988 [1965] *Madness and Civilization: A History of Insanity in the Age of Reason*. New York: Vintage Pages 45; 47.

43 Foucault, M. 1988 [1965] *Madness and Civilization*. Pages 177; 221.

general arguments of governmentality and biopolitics, self-regulation and the acceptance of social control are linked and become expected modes of relation between those deemed mad and society in general. Here Foucault argues for the paradoxical coexistence between social sympathy (the mad are no longer guilty) and personal responsibility (yet they should be accepting of their deserved punishment).

> The obscure guilt that once linked transgression and unreason is thus shifted; the madman, as a human being originally endowed with reason, is not longer guilty of being mad; but the madman, as a madman, and in the interior of that disease of which he is no longer guilty, must feel morally responsible for everything within him that may disturb morality or society, and must hold no one but himself responsible for the punishment he receives.[44]

The tension between the dual social roles of victim and perpetrator - unfortunate and criminal - is still extremely relevant to on-going debates about categorization and causation among the homeless mentally ill broadly speaking, as specifically among pregnant addicts. As causation is debated, the specter of responsibility and the necessity to assign blame often emerge. In the production of evidence about victim-perpetrators disciplinary camps are often forced into an uneasy reconciliation of this debate: presenting statistics and cases which garner sympathy and presenting numbers and narratives that expose individual or collective criminality and abuse. In this way, causation and categorization become ideologically linked to the methodological decisions scholars make when they stake evidentiary claims.

Knowledge produced about drug users can become imbued with the power of scientific certainty in diagnosis, statistical objectivity, and in humanistic narratives. These evidence claims become cogent to the types of work that can be done in social policy arenas. This is not to say that epidemiological research produces falsehood about drug users. Just like ethnographic data, and bioclinical evidence, it is epidemiological research's claim of objective certainty that is problematic. Ways of

44 Foucault, M. 1988 [1965] *Madness and Civilization.* Page 246.

knowing, and the methods we deploy to know the addicted and the mentally ill has everything to do with framing the problem and offering solutions. Here it is useful to view evidence production and circulation in constitutive relationship to the solutions offered in response to it. To Foucault the practice and the theory, that is to say, the *techniques of power* and their *political rationalities,* are co-constitutive and analytically inseparable. As Miller and Rose assert:

> There was little point, or so it seemed from the perspective of government, in identifying a problem unless one simultaneously set out measures to rectify it. The solidity and separateness of 'problems' and 'solutions' are thus attenuated. Or, to put it a differently, the activity of problematizing is intrinsically linked to devising ways to seek to remedy it."[45]

Theoretical attention to the practices of interventionist governance in this setting is ethnographically essential. If we follow the metaphor that theory is indeed like pregnancy, then we must attend to the parts which combine to make a new form. When evidence-making about pregnancy and addiction, it is the metrics and their effects which circulate to create a new interaction, a new theory born of past parts and drawing upon their material to forge something different and uncertain. Forms of evidence cross boundaries between figures in this ethnography. The metric of cost effectiveness (money) comes to matter for the neurocrats who inform housing and health polices and for the proto-capitalist daily-rent hotel managers who exploit women's work. Numerical categorization is not the sole domain of the category-maker. The anthropologist and the pregnant addict struggle with its limits and possibilities as well, as the field note below between Lexi and I demonstrates.

Categorizing the everyday **September 2009**

Lexi and I are going to pick up some paperwork on her son, Lionel, who is in her mother's care. We park in front of the Child Protective Services Building while Lexi is telling me about a regular (a long-term trick), Gregory. She is afraid he will be picked up by the police because he always parks in the same place, everyday. She explains that she "has trained him not to want to have sex too often." But she still gives him a blow job or a hand job everyday for $40. Gregory is upset that Lexi hasn't been available since her recent hospitalization. I wonder if he is also worried about her. I have met Gregory and he takes care of Lexi by giving her food, gifts, and

45 Miller, P. and Rose, N. (2008) *Governing the Present: Administering Economic, Social and Personal Life*. Polity Press. Page 15.

clothes constantly as well as money. He sees himself as her benefactor. He even celebrates both his own and her birthday with a party which Pano is invited to as well. Pano, Gregory, and Lexi hang out often.

Lexi suddenly realizes she doesn't have her phone. "Pano is just waiting for me to leave my phone." She tells me. If she leaves her phone in her room, she fears Pano will sell it for crack. She gives me a piece of paper to hold while searching for her phone.

"What's this?" I ask, looking at a form with a bunch of numerical category codes on it and boxes to check. The codes look like diagnostic codes.

"I was just doing my 'research'." She says. "I was pretending like I was drug counselor. There is a bunch of these things [pointing to the category check boxes] and I was filling this stuff out here. [Shows me the form, pointing to a question] Based according to, see I was at home [she laughs, embarrassed], and I pretended like I was a social worker or something. [she laughs again]. Actually I got a bunch of those papers. See I was actually trying to figure it out. See on the back. [She flips the form over where a list of numbers and associated diagnostic conditions are listed]. See I was pretending I had a client in the mirror, and I was talking, 'Ok. What's your name? How long have you been using alcohol?' And then I fill in the code on the front of the paper. I asked at the methadone clinic if I could have them, they had a whole bunch of them. See this is for BHS [Behavioral Health Services]. They fill them out every year. This is for the Department of Public Health. It is confidential patient information. You see this [pointing to the place on the form where it says "confidential"]. This is for data and shit.

She finds another form in her purse that is filled out. "I just did this for myself. Primary diagnosis, OK? So my primary is '294AA.' But see I should have put "3" in there because I was referred by myself, not by the police. I was just playing, though. Because those numbers aren't right. See the way to do it is…Axis I. Wait [flips the sheet over] is 303.0X. No wait, that isn't alcohol, that's heroin. But anyway, you get it. There'0s codes for all that shit.

Kelly: What about conflict days with family? 'Number of conflict days with family?' What do you think that means?
Lexi: Yeah. Huh. I think that isn't Pano I think that is your family, family. Because see they have other questions for him. Like 'number of days your partner used substances.' That is for him. Or that is the same thing [as conflict days] anyway. [laughs]. See there are a bunch of them: 'In the last 30 days: Visit to the emergency room?" [She indicates her answer on the form] 'Yes' 'Visit to the psych ER?' 'Yes'"

She quickly mumbles through several other questions: "jail, 12-step, physical health problem, diagnosis TB, hepatitis, children in placement, children in the home. This is a trip! Living arrangement, primary source of income. This is a trip."

The following section will attempt to outline what comes "to count," or put another way, "what matters" to each of the key figures when they construct their truth about pregnancy and addiction.

III. To each figure, their own evidence

The power of numbers for the category maker

The category maker – the epidemiologist-clinician who extracts and surveilles the behaviors, blood and urine which quantify diagnoses, risks and points of intervention.

Three key concepts inform the evidence production of the category maker in this ethnographic locale: objectivity, categorical bounding and generalizability, and probable risk. I will discuss each concept and its critiques in order to paint a picture of how scientific truth claims gain power and credibility – how the effects they produce in the world of pregnancy and addiction are propelled by the force of "validity." The uneven integration and contradictory clashing of scientific "facts" with other forms of knowledge production can destabilize and politicize clinical and epidemiological data.

Objectivity

Arguing against the naïve idealism toward scientific rationalism that was offered in Kuhn[46], Pierre Bourdieu claims that the scientific field presents itself as falsely disinterested, hiding behind the veil of objectivity. Epistemological questions are in fact always political ones: "[E]pistemological conflicts are always, inseparably, political conflicts: so that a survey on power in the scientific field could perfectly well consist of epistemological questions alone."[47]

Using the language of political economy, Bourdieu discusses scientists bartering in "symbol profits."[48] These profits entail primarily the recognition of "competitor-peers," but also include access to material gain (such as research grant money), and the ability to indoctrinate future scientists in order to maintain a hegemonic grip on what is accepted scientific knowledge production.

46 Kuhn, T. 1996 [1962] *The Structure of Scientific Revolutions*. University of Chicago Press.

47 Bourdieu, Pierre. (1975) The Specificity of the Scientific Field and the Social Conditions of the Progress of Reason. *Social Science Information* Vol. 14 No. 6. Page 32.

48 Bourdieu, P. (1975) The Specificity of the Scientific Field. Page 33.

> Every scientific 'choice' – the choice of an area of research, the choice of methods, the choice of place of publication - is in one respect – a political investment strategy, directed, objectively at least, towards maximization of strictly scientific profit.[49]

If the scientific field is designed to serve its own need for symbolic capitol, there are no bodies or mechanisms for self-generated legitimacy. In contrast to Hacking's focus on the stability of the objects of scientific research, Bourdieu tackles the field of science itself as an unstable, and insidious, misrepresentation:

> In the scientific field as in the field of class relations, no arbitrating authority exists to legitimate legitimacy-giving authorities; claims to legitimacy draw their legitimacy from the relative strength of the groups whose interests they express: in so much as the definition of the criteria of judgment and the principles of hierarchization is itself at issue in the struggle, there are no good judges, because there is no judge who is not party to the dispute.[50]

Bourdieu highlights how scientific research problems come to be formulated, always and already, in consideration of where they might fit into the larger dynamics of symbolic capital - as outcomes. In relation to the evidence production, this orientation helps ask questions such as: Why this set of behavioral, or anthropological, or bioclinical research studies? And more generally, how does the legitimacy of scientifically-derived research become established? How does this "legitimate knowledge" become exercised within the realm of political economic decision-making about the pregnancy and addiction?

Bourdieu's insistent focus on institutions and the manner by which they condition the possibilities for what can be scientifically researched is relevant to an analysis of temporality and historical contingency. For example, if one is asking: Why is "the homeless mentally ill" or "pregnant addicts" one kind of group in the early 1980s (or 1940s, for that what matter) and quite another kind of group at the turn of the 20th

49 Bourdieu, P. (1975) *The Specificity of the Scientific Field*. Page 33.

50 Bourdieu, P. (1975) *The Specificity of the Scientific Field*. Page 34.

century?[51] Understanding the conscriptions on scientific knowledge production that are institutionally performed and policed is also useful methodologically. It reminds one that any investigation into evidence production and circulation has to render visible the institutional contexts within which evidence is produced. Bourdieu argues:

> When the scientific method is built into the mechanisms of the field, revolution against instituted science is carried out with the aid of the institutions which provide the institutional conditions of the break; the field becomes the scene of a permanent revolution, but a revolution that is increasingly devoid of political effects.[52]

Categorical bounding and generalizability

Philippe Bourgois' provocation to consider drug use as both a symptom and symbol instead of a considering "drug users" as a behavioral bounded and meaningful category runs counter to how drug users (and persons with mental illness) are represented in epidemiological research.[53] Categorical bounding is essential to the ability to perform statistical analyses on the variables collected about a specific population. In the parlance of one epidemiologist: "The first, and most important, thing is to know is *who* you've got." In epidemiological terms this is established through sampling. Sampling involves creating the category to fit the research question. If, for example, one designs a study of "HIV risk factors among crack users", an epidemiologist needs to define the category "crack user." She might decide that "a crack user" is someone who reports "yes" on a survey to the question "Have you *ever* smoked crack cocaine?" Or, the epidemiologist might decide that "a crack user" is someone who

51 See Hopper, K. (2003) *Reckoning with Homelessness* and Nancy Campbell (2000) *Using Women: Gender, Drug Policy and Social Justice* for historical analyses of changing social and scientific understandings of these groups.

52 Bourdieu, P. (1975) *The Specificity of the Scientific Field*. Page 40.

53 For a general discussion of epidemiology, statistics, and the rise of quantification in the health sciences, politics, economics, and everyday life see Porter, T. (1996) *Trust in Numbers.* Princeton University Press; Timmermans, S. and Berg, M. (2003) *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Temple University Press; and, Lampland, M. and Star, S.L. (2009) *Standards and Their Stories: how quantifying, classifying, and formalizing practices shape our everyday life*. Cornell University Press.

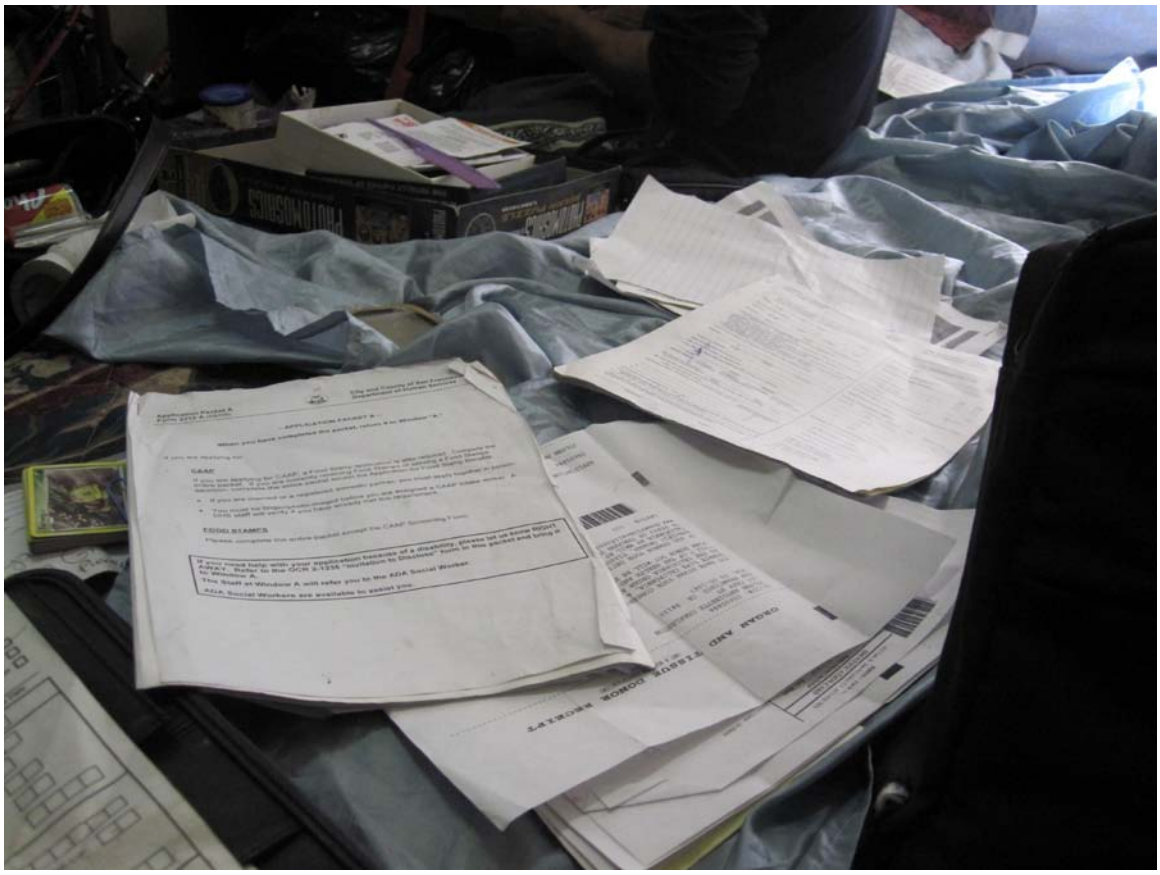
reports that they smoke crack weekly, or monthly, or yearly, or has smoked crack at all in the last 6 months.

When studies of "crack users" are compared, such as in an epidemiological literature review, there is often a lack definitional stability across studies as to what might constitute a population deemed "crack users". Thus, characteristics that are statistically correlated to "crack users" in epidemiological research, such as frequent sexual activity, depression, homelessness, and experiences of violence may *appear* to be attributable to crack use – when the participants in these studies actually have widely divergent temporal and frequency relationships to crack use. The disciplinary goals of reduction and generalizability that guide epidemiological research lend a veneer of objectivity to these complex study procedures. Inappropriate, or perhaps sloppy, comparison of dissimilar samples in epidemiological research on drug use offers one explanation for the sometimes widely divergent, and often contradictory, results found in epidemiological studies. However, it is important to note that these methodological decisions are typically outlined in great detail in epidemiological texts, and these limitations are often discussed. In anthropological texts such methodological detail and transparency can be a relative rarity.

Another important aspect of the way in which evidence about drug use is represented in epidemiological research is through the process of the development and selection of survey measurement items and the validation of measures across populations and studies. On questions of mental health, a survey taker could misunderstand a question because the wording does match their experience. For example, in answering "Did a health provider ever give you a bi-polar diagnosis?" The person who was told they were "manic-depressive" may not answer "yes." This answer does not reflect their mental health status, but underscores Emily Martin's, and others', observation of the instability of mental health categories, reflected by the changing

names that are in circulation[54]. The idea that social, racial, and gender bias is uncritically deployed in survey research questionnaires has been well documented. Perhaps the most familiar example of this is the bounded racial categories on the US census which force persons of multiple racial and ethnic affiliations to select the category "other" to identify themselves.

Neurocratic Facts



Small sampling of Lexi's extensive paperwork, for entitlements such as welfare, disability, and food stamps strewn on her bed in the Chandra Hotel, September, 2009.

54 The literature here is too numerous to cite in its entirety. I indicate several scholars who established, and are still contributing to, the critical studies of mental illness scientific categorization and its social contexts: Young's work on PTSD in the United States; Arthur and Joan Kleinmans' work on depression in China; Byron Good, Mary-Jo DelVecchio Good and Robert Moradi's work on depression in Iran; Estroff's studies of homelessness and the subjectivity of schizophrenics in the United States; Scheper-Hughes work on "delerio de fome" and "nervos" in Brazil and earlier work on schizophrenia in Ireland, and Martin's recent work on the diagnosis of bi-polar disorder in the United States. This short list names pivotal contributions to the social construction of mental illness, and its political and subjective dimensions, which provide essential background to my engagement with questions of evidence.

The neurocrat is a social worker or entitlements counselor who legitimizes drug using women based on health and mental illness diagnoses which garner material benefits. There are two sets of neurocratic facts that serve as evidence to put the material benefits machine in motion. These facts apply broadly to drug using people in the urban poor milieu, not only to pregnant addicts. Broadly, they center around claims about diagnostic validity. Is there "fit" between the social experience, the biological and behavioral manifestation, and a doctor's documentation of disability to forward a claim? How would such a claim and its attendant material and social capital impact the life of said (pregnant) drug addict? In short there is cause – of the disability so claimed, and there is effect – of making it, and so her, the pregnant addict, legible to state welfare regimes.

The mental health diagnoses which tend to be applied to homeless, drug using persons highlight particularly thorny questions about causation: Were these conditions pre-existing, or perhaps not environmentally induced? Or are they environmentally instigated, responsive, transgressive behaviors? As establishing the validity of the diagnosis as a naming label is necessary, these are vexing questions for clinicians, social workers and anthropologist alike. In one example, Lorna Rhodes self-reflexively questions the binaries of blame and sympathy in her ethnographic analysis of the categorizations of madness and responsibility in a maximum security prison. In her analysis of the "strange behaviors" that men in maximum security confinement demonstrated, Rhodes asks:

> Are these strange behaviors signs of underlying disturbances – "madness" in one of its many forms – in those subjugated to intensive confinement? Or are they willful, character-based attempts to exert a minimal, if counterproductive, resistance?[55]

Tanya Luhrmann in her study of social defeat and schizophrenia writes: "Over time, the great debate has not been whether the illness [schizophrenia] exists but,

55 Rhodes, L. (2004) Total Confinement: Madness and Reason in the Maximum Security Prison, UC Press. Page 4.

rather, how to draw the boundaries of the category so as to infer, from that grouping, a reliable association of cause, course, and outcome."[56] Many "Axis I/II" mental health disorders[57], such as schizophrenia and bi-polar disorder, have been found to be disproportionately prevalent among homeless populations as have alcohol and substance use problems, when compared to non-homeless persons in United States epidemiological studies.[58] However, a 1997 review of the "Anglo-Saxon" epidemiological literature identified the problems of categorization and causation found in these studies. The abstract reads:

> A multitude of epidemiological surveys have been organized in Great Britain, Australia, Canada, and mainly in United States, and have attempted to evaluate scientifically the psychiatric morbidity of this population. This literature review reveals disparity of epidemiological methods in assessing the type and extent of mental illness among homeless adults. The lack of consensual definition of homelessness, the choice of different settings in which the research is organized (street, health centres, shelters), and the use of diverse instruments of psychiatric evaluation (diagnosis by clinician, by scale or by structured diagnostic interview) lead to a great disparity of the results. Thus, 1/3 of the homeless adults had prior history of psychiatric hospitalisation. Rates of psychosis range to 70% and it is estimated that 4% to 74% of the homeless persons suffer from affective disorders. Substance abuse disorder remains a problem for a significant number of these individuals, with a high frequency of dual diagnosis. Such divergent data highlight the anglo-saxon debate between those who accuse desinstitutionalisation as a reason of homelessness, and those who blame the socioeconomic background.[59]

To complicate matters, there is also a parallel set of mental health conditions – commonly attributed to the homeless- with denominations that echo Rhodes' confusion of psycho-social categorization: anti-social personality disorder, anxiety, post-traumatic stress disorder, hyper-vigilance - commonly clinically diagnosed and witnessed by social workers. In a recent ethnographic article written to a psychiatric audience, Tanya

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56 T.M. Luhrmann. 2007. Social Defeat and the Culture of Chronicity: Or, Why Schizophrenia Does So Well Over There and So Badly Here. *Culture, Medicine, and Psychiatry*. 31: 135-172.

57 The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability: Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, phobias, and schizophrenia. Common Axis II disorders include personality disorders: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, and mental retardation.

58 See Fischer PJ, Breakey WR. (1991) The epidemiology of alcohol, drug, and mental disorders among homeless persons. *Am Psychol.* 46(11):1115-28.

59 See Ducq H, Guesdon I, Roelandt JL. (1997) Mental health of homeless persons. Critical review of the Anglo-Saxon literature. *Encephale* 23(6):420-430. Article in French.

Luhrmann explains the problem of overdetermined clinical diagnostic categories as they can operate to create refusals of services among homeless women with mental illness. She states: “These data suggest that offers of help-specifically, diagnosis-dependent housing-to those on the street may be more successful when explicit psychiatric diagnosis is downplayed.”[60] The neurocrat’s job is the opposite: to document and advocate for recognition of health and mental health disorders to material resource allocation.

In parallel to the on-going ambiguities of mental health categorization, notions of addiction are undergoing a scientific makeover which bears weight upon neurocratic evidence. The debates about neurobiological etiologies of addiction and its forms of social causation are rife within addiction research settings. They circulate among clinicians - psychologists and psychiatrists, and also among lay practitioners, such as outreach workers and service providers who are often the untrained frontline recipients of the abhorrent and self-destructive behaviors of the many homeless mentally ill persons. Categorization issues resurge as bioclinical advocates forward evidence of “addiction as a brain disease”, while existing treatment models, and much of popular opinion, maintain an understanding of the addict as an individual lacking in willpower. If the addict has any disease, this public decries, it is a moral deficiency not a chemical one. When evidence about the homeless mentally illness is forwarded, the slippage between references to “mental illness” and “addiction” and “co-morbid conditions” (both addiction and mental ill) often occurs unnoticed, as if these conditions necessarily co-occur, or co-produce each other. Prior to an exploration of the historical and current categorization of “homelessness,” it is important to demarcate the similarities and differences in the evidentiary discourses of mental illness and addiction.

60 Luhrmann, T. (2008) "The street will drive you crazy": why homeless psychotic women in the institutional circuit in the United States often say no to offers of help. *Am J Psychiatry*. 165(1):15-20

The National Institute of Drug Abuse (NIDA) currently proposes a biomedically informed understanding of addiction, in part to create a more sophisticated dialogue about both the vulnerability to drug abuse and its physical and mental side effects. NIDA now defines addiction as a brain disease with social, economic, and behavioral consequences *as well as* a set of behaviors (chronic drug use) which alter the brain in a negative manner.[61] The social etiologies of addiction are not completely elided by NIDA in this biomedical medical claim, but they are often reduced to "environments" in which neurons can be triggered. The biomedical focus and its associated visible evidence (brain scans) identify the brain as the site of vulnerability and reparation. Social welfare institutions, families or other social entities had previously occupied much of the attention of prevention and treatment interventions. In *Drugs, Brains, and Behavior: The Science of Addiction,* NIDA Director and Neuropsychiatrist, Nora Volkow, describes this sea change:

> Throughout much of the last century, scientists studying drug abuse labored in the shadows of powerful myths and misconceptions about the nature of addiction. When science began to study addictive behavior in the 1930s, people addicted to drugs were thought be morally flawed and lacking in willpower. Those views shaped society's responses to drug abuse, treating it as a moral failing rather than a health problem, which led to an emphasis on punitive rather than preventative and therapeutic actions. Today, thanks to science, our views and our responses to drug abuse have changed dramatically. Groundbreaking discoveries about the brain have revolutionized our understanding of drug addiction, enabling us to respond to the problem effectively. As a result of scientific research, we know that addiction is a disease that affects both brain and behavior. We have identified many of biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease.[62]

In light of the changing understanding of addiction, it is instructive to examine a previous anthropological analysis of how the "mutable objects" of science come to attach themselves to truth claims about illegitimate and illegitimate suffering. The

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61 "Drug addiction is a brain disease because the abuse of drugs leads to changes in the structure and function of the brain. Although it is true that for most people the initial decision to take drugs is voluntary, over time the changes in the brain caused by repeated drug abuse can affect a person's self control and ability to make sound decisions, and at the same time send intense impulses to take drugs." National Institute of Drug Abuse. NIDA InfoFacts: Understanding Drug Abuse and Addiction. September, 2007. Page 1. Emphasis: NIDA.

62 National Institute of Drug Abuse. Drugs, Brains, and Behavior: The Science of Addiction. NIH Pub No. 07-5605. April 2007. http://www.nida.nih.gov/scienceofaddiction/

reconstruction of addiction as a brain disease does much of the same work as Young's outline of the social construction of PTSD. Addiction becomes "a thing" in the brain which can be targeted for pharmaceutical intervention. Addiction is also a set of behaviors which disable, first and foremost, the brain, and then cause a cascade of associated social and interpersonal problems. While this is not necessarily inaccurate, it does not map well onto everyday experience, because it erases the social histories and political economies that strongly influence lived experience of addicts. An article in *Science*, for the October, 2007 special issue "Advances in Neuroscience: Decision Making"[63] illustrates the degree to which the social reality of poverty can be evacuated from the biochemical framing of addiction to the extent that food and drugs are juxtaposed as equivalents, and the "wrong" choice indicative of psychiatric disorder (see image on next page).

Interestingly, the bodies rendered here are female, and the "individual with a psychiatric disorder" appears as a darker colored woman. An excellent example of racial and gender bias entering into to an apparently objective visual representation of scientific evidence[64] that legitimates the predominance of neuropsychiatric discourse. The unmentioned bodies and the social histories of the "two individuals" in the schema are evacuated. Yet, they reappear when this form of evidence enters into current public debates about drug addiction and personal and social responsibility. In the United States, media attention about the biological etiology of addiction runs parallel to debates about the efficacy of the "War on Drugs" and the mass incarceration of people of color

63 M.P. Paulus. Decision-Making Dysfunctions in Psychiatry – Altered Homeostatic Processing. *Science* 318 (5850): 602-605.

64 Here I am directly referring to Bruno Latour's analysis in "Visualization and Cognition: Thinking with Eyes and Hands" *Knowledge and Society*. Vol 6: 1-40, 1986. It is not a difference in knowing as such that interests Latour, but rather a difference in seeing that is achieved through the creation, access to, and circulation and return of inscripted knowledge (7-8). The process of inscription creates "facts" which are difficult to argue against (12-3) and shore up allies through their very existence as material reductions of the complex natural world. Specifically, inscription achieves nine basic "advantages": They are mobile, immutable, flat, impervious to scale, reproducible, able to be recombined, super imposable, codified in writing, and reducible to geometry or quantifiable (20-21).

under its policies.[65] In contemporary juridical settings, brain scans and testimonials about impoverished social environments are served up side by side as evidentiary platforms, proclaiming guilt or innocence.[66]

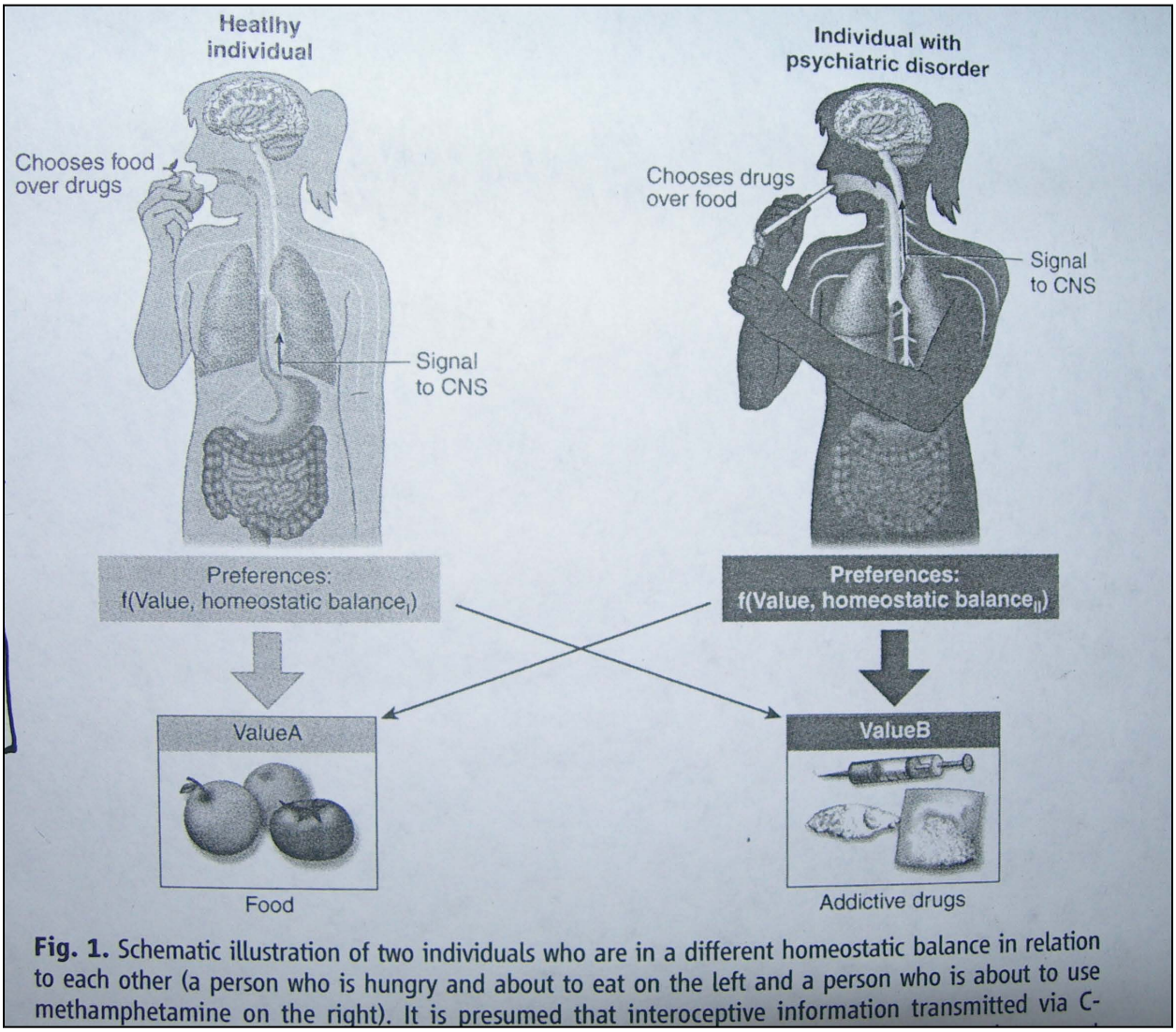

Fig. 1. Schematic illustration of two individuals who are in a different homeostatic balance in relation to each other (a person who is hungry and about to eat on the left and a person who is about to use methamphetamine on the right). It is presumed that interoceptive information transmitted via C-

Anthropologists have often attempted to fill the socio-historical knowledge gap by offering alternative explanations for the phenomenon of addiction. In the realm of mental

65 See, for example: Washington DC Area Teachers are Briefed on the Biology of Drug Addiction at NIDA Workshop: http://www.nida.nih.gov/NIDA_Notes/NNVol12N2/Workshop.html; Avram Goldstein. Addiction: From Biology to Drug Policy. Oxford University Press. 2001; Nora Volkow interview on National Public Radio: Fresh Air. "No Really, this is your brain on drugs." July 10, 2007. http://www.npr.org/templates/story/story.php?storyId=11847222.

66 See, for example a description of "Neurolaw", in which MRI diagnostics are used to "prove" that despite seemingly intact moral judgment capabilities, some individuals are presented as biologically incapable of controlling their behavior and therefore exceptional to certain legal retributions. (Jeffrey Rosen for the New York Times Magazine, March 11, 2007).

illness, the source of the emotional anguish and troubling behaviors is still debated as generating from an unconscious, familial, social or biological source.[67] Addiction operates slightly differently in the sense that the physiological impacts that drugs of addiction have on the body – the ability to chemically alter the body to produce pleasure, inebriation, unconsciousness, and withdrawal - are not debated. Drugs have biological effects. What is still debated is the ability of individuals to control the response to cravings, withdrawal, and to resist inebriation. One neurologist of addiction that I interviewed discussed impulsivity as the inability to delay gratification. Drug use was not a result of bad choices, but rather of learned behavior, learned behavior that addicts do not consciously nor understand.

> Neurologist: If you ask someone why did you do something? They will give you a reason. 9 times out of 10 that is not why they did it. I think that your brain guides you to engage in a particular action and then you make a story so that it makes sense. Right? Everybody's got their personal narrative. Well, you know that because you have been living with these people. They have a *reason* it is very clear to them why they do everything. But that is because everything fits together for them. I don't believe that that is why they actually make decisions. Like you go to reach for this pen [picks up a pen off the desk] and then you explain to yourself why you picked it up. The reason you picked it up is not the reason you said. In fact you may not even know why you picked it up. People engage in habitual behaviors. They do things, actually without thinking. But if you ask them, why did you do that? They will always give you a reason. Like you know you are you going to harm you fetus, why did you do that [use drugs]? Will they say they don't know? See I think that is the right answer: that they don't know.
>
> So getting back to the neuroscience a bit. We have been studying impulsivity because it is risk factor for all addictive behaviors. And there seems to be a genetic component. We don't know if there is a learned component. But, what we can do is we can put people in a scanner (a MRI machine) and have them engage in the task, and we can spread them out by their impulsivity (measured profile) and we can see what of the brain show differences that correlate with impulsivity. Once we get those parts of the brain, we can then go to animal studies, look at regions in the brain, find out what the neurons are doing find out what the pharmacology is and see if we can have a medical intervention that would change, like make them less impulsive. So they might now respond more to long-term goals as opposed to having a tendency to respond to immediate goals. So the problem that we have now is that most people have long-term goals, but they also have the immediate moment. And I would describe most addictive behaviors as responding to the immediate goal, regardless of the long-term consequences. That is a simple way to explain it, but I think it is all neural. I think you can train people to be less impulsive, I'm

67 In addition to works cites by Rhodes, Young, Estroff, Luhrmann, and Martin, see Authur and Joan Kleinmans' work on depression in China; Byron Good, Mary-Jo DelVecchio Good and Robert Moradi's work on depression in Iran; Scheper-Hughes work on "delerio de fome" and "nervos" in Brazil and earlier work on schizophrenia in Ireland, all of which question the purely biological source of mental illness and provide insight into its social construction, and consequent political and subjective repercussions.

> sure you can. Alcoholics Anonymous. Some people go to that and they really benefit from it. They stop harming themselves.
> Kelly: From your perspective are they retraining their brains?
> Neurologist: I would always say that. If your behavior has changed then your brain has changed, by definition. There is no other way. Can you give me an alternative? I am open to the possibility that there is an alternative but no one has ever given me a cogent alternative explanation.

In parallel to theories of drug addiction as a brain disease, social scientists have often offered ethnographically evidenced explanations for why persons might turn to drugs, become drug addicts, and why they find it extremely difficult to stop using drugs. These sets of evidentiary claims do not reject the physical power of addiction, but rather, they privilege the role of social context in creating subjectivities and social environments which opportunistically prey upon vulnerable persons in specific ways. They bring a different form of evidence to bear on the problem of causation, categorization, and the assignment of moral responsibility.

In the past bureaucrats who administered the benefits of drug addicted men and women could claim substance use disorder as a qualifying, disabling diagnosis. In January of 1997, federal law was changed to disallow chronic drug and alcohol dependency as a disabling condition for the Social Security Income (SSI) entitlement program. Prior to the change many chronic drug addicts had access to SSI entitlements. However, legislators, the media, and the public became concerned about reports that welfare money was being spent to purchase drugs and alcohol for use and for sale.[68] Once the change was enacted, persons could reapply for benefits but only if they could prove a health and mental health disabling condition, such as an HIV/AIDS diagnosis or an Axis I/II mental health diagnoses, such as schizophrenia or bi-polar disorder. The

68 See Bluthenthal, R. N., Lorvick, J., Kral, A. H., Erringer, E. A., & Kahn, J. G. (1999). Collateral damage in the war on drugs: HIV risk behaviors among injection drug users. *International Journal of Drug Policy*. 10:25–38.

commodification of disease status, produced through changing access to these entitlements has had HIV prevention consequences in San Francisco.[69]

The long-term repercussions of the SSI policy charge are still felt today on several registers. At the community level, a massive activist, benefits entitlement counselor and clinical effort was mounted to ensure that drug using clients and patients did not lose access to the entitlement funds. Admittedly, these were often used to support drug habits, but they also served to stave off homelessness and provide for basic needs such as food and clothing. The shared perspective of these three constituencies is that the policy change amounted to punishing drug users for chronic health conditions (physical/mental addiction to drugs and alcohol). They feared a loss of income entitlements would create emotional and physical destabilization, worsening drug users access to health and social services. This policy shift was consistent with other sweeping federal welfare reform measures - such as the Clinton administrations "Welfare to Work" program – and set a precedent for cuts to welfare entitlements as a public policy response to homelessness and drug addiction.

Now neurocrats – a new kind of "social worker" - must navigate between competing and changing discourses about addiction is an individual lifestyle choice or a disease, about the presence of qualifying mental health disorders, such as chronic PTDS, severe depression, or bi-polar disorder. One the one hand neurocrats adjudicate the social reality of poverty – they seek money for persons who can prove they can't work. They are first responders to the ways in which poverty, homelessness, and violence might disable individuals to the point that they are what anthropologist Kim

69 See Crane, J., Quirk, K. & van der Straten, A. (2002). "Come back when you're dying": The commodification of AIDS among California's urban poor. *Social Science & Medicine*. 55:1115-1127. Also see Petryna, A. (2002) Life Exposed: Biological Citizens after Chernobyl, for a discussion of the commodification of illness diagnoses in relation to the welfare state.

Hopper refers to as "surplus populations"[70], marginally housed individuals crippled by addiction, mental illness or both who are outside the labor market. On the other, neurocrats face the politically-generated problem of reconstituting many, many persons with substance use disorders into new categories, the most typical of which is mental illness. Thus the evidence–making activities of the neurocrats make visible the social suffering of the very poor. Yet, they also leverage category making to document prevalence of mental illness which was poorly documented prior to the policy changes to disallow substance use disorder in the mid 1990s. Finally, neurocratic efforts to make addicts socially legible produce material rewards – money - for the protocapitalists hotel-pimps who can legally serve as "payees" for SSI recipients who live in their buildings.

Profit and Debt

What the private residential hotel owners and managers care about is money. They survive and thrive on a capitalist mentality which is dependent on a consistent market of poor drug addicted persons who without credit, employment, or the mental and physical skills or gumption to live elsewhere will rent rooms in their hotels at exorbitant prices. The theory at work here is political economy on a zero-sum gain. While renters in publically funded supportive housing are measured by the length of time they – as individuals - remain housed; renters, as individuals, in private hotels do not matter. What is measured is the occupation of the room, and daily rent is more profitable that weekly or monthly; who occupies a specific room and for how long does not count in the metric of success.

The system that propels the protocapitalist hotel pimp is built on the foundations of neoliberal welfare policies which have informed the history housing and welfare benefits for urban poor drug users in San Francisco. The private hotels that

70 Hopper, K. (2003) *Reckoning with Homelessness*. Cornell University Press.

protocapitalist manage, primarily as brothels, exist to fill the space that publicly funded supportive housing does not. However, that is not to infer that supportive housing, or other health and housing progressive initiatives, are not active in San Francisco. Quite the contrary. San Francisco's housing initiatives are touted as some of the most innovative efforts to respond to chronic homelessness and mentally illness in the United States and around the Western world.[71] The symbiotic relationship between the practices of the protocapitalists hotel managers in the private hotels and the larger supportive housing domain helps to explain their orientation toward truth and knowledge. What is true for supportive housing parallels that of the neurocratics, state legibility is largely dependent on and determined by illness severity. Those housed in supportive housing are what one housing official referred to me as "the lowest hanging fruit," meaning those who are severely disabled by health, mental illness, and substance use conditions to the point that supportive housing can easily become "hospice warehousing." Those who circulate in the privately run hotels run by protocapitalists are more "functional," though no less poor. It is important to situate recent progressive housing policies in San Francisco in order to understand the ways that protocapitalist come to recognize the women, the pregnant addicts, who rent through rooms through the evidentiary lens of profit and debt.

In 2002, current San Francisco Mayor Gavin Newsom ran his first Mayoral campaign on the promise to respond to the homeless problem in San Francisco. He put before the San Francisco voter a controversial ballot measure (Proposition N) entitled "Care Not Cash", which won voter approval. After losing a series of California State Supreme Court appeals, the program began initial implementation in May 2003. The Care Not Cash policy diverted General Assistance – a California State welfare subsidy-

71 For example, Prince Charles visited the Empress Hotel, an SRO which was taken over by the San Francisco Department of Public Health, to learn about model programs for housing the chronically homeless in cities.

from the individual recipient to a fund which acquires housing units in Single Room Occupancy (SRO) Hotels in the Tenderloin and Mission Districts in San Francisco[72]. Average monthly cash subsidies were reduced from $322-422 to $59-65/month. Homeless individuals without dependent children currently receiving General Assistance funds (N=2497) through the San Francisco Department of Human Services (SFDHS) were asked to self identify as homeless and subsequently receive a greatly reduced cash stipend and be placed into permanent housing by acquiring a SRO hotel room through Care Not Cash. However, as a requirement of the program, homeless men and women had to agree to stay in the publicly funded shelters until a room could be made available.

By April 2005, Care Not Cash was touted as a "success" despite the fact 66% (n = 1648) of persons who were defunded had lost contact with SFDHS staff. By its own admission, SFDHS did not know the health and social service outcomes of those 1648 clients who were "off the rolls". While Care Not Cash did succeed in housing - some permanently and some temporarily – persons who were homeless, many were diverted to private SRO rooms without welfare support to pay for the daily rate of $50-60, or remained homeless and more cash-poor that prior to program implementation.

During this same period (2004-5) two programmatic responses to homelessness - both considered progressive and innovative - were introduced from two different governmental bodies. First, the Direct Access to Housing (DAH) Program was opened in the Department of Public Health. The DAH Program represented the first program in the United States to provide housing through a Department of Pubic Health, as opposed to the Department of Human Services (DHS), were it typically resided. Symbolically and

72 *Care Not Cash Overview and Progress Report*. (2005). Prepared for the Ten-Year Implementation Council: San Francisco Department of Human Services.

practically this program constituted sustainable housing as a health care issue. As the Corporation for Supportive Housing website indicates:

> **Goals and Philosophy:** The Direct Access to Housing program offers its residents an opportunity to regain stability and control in their lives, while reducing the costly and inappropriate utilization of emergency services. "Our goal is to provide clean, safe housing for individuals who would otherwise revolve through the City's emergency shelters and medical systems due to lack of stable, affordable housing options," observed Mitchell Katz, MD, Director of Health at the opening of the Windsor Hotel.
>
> **Tenancy Profile:** The DAH Program's targeted population - chronically disabled homeless adults with histories of severe, persistent mental and emotional disorders - typically have trouble sustaining connections to public support agencies and consequently are unable to maintain stable treatment or housing arrangements. Many not only have histories of hospitalization, but also of institutionalization, substance abuse, poor medication compliance, and difficulty in living independently and participating in structured activities. Having a history of felony conviction, fire starting, or drug or alcohol addiction does not disqualify potential tenants. Undocumented tenants are also admitted. Participation in treatment and services is encouraged but not required.
>
> **Housing Description:** Currently, the DAH program provides 623 units of permanent supportive housing in nine Single Room Occupancy (SRO) hotels and one licensed residential care facility ("board and care").[73]

The second progressive initiative came from the Mayor's office, not the Department of Public Health. Gavin Newsom, in 2004 began sponsoring a one-day, massive triage referral and service provision event to respond to the immediate needs of homeless persons in San Francisco. This program is called Project Homeless Connect (PHC), and it encourages "everyday San Franciscans" and corporate sponsors to volunteer at various service booths. In many ways the program emerged out of the criticism and controversy of the Care Not Cash legislation, as an effort on the part of city government to look engaged in providing social services to the homeless. Ironically, housing is rarely available at Project Homeless Connect, although many others services are available on demand for those who take a number and wait in line. Many women I know have received service - such as methadone treatment slots - by attending PHC. Many service providers and activist share a criticism of PHC as a public relations ploy by the Mayor's Office to appear to be addressing the needs of homeless people. By offering

73 Corporation for Supportive Housing Website accessed April 2009. www.csh.org

unsustainable access to services every other month, the city is not addressing why the needed service are not available all the time. On the website, Mayor Newsom describes Project Homeless Connect by attempting to connect all San Franciscans and motivate working volunteers toward altruistic volunteerism:

> "We all have a story, we have this remarkable narrative called "life". And for some of us it is going very well, and for others of us it has gotten off track, and it's not going so well. And what purpose is greater than this purpose in life than to be an individual who is part of someone else's narrative, part of someone else's story, and helps get them back on track?"[74]

Steeped in liberal rhetoric of social contractual democratic values and neoliberal narratives of individual triumphant over adversity, Newsom's Care Not Care and Project Homeless Connect are irresistibly appealing to most San Franciscans, based on their votes. The DAH Program operates through a medical model of care, built on a politics of Housing First, briefly summarized as the chronically homeless cannot get well unless they are inside. Helping chronically homeless men and women with multiple mental and health diagnoses succeed by staying housed within community settings is the first and foremost goal of the DAH program.

Women who bomb out of supportive housing, who are not sick enough to be eligible for it, or who resist the deferral of their welfare payments to the government for housing end up in the private hotels. The private hotels charge between $50-60 a day to rent a single room. None of the rooms have bathrooms and stained walls, dirty, broken furniture, chipped and peeling paint, often with blood stains and graffiti on the walls. Most rooms have terrible bed bugs, rats and mice – there are flies everywhere and often garbage in the hallway, along with broken TVs, dirty bed sheets, old mattresses, and other odds and ends.

74 Gavin Newsom speaking to PHC volunteer in the promotional video " We all have story"; Project Homeless Connect website, accessed April 2009; www.porjecthomelessconnect.com

Before I understood the political economy of the private SROs I had assumed that the women with access to Social Security Income (SSI) - federal entitlements payments ranging from about $450-800 per month – would be the desired tenants of the private SROs. As I discuss below, SSI is a trying, though not overly difficult entitlement to access for persons who can document a serious, chronic health-related disability. For urban poor drug users in San Francisco the diagnoses that translate to SSI access are HIV/AIDS and Axis-I/II mental illnesses, such as schizophrenia or bi-polar disorder. It is more difficult to gain access to SSI with mental health conditions such as depression and post-traumatic stress disorder. More time in SROs taught me that SSI-benefited persons are not the most desirable tenants. The hotels actually make a tremendous amount of money from charging renters daily, and accruing renter debt. The primary source of this income is through charging visitors fees for sex workers.

Charging visiting fees, like musical rooming, is illegal in the city of San Francisco; and it is widely practiced in the SROs in which I conduct participant observation. This is how it works: a woman rents a room for the day, paying $50. Every trick she brings into the room has to pay the manager a $10 fee to visit, plus paying for the cost of the transaction. The cost of the transaction can vary by a variety of factors including the price of specific sex acts, how much the sex worker thinks she can charge the trick, the degree of desperation of the sex worker, pressure from pimps to earn a certain amount of money in a night, and how the sex worker is feeling mentally and physically at that moment – dope sick, depressed, energetic, exhausted.

Some quick math reveals that this is an extremely profitable form of gendered economic exploitation on the part of the SRO hotels. An SSI-benefited tenant will pay between on average $500/month for a room. A sex worker will pay $350/week. Assuming only five tricks a night, another $350 in visiting fees is garnered from her labor for the hotel. She keeps whatever money gained from the sex work, minus her rent cost,

minus payouts to pimps, minus money for drugs. It easy to see how the relationship between hotel management and women engaged in sex work in their SROs is a mutually dependent, yet exploitative labor market. This is equally true for women who are dealing drugs out of hotel rooms where visiting fees are charged, although with less consistency. The everyday economic reality of women in the SROs is one of perpetual indebtedness.

Debts are often called in by hotel management, but different women are able to negotiate different lines of credit with their hotels. Some hotels are known to be more lenient about letting women accrue debt. Other hotels are very strict, still others are apparently arbitrary. For example, on a single floor of an SRO it is not unusual to have one woman struggling to get enough tricks to pay down her hotel debt and avoid a night outside; another woman is unfazed by owing the hotel several hundreds of dollars; and, yet another woman will be calling in the debts others - boyfriends and friends- owe to her to pay down her own debt to the hotel. Hotel management will often “employ” women, to clean bathrooms or work the front desk, and this is sometimes in exchange for paying down debts. Sometimes it appears that women are feeling threatened that they will loss favor in the hotel and perform this labor even when they still are paying $50/day in rent, and not in debt. I need to investigate further the conditions under which hotel labor and debt are negotiated. What I have observed is that women are intimated by hotel management and fearful of their arbitrary actions. Even as I have witnessed heated verbal exchanges, but these are more show than action. Women who overly anger the hotel management end up kicked out. All of their possessions are thrown out for others to rummage through on the street out front.

Narratives of suffering, survival and redemption

The pregnant addict – a social constructed category of person with diagnoses to explain the irrationality of her existence, and a diverse lived identity and embodied experience.

Narratives of suffering, survival and redemption surely emanate from women drug users. They emanate as often as they are elicited by eager social scientists. In fact, most of the writing that has been done in social science and in the public health literature constructs women drug users, and specifically pregnant drug users, as victims and survivors[75]. I am not arguing that this perspective is incorrect. I have even, in the past, participated in the production of some of this evidence[76]. However, the humanistic project of claiming or reclaiming groups of people in order to create visibility and incite intervention runs the risk of sanitation, as the everyday realities of addiction rarely square with overly simplistic characterizations of victim and perpetrator.[77] Veena Das and Arthur Kleinman have both written extensively about theorizing narratives of suffering and survival – how words are essential for expression and understanding, yet remain forever inadequate to the experience that expresses "social trauma and the remaking of everyday life."[78] They write:

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75 Several ethnographic engagements with pregnancy and drug use follow phenomenological approaches which favor presenting narratives of both victimhood and survival. They are discussed in more detail in other chapters. But briefly see Susan C. Boyd *Mothers and Illicit Drugs: Transcending the Myths and From Witches to Crack Moms: Women, Drug Law, and Policy*. Claire Sterk: *Fast Lives: Women on Crack Cocaine*. Sheilga Murphy and Marsha Rosenbaum. *Pregnant Women on Drugs: Combating Stereotypes and Stigma*.

76 Much of my own writing about women drug users, contributes to this narrative construction in the public health literature. See for example: Knight, K.R.; Rosenbaum, M.; Kelley, M.S.; Irwin, J.; Washburn, A.; Wenger, L. (1996) Defunding the poor: the impact of lost access to subsidized methadone maintenance treatment on women injection drug users. Journal of Drug Issues. 26(4): 923-942. ; Knight, K.R.; Rosenbaum, M.; Irwin, J.; Kelley, M.S.; Wenger, L.; Washburn, A. (1996) Involuntary verses voluntary detoxification from methadone maintenance treatment: the importance of choice. *Addiction Research* 3(4): 351-362.; Kelley, M.S.; Rosenbaum, M.; Knight, K.R.; Irwin, J.; Washburn, A. (1996) Violence: a barrier to methadone maintenance treatment for women injection drug users. *International Journal of Sociology and Social Policy* 16(5): 143-164; van der Straten, A.; Vernon, K.A.; Knight, K.R.; Gómez, C.A.; Padian, N.S. (1998) The management of HIV, sex, and risk among HIV serodiscordant heterosexual couples. AIDS Care. 10(5): 533-548.

77 See for example, Campbell, ND & Shaw, SJ (2008) Incitements to Discourse: Illicit Drugs, Harm Reduction, and the Production of Ethnographic Subjects. *Cultural Anthropology.* 23(4):688-717..

78 Veena Das and and Authur Klienman. (2001) *Remaking a World: Violence Suffering and Recovery*. UC Press. Page 1.

> There is clearly a tension between interpreting a violent event in the form of text (even text that is performed) and trying to find ways in which violence is implicated in the formation of the subject, foregrounding the category of experience.[79]

Interestingly, when women addicts construct themselves – unedited – one often hears both narratives. The narratives of suffering, trauma, exploitation, and abuse are repeated, as are the narratives of survival and "push back", including unapologetic claims to illegal activities, abuse, and violence that women themselves commit. Narratives of redemption are frequently steeped in the language of recovery. Yet narratives of irrationality, poor choices, regret, violence, callousness and imperfection also pervade. What evidence do pregnant addict use to understand themselves? Like all forms of evidence discussed here, they are often contradictory and constructed at the intersection of multiple truth claims. Just as epidemiology tries to reduce the messiness of the everyday, and in doing so misses some of the most relevant practices through oversight or omission – pregnant addicts construct partial and incomplete narratives of themselves and their peers. Often women asked me to take photographs of their housing situations and their interactions, in order to "show" what everyday life was like, the conditions in which they lived, and the "mess" of drug paraphernalia, clothes, dirty bedding in which they lived and worked. But they also told stories, and sometimes retold stories with more detail and nuance as time went on.

Witnessing

The info-vulture – the medical anthropologist who performs the roles of researcher, story recorder, confidant, food buyer, chauffeur, medic, outreach worker, friend.

Drop-in Center Mission District, San Francisco November 2009
Anita is finally well, not dope sick. She has spent about 30 minutes in the bathroom doing her make-up and getting her clothes changed. We talk while she eats the pasta, salad, and bread they are serving tonight. "It's good," she says. Then she looks at me. "I knew you had to leave at 7, so I got back here right on time." I have her suitcase in my car. "Thanks I appreciate that." I say. "So, what…do you just talk to the women, like what we talked about before [when she dope sick and looking for her rock of crack on the street], you keep notes on that?"

79 Veena Das and and Authur Klienman. (2001) *Remaking a World: Violence Suffering and Recovery*. UC Press. Page 5.

"Yeah", I say "I tape record when I can, like we did when we had that long talk in September in my car. But mostly I write notes on my computer when I get home. I try and remember everything."
"Try to get it right, huh?" She smiles.
"Yeah, your words are valuable."
"Huh. You are taking it all in. I seen you up on Mission street quite a bit."
"Yep, I hang out."
"Well, that is what we [the other "girls" she means] are all doing anyway." She laughs.

As my conversation with Anita indicates, the info-vulture's evidence consists of what she can scavenge. It is a partial construction, to be sure, unevenly composed of a series of "encounters" which are the result of both chance and strategy. The info-vulture is seeking to transform the particularities of these many encounters into a wider explanation, one which can gain traction on a larger theoretical and policy stage. This translational activity is inherently risky. Not at risk only of being called illegitimate by category-markers who value statistical proofs, or neurocrats mired in cost-effectiveness logics. It is risky, also because drug ethnography as an evidentiary form, can reproduce the same bio-political governing practices it seeks to expose. As Nancy Campbell warns:

> Explanations that rely on individual deviance marginalize the systematic and everyday aspects of drug use and addiction…As a mode of knowledge production, ethnography generates frames of references that confirm the governing mentalities and become the nightmares writ large in media and popular consciousness.[80]

Ethnographic examples are dangerous "because they allow knowledge claims to be smuggled in via narrative."[81] I introduce the info-vulture as a specific figure of anthropological evidence production in this project. The info-vulture seeks to use the forms of production – narrative interviews and participant observation – to address, rather than to omnisciently reveal, the problematics of evidence production as they intersect with the everyday social suffering of pregnant and addiction.

For better or for worse, there are no easy villains here. What is seen and spoken, what is witnessed in the moves from conception to concept, from pregnancy to theory is

80 Campbell, N. (2001) *Using Women*. Page 202

81 Campbell, N. (2001) *Using Women*. Page 203

a sea of shifting evidence. What is pathological in the social world of pregnant addicts living in the daily rent hotels is under construction, as new configurations of mental illness and the social welfare benefits that travel with them circulate. These new configurations match the emotional tenor and everyday trauma/drama of the streets, making it difficult to distinguish the proliferating symptoms. Then info-vulture seeks to make sense-make of what she witnesses. It is an exercise of imposed order: placing rational frames and theories upon the apparent irrationality of everyday evidence production. Ramona, of course, was quick to point this out to me:

"How you gonna say that you know?"
McDonald's, Mission District San Francisco December 2009
Ramona, me, and her baby-daddy, Duke, are on the way to visit their newborn baby, Michael, at the hospital. But we stop to eat first. Ramona and Duke get into a fight. Ramona is convinced that Duke has been smoking crack all morning while she and I were getting her intake done at PPMT [Prenatal and Post partum Methadone Treatment, the methadone program specifically funded for pregnant women]. She also thinks he hooked up with Beverly when we left. She is also pissed because he ordered her an orange juice instead of an orange soda with her cheeseburger. "I said orange soda five times." She scolds him loudly. He gets up from the table to leave, pissed at her attitude and the humiliating scolding she is giving him. She yells as he walks away, "That's right Daddy, you don't even care to go to the hospital to see your own son."

No one really pays attention, this kind of yelling back and forth is normal "street" stuff. Michael is seven days old and being held for D.O.T. – Directed Opioid Therapy. Ramona was clean – three days clean - and on 40 mg of methadone - when he was born, so he is on a relatively low dose of D.O.T.

Ramona and I are talking about S.S.I. (Supplemental Security Income), and I ask her whether she thinks most folks are on it for mental health reasons or health reasons. The conversation is confusing and I ask multiple times in different ways. She looks a bit amused at my questions. "I am just trying to figure out it" I say.

"Well, that is your mistake right there. You should not try and *figure out* what happens down here. All this crazy. It is not gonna make sense."

"Well I don't think they are gonna give me the PhD if I just say 'I don't know.'" I shoot back.

Ramona laughs, "Ha. I guess they want more than that. I am just saying. There are a lot of stories. People on the SSI, for instance. You either need to be "insane" or have a fucked up something [a health problem], and you can't work. But looking at drug users, folks coming down off crack, how you gonna tell?" She gives an example:

"Listen. Here's me with my bipolar, right? And I am racing, and I am paranoid. I am uncomfortable and pissed, really angry. I am depressed. And here's you coming down off crack. We *act the same*. It looks *just the same*. How you gonna say that you *know*? You can't tell the difference. You should put that in your book. Damn, put this whole conversation in the book."

"I will," I answer.

“Good.” She says. She sneaks a look over at Duke, sulking in the corner, drinking the rejected orange juice. “He would have been half way back home by now if his bag wasn’t in your car. That dog.” Ramona scowls and eats a big bite of cheeseburger.

The three of us leave for the hospital to visit their son, but first Ramona runs back into McDonald’s to show someone a picture of the new baby. She is proud and beaming as we drive away.

Chapter 3: Stratified reproduction, biological inheritance, and kin of last resort

I. Reproduction: social/actual

Cupcake **Metropica Hotel** **November 2009**

"I got two kids...both my daughters got adopted. The first one was born in 1999. I was too young, I was like 15, just turned 16. I didn't have a place to go so they [CPS]took her. I wasn't able to get custody back of her because they said I wasn't stable…[I feel that] I was too young. I wasn't ready. She's better off. Not better off, better off's not the right word. But I think she alright. I didn't feel like it was a good decision at that time, because a mother, well every - well not every [pause] but a mother wants to be with her child. And I look back on it now and it is probably good that she has had something stable, because even since then, you know, I have been through a lot of shit."

"And then my other daughter. I had her in 2004. I was in a [drug treatment] program and then I relapsed and lost her. I had been court mandated to the program at three or four months, and I stayed there my whole entire pregnancy. But I was on drugs too (before the program) so it was good that I got clean when I did (early in the pregnancy)."
"Did you catch a case [a sex work arrest]?" I ask.
"Yeah. But I got treatment, through Prop 36[82]. You know when they give you like 20 chances and I had pretty much expended every chance that they gave me. You know like I was just one [chance] before they would have canned my ass. [We both laugh]. If I wasn't pregnant, I don't know. I think they would have given me [jail] time. Cause I just didn't care, like I said, I didn't like rules."
"You were smoking a bunch a crack at that time, were you thinking about treatment?" I ask
"No. Not before I knew I was pregnant. Not before they tested me in jail. But I didn't want to have no crack baby either. So once I tested pregnant I thought maybe this is my chance to straighten up. So "fine," give me the program. So I was *willing*. But I still wasn't completely [pause] giving up. I didn't like the rules. I got tons of consequences, but still, I stayed. But after she was born it was a big jump from the program to transitional [housing] for me. I wasn't ready. And I relapsed and lost her."

82The Substance Abuse and Crime Prevention Act, also known as Proposition 36, was passed by 61% of California voters on November 7, 2000. This vote permanently changed state law to allow first- and second-time nonviolent, simple drug possession offenders the opportunity to receive substance abuse treatment instead of incarceration. Proposition 36 went into effect on July 1, 2001, with $120 million for treatment services allocated annually for five years. Over 36,000 Californians enter treatment each year through Prop 36.Source: Drug Policy Alliance website.

"How did that work? Were there case workers coming to see you?"
"Yeah. They are *always* coming to see you. And you got to go in on your certain days and you can't be late and all that. Same thing as like a probation officer. [pause] I got overwhelmed I guess, and it was a lot and I was trying to find employment. You know, I never had had a job before, you know what I mean? It was just a lot of different stuff. And so I went to another program, but you couldn't have your kids there, but you could have visits. And I did that, and I graduated from that program. The judge said I had to do a six month program, without her, and that was part of the stipulations of getting my daughter back. So I did the program. But once again I did it for *her* [for her daughter]. I wasn't doing it for myself. And that is where a lot of my whole thing was, was not doing it for me, you know?"

The image of the child in the *Prevention Project's* advertisement for paid birth control and sterilization of pregnant addicts and Cupcake's narrative of her experiences with incarceration and drug treatment during pregnancy tell two different stories in two different ways. On the one hand, pregnancy and addiction is reduced down to a disturbing image of a suffering baby, with an paid offer to avoid a similar future tragedy. On the other, we see the complex world of Cupcake, 15 years old, pregnant – and initially unaware of it – attempting to manage the pressures of addiction, poverty and motherhood under the adjudicating eyes of the state.

The pregnant addicts I studied in this ethnographic project were "socially dead" because their claims to citizenship were dependent upon their recognition by state apparatuses of biomedical control; their lesser social status was determined by dual biologically-manifesting constraints: first addiction, then pregnancy. The multitude of ways in which pregnant addicts came to interact with and avoid systems of care and control throughout their pregnancies is demonstrative of "stratified reproduction" at work in the United States. Stratified reproduction was first coined by Shellee Colen, and applied broadly by Faye Ginsberg and Rayna Rapp in their work to "transform traditional anthropological analyses of reproduction and to clarify the importance of making reproduction central to social theory."[83] Stratified reproduction is a concept used to "describe power relations by which some categories of people are empowered to nurture

83Faye D. Ginsburg and Rayna Rapp (1995). *Conceiving The New World Order: the Global Polictics of Reproduction.* UC Press. Page 1.

and reproduce, while others are disempowered."[84] Examples of stratified reproduction are plentiful, in the United States and throughout the world[85]. State-funded efforts to forcibly sterilize women in communities of color, particularly African-American poor women, offer a poignant and liberally shaming example that is both historically rooted[86] and circulating in current political discourse in the United States. For example, state representative John LaBruzzo recently proposed to pay poor women in Louisiana $1000 to undergo surgery to have their fallopian tubes tied in order to "reduce the number of people going from generational welfare to generational welfare."[87]

While the concept of stratified reproduction applies to varied groups of women, the specific vulnerability of substance using women in relation to pregnancy and parenting has been highlighted by several authors. Nancy Campbell offers an astute and thorough examination of the historical construction of women drug users in the United States in *Using Women: Gender, Drug Policy and Social Justice*. Campbell's work offers a bellwether for the seedlings of ideological constructs that continue to haunt emergent debates about pregnancy and addiction. It also serves as an indication of which constructs are currently being, however unevenly, displaced by new scientific imaginaries of pregnancy, addiction, and mental health.

Nancy Campbell's argument is rooted in science studies and critical analysis of discourse. She offers critiques of both positivist renderings and narrative representations of drug users in the United States – focused on each discipline's lack of methodological transparency and dangerous, widespread influence in policy arenas. She writes:

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84 Faye D. Ginsburg and Rayna Rapp (1995). *Conceiving The New World Order: the Global Polictics of Reproduction.* UC Press. Page 3.

85 See for example. Nancy Scheper-Hughes. (1992) *Death Without Weeping: The Violence of Everyday Life in Brazil*. (UC Press) 1992. Faye D. Ginsburg and Rayna Rapp (1995). *Conceiving The New World Order: the Global Polictics of Reproduction*. UC Press.

86 See Larson, Edward J. *Sex, Race and Science: Eugenics in the Deep South* (John Hopkins U. Press, 1995); Reilly, Philip R. *The Surgical Solution: A History of Involuntary Sterilization in the United States* (John Hopkins U Press, 1991); Davis, Angela Y. *Women, Race, and Class* (NY, Vintage Press, 1981); Dreifus, Claudia "Sterilizing the Poor", in *Seizing Our Bodies: The Politics of Women's Health* (NY, Vintage Books, 1977); Pickens, Donald K. *The Sterilization Movement: The Search for Purity in Mind and State*, Phylon 28 (Spring 1967):78-94;

87 New Orleans Times-Picauyne. LaBruzzo: Sterilaization plan fights poverty. Tying poor women's tubes could help taxpayers, legislator says. September 24, 2008.

> [W]omen who use illicit drugs embody both individual deviance and social failure; the difference between drugs and their users have been racialized and their meaning encoded in the "figures" of drug-using women on which political discourse relies. This book recounts such gendered and sexualized meanings of women and drugs in order to show how public constructions are produced, how they circulate, especially in public policy, and the assumptions that shape them.[88]

Campbell does not conduct any ethnographic engagement with drug using women. She analyzes media representations, public court cases involving women drug users, and importantly, critiques drug ethnographers of women to make a case for the ways in women drug users are construed as "spectacular failures." [89] She argues that all these forms of representation contribute to the "governing mentalities" which underpin drug policies: "Basically how we 'know' drug addicts matters for how we govern them."[90]

According to Campbell, then as now, "[a]ddicted women are understood to reproduce their own (in)humanity, as well as offspring who are not fully human."[91] They also place undue financial pressure upon the state. Campbell argues that the fact the women in general bear the brunt of responsibility for social reproduction lies at the heart of medical intervention and state management strategies which seek to exert biopolitical control over the lives of pregnant addicts and their offspring. In her analysis of *Born Hooked*[92] - the transcripts of congressional debates and expert testimony about drug use, pregnant mothers, and their children that took place in House Select Committee on the Welfare of Children, Youth and Families in 1989 – Campbell demonstrates that the

88 Campbell, N. (2001) *Using Women: Gender, Drug Policy and Social Justice*. Routledge. Page 1-2.

89 Campbell, N. (2001) *Using Women*. Page 1.

90 Campbell, N. (2001) *Using Women*. Page 35.

91 Campbell, N. (2001) *Using Women*. Page 138.

92 ED314920: *Born Hooked*: Confronting the Impact of Perinatal Substance Abuse. Hearing before the Select Committee on Children, Youth, and Families. House of Representatives, One Hundred First Congress, First Session. Abstract: This hearing was called to develop a better understanding of the damage to women and their babies resulting from substance abuse during pregnancy. The hearing transcript addresses prevalence and trends, impacts on mothers and children, impacts on health care costs, impacts on the child welfare system, legal and health policy issues, intervention strategies, and policy recommendations. The document contains statements, letters, and supplemental materials from: (1) Congressional Representatives Thomas Bliley, Jr., Ronald Machtley, George Miller, Nancy Pelosi, Charles Rangel, and Curt Weldon; (2) nurses, doctors, child development specialists, health educators, hospital directors, and substance abuse specialists; (3) attorneys; and (4) a representative of the National Council of Juvenile and Family Court Judges. Included are the findings from a telephone survey of 14 public and 4 private hospitals in 15 cities, and article reprints from a newsletter and two medical journals.

divisive political climate over fetal rights between feminists and conservatives in the United States forced a new form of biopolitical management of pregnant addicts to emerge. "[A]nti-abortion advocates forced feminists to defend 'unfit' mothers and occupy and almost (but not quite) indefensible position."[93] Through these intricate acts of deferral, political consensus came to rest upon the health of the fetus through the course of hearing, and what Campbell call "postmodern progressivism," was born.

> Postmodern progressivism occurs with "the redefinition of coercive measures as compassionate rehabilitation – and the inevitability of punitive sanctions. I call this reconfiguration "postmodern progressivism," distinguishing the expansive Progressivism of the earlier twentieth century from today's version, which takes place in the context of the ideological contraction of the state's responsibility for social provision."[94]

Anita had given birth to her eldest child, now 21 years, when these laws were changing toward pregnant drug users. She told me a story of a baby the hospital staff had put on "hold" in the neonatal intensive care because the mother admitted to smoking crack while pregnant. She said, "My daughter was born clean in 1989, but she had meconium and could not breathe well at first. So she went to ICU for awhile first. I remember I went there to see her, and I saw this other baby, a big baby, who looked perfectly fine. I asked the nurse why the baby was in the ICU, and she said, 'Oh, that baby has a drug hold on it.' I was so glad not to be in that situation, because that baby looked just fine, but the mom got caught using [drugs]." One day when Lexi and I were driving back from her methadone program, she pointed to a hospital nearby. "This is where all the [drug using] women would come to have their babies back in the day. You know I had Lionel late, I wasn't pregnant until 1999, but I remember hearing stories about this hospital. You see the nuns never took no mamma's baby away. If you had your baby there, you could keep it."

93 Campbell, *Using Women* Page 139.

94 Campbell, *Using Women* Page 183.

As pregnant women, drug users became increasingly criminalized during the late 1980s and early 1990s, and feminists fought back successfully against criminal measures to arrest and incarcerate women who used drugs while pregnant. Currently there is only one state, South Carolina, which holds prenatal substance abuse as a criminal act of child abuse and neglect.[95] According to Campbell, winning this battle meant advocating postmodern progressivism, which included feminists supporting increased involvement on the part of the drug treatment and child protective services establishments in order not to appear as if they were laissez-faire about the pregnant women using drugs.

> [F]eminist had to argue for increased access to treatment, gender-specific treatment, and parenting education, even though these techniques lend themselves to a form of social discipline and surveillance. By broadening the analysis to what pregnant drug users need from the state and society, feminist were paradoxically placed in the position of arguing for the expansion of postmodern progressivism as the lesser of two evils.[96]

Sheilga Murphy and Paloma Sales, two medical sociologists, offer a critique of neoliberal policies directed toward pregnant women from their qualitative work in two studies spanning from 1991-1998,[97] which mirrors aspects of Campbell's thesis. To Murphy and Sales, pregnant drug users are the "ideological offensives," created through mediated constructions of the "welfare queens" who only get pregnant to receive welfare moneys from the state and the pregnant crack smokers who deplete public health and

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95 Other states have laws that address prenatal substance abuse: Iowa, Minnesota, and North Dakota's health care providers are required to test for and report prenatal drug exposure. Virginia health care providers are only required to test; Arizona, Illinois, Massachusetts, Michigan, Utah, and Rhode Island's health care providers are required to report prenatal drug exposure. Reporting and testing can be evidence used in child welfare proceedings; Some states consider prenatal substance abuse as part of their child welfare laws. Therefore prenatal drug exposure can provide grounds for terminating parental rights because of child abuse or neglect. These states include: Colorado, Florida, Illinois, Indiana, Maryland, Minnesota, Nevada, Ohio, Rhode Island, South Carolina, South Dakota, Texas, Virginia, and Wisconsin; Some states have policies that enforce admission to an inpatient treatment program for pregnant women who use drugs. These states include: Minnesota, South Dakota, and Wisconsin; In 2004, Texas made it a felony to smoke marijuana while pregnant, resulting in a prison sentence of 2-20 years. Retrieved: December 2009 from www.Americanpregnancy.org

96 Campbell, *Using Women* Page 191.

97 National Institute on Drug Abuse-funded studies entitled, "An Ethnographic Study of Pregnancy and Drug Use" (Rosenbaum and Murphy 1991-94) and "An Ethnography of Victimization, Pregnancy and Drug Use," (Murphy 1995-98)

welfare resources by producing sick offspring.[98] These two socially constructed figures allowed neoliberal policies to be pushed forward in the mid and late 1990s. For example, the Personal Responsibility and Work Opportunity Grant, as welfare reform was formally named, became the instantiation of individualization of poverty risk and its consequences. According to David Harvey, neoliberal projects create groups of persons who are included and those who are excluded. By "attacking all form of social solidarity,"[99] (such as trade unions), dismantling the social welfare systems and privatizing public institutions (such as social housing), neoliberal policies were able to maintain the power-base of "a new class of entrepreneurs" and elites.[100] Unemployment and poverty were reconstructed as the result of *individual choice*, rather than structural forces. The inability to effectively participate in the "free market" was deemed a personal failure by neoliberal theorists[101]. At the population level, Harvey argues that the "financialization of everything" led to the harsh reality: "In the event of a conflict between Main Street and Wall Street, the latter was always favored."[102]

Lexi described the mired situation these welfare reforms left her in 2004, shortly after her daughter had died. While she was able to access methadone during her pregnancy, other benefits (general assistance and food stamps) were in jeopardy because she had a drug-related felony on her record. Lexi argued that the she needed

98 Murphy and Sales borrow the concpet of "ideological offenives from "Vincent Navarro, a medical soioclogist who analiyzed trends in national and internationla helath care provision [and] reminds us thta radical restructing of a social welfare system "...cannot take place only by reprssion but has to rely on active ideological offensive that could create a new consensus around a new set of values, beliefs, and practices." (1986,p.26), quoted in Murphy and Sales, *Pregnant Drug Users: Scapegoats of the Reagan/Bush and Clinton Era Economics* January 13, 2001.

99 Harvey, D. (2005) *A Brief History of Neoliberalism*. Oxford University Press. Page 23.

100 Harvey, D. (2005) *A Brief History of Neoliberalism*. Page 31.

101 Harvey, D. (2005) *A Brief History of Neoliberalism*. Press.Page 53.

102 Harvey, D. (2005) *A Brief History of Neoliberalism*. Press.Page 33. This is eerily reminiscent of recent Presidential campaign rhetoric, as well as circulating questions about why the treasury has released the majority of the 750 billion dollar bailout monies to banks as opposed to spending the money to prevent housing foreclosures on "Main Street." In other words, Americans, and others, are facing a crash course in the mechanisms and forms of accountability that exist in a neoliberal, finance-driven economic collapse. In this sense Harvey's descriptions of Mexico's experience with structural adjustment resonate with the current US context.

to produce a "seeable child" – she needed to have already had her baby, in order to access material resources which might have stabilized her pregnancy:

> What happened was, I got off GA [General Assistance] because of the fact that I was pregnant, I am trying to remember exactly how this happened…I got pregnant, I went on methadone, but they told me I couldn't be on GA that I had to apply for AFDC [AIDS to Families with Dependent Children]. But AFDC told me…when I went down there AFDC told me I could not receive AFDC because I was a felon. I could only receive AFDC once the baby was born…and I wasn't six months pregnant, and I was felon. If you have other kids and you are not that pregnant fine, then they are eligible for it. Fine. But being a felon, I am not eligible unless I have a seeable child.

Even for those living at the stigmatized outer boundaries of "Main Street," individual responsibility for social welfare was entrenched during this period in the United States. Murphy and Sales report that the women repeatedly tried and failed to perform the "technologies of the self," the sets of individual practices in which citizens come to discipline themselves as members of societies that Foucault argued became a requirement of docile citizens in neoliberal regimes[103]:

> Our [pregnant drug using] interviewee's mothering standards and values resonated with most American mothers: mothers should protect their children from harm; keep them fed, warm, presentably clean; and see they are educated, prepared for the work world and shown right from wrong. These goals are a tall order under conditions of lifelong victimization, lack of skills and education, unplanned childbearing, single parenting, violent and unsafe housing and scarcity of resources, not only for the child's play and learning but for the basics, such as food, clothing, and shelter. Nevertheless, our interviewees tended to hold themselves personally accountable for their poverty and for caring for their children.

Murphy and Sales connect the move toward individualization of responsibility for social failure and vulnerability among pregnant drug users to a lack of health and social services, or a lack of non-judgmental services. Interestingly, we can see a proliferation of the forms of governmentality in operation decade further on. Campbell described the 1990's advocates settling on greater state intervention and control (postmodern progressivism) in order to starve off racist criminalization of pregnant drug users. In 2009, pregnancy also served as site of exception *for* access to drug treatment and

103 See Barry, A; Osbourne, T; Rose, N. (1996) *Foucault and Political Reason: liberalism, neo-liberalism and rationalities of government*. University of Chicago Press.

entitlements among the women in my ethnographic sample. This might mark a temporal difference in the current policies for access to drug treatment in general in San Francisco, and specifically to pregnant women, in 2009 as compared to decade earlier when Murphy and colleagues conducted their ethnography, although efforts to prioritize pregnant women for drug treatment access are not new.[104] Witness Ramona's comments about her SSI disability payment going right to her drug treatment. "I don't need SSI to get into the program. No. They have to let me in [as a post partum drug user trying to maintain custody of her newborn son]. But they [the program] will sure as hell take all my money. They will take it *all*."

Lexi also experienced pregnancy as an exceptional form of access to drug treatment service in 2004. She was eligible for methadone while pregnant. However, these same services were suddenly and traumatically discontinued upon the premature death of her daughter, when Lexi was 6.5 months pregnant. This loss of service experience was a key determining factor to her refusal of prenatal-associated methadone maintenance during her pregnancy in 2009. Sales and Murphy argue that the structural violence of neoliberal Clinton era welfare reform easily sacrificed poor women – especially black crack smoking mothers - on the alter of reform. Funding linked to biological status (pregnancy) served to stabilize and then ultimately destabilize Lexi during two pregnancies. Lexi's reconstitution as disabled by PTSD became the only viable source of state recognition through welfare acquisition available to her after the death of her child.[105] She refused to join the same program that linked methadone funding to her pregnancy status in 2009, and did not receive prenatal care during that pregnancy. Lexi's experience provides a proximal convergence of two forms of

104 Rosenbaum and Irwin write that "Shortly after the National Institute on Drug Abuse (NIDA) was established in 1974, physicians and scientist expresesd concern about the effects of drug use during pregnancy. In 1974 Publoic Law 94-371 mandated that drug abuse and dependence among women be given special consideration for treatment and prevention (Kandall 1996)." Rosenbaum, M. And Irwin, K. *Pregnancy, Drugs and Harm Reduction*, accessed on the drugpolicy.org February, 2010.

105 Disability, viability, and state recognition will be discussed further in Chapter 6.

biological citizenship produced in relation to social suffering. For a definition of "social suffering" here, I reference Petryna (2002) who draws a connection between pain and suffering as a manifestation of both a personal experience/history and social context. This mediation between the embodied and the social comes to "illustrate the extent to which explanations and claims of health and their failures are understood within the scientific, economic, and political domains in which they are coming to be addressed."[106]

The practices of the biopolitical regimes of care and control in the lives of the pregnant addicts in my ethnographic investigation reveal the slippage between categories of addiction and categories of mentall illness. The scientific technologies to begin mapping addiction as a brain disease and to investigate further the connections between mental illness, hereditary and addiction existed during the time of Murphy, Sales and Campbell's analysis of pregnancy and drug use, but they had not gained mainstream media and entrenched political support. Several examples of the more recent sea change include the proliferation of mainstream media on addiction and mental health in relation to the brain that has exploded since the late 1990s; The election of Nora Volkow, a Neuropsychiatrist and ground breaking researcher on Magnetic Resonance Imagery (MRI) to map drug's effect on the brain as Director of the National institute of Health's National Institute of Drug Abuse; and that in the decade 1997-2007 psychotropic medications ranked highest for "most promotional spending" by pharmaceutical companies in direct to consumer advertising.[107]

While addiction and metal illness sharing co-location in neurological etiology is emergent, it has a parallel social, psychoanalytic history as well. One in which "mothering" was already causally implicated in the development of both addiction and serious mental illnesses. Andrew Lakoff describes the epistemological debates in his

106 Petryna, A. (2002) *Life Exposed: Biological Citizenship after Chernobyl*. Princeton University Press. Page 14-15.

107 Donohue, JM; Cevasco, M; Rosenthal, MB. (2007) A Decade of Direct-to-Consumer Advertising of Prescription Drugs. *New England Journal of Medicine* 357:673-681. Table 2.

study of the emergence of bipolar disorder in Argentina as evocative of the political histories of violence and repression and the associated sense of moral and social obligation for the health (and mental health) of Argentine citizens.[108] In his ethnographic work, proponents of biomedical models of psychiatric treatment press for joining the modern era and expanding access to pharmaceutical treatment. These variable camps occupy diagnosis of mental impairment as a site for staging a political-ideological battle. Lakoff quotes an Argentine psychoanalyst:

> 'The pharmaceutical companies have a great interest in reductionism.' Psychoanalysis, in contrast, protects social rights: 'We psychoanalysts privilege speech [la palabra], social politics, primary care, social inclusion. We are defending the rights of patients in the face of globalization.'[109]

Historical attributions of American visions of mothering and responsibility - heavily influenced by the psychoanalytic constructs - come to haunt and clash with current scientific understandings of addiction and mental illness among women.

II. Convergent models of the toxic mom

Debates, both publicly mediated and within scientific circles, about the effects of maternal drug use on fetal development and later child health and behavioral outcomes began to emerge in the United States as early on as the 1830s, when physicians first documented infants with withdrawal symptoms from maternal opioid use during pregnancy. Yet the gaze turned away from congenital concerns toward theories of addiction causation, in which mothers took center stage as the causal agents for their children's addictive behaviors.

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108 Interestingly, the current debates among Harm Reduction advocates for health care and social benefits for drug users in Argentina follow along this same political-rhetorical trajectory. Claims are made about human rights, and anti-discrimination policies are forwarded in light of the state's overall social responsibility toward all citizens. This varies significantly from American rhetoric about rational actor-individuals whom should be transformed from deviants into productive (neo-liberal) citizens. Shana Harris, personal communication.

109 Lakoff, A. (2005) *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry*, Cambridge University Press Page 68.

Campbell describes the historic situatedness of the discourses of blame that implicated the mother's role in raising drug addicted children. Up until the mid 20th century addiction was considered "adaptive" for male addicts who were struggling under the constraint's of their mother's over-controlling behavior. Women addicts were largely left unexplained by this psychoanalytically-informed focus on the dynamics between mothers and sons.[110] During this same period another form of toxic mom emerged. "Schizophrenogenic mothers" produced children (again mostly males) with schizophrenia, whose root cause was located in the assumed mother's coldness and neglect. Tanya Luhrmann argues that residual shame in the psychiatric community over blaming and stigmatizing so many mothers for a disease that is now considered primarily organic in nature has largely contributed to the eager acceptability of biomedicialization of that mental illness.[111]

This move from bioclinically informed observations of opiate addicted babies in the early 20th century to psychoanalytically informed theories about maternal responsibility for addiction in society in general, was reflected not only in theories about addiction but also about mental health conditions, specifically schizophrenia. A convergence of the individual, social, and biological manifestations of both addiction and mental illness are again being replayed in the slippage between the characterization of the etiologies of *both* addiction and mental illness as neurological located.

Expert constructions of addiction and mental health in the United States have and still do center on the dysfunctional family, with the mother at the helm, became the breeding ground for madness and drug-addled criminality. As Campbell writes, "Dysfunctional families may be seen as an outcome of social practices, or as the sum of

110 Campbell, *Using Women*, Page 65.

111 Luhrmann, TM. (2007) Social defeat and the culture of chronicity: Or, why schizophrenia does so well over there and so badly here. *Culture, Medicine and Psychiatry.* 31:135_172.

the pathological individuals within them. As a nation we prefer the latter explanation, locating 'problematic mothering' as the source of our dysfunctionalities."

III. Cocaine exceptionalism in social theory and biomedicine

> [W]hen animals have free availability of cocaine, the animals stop eating, they stop sleeping, and 100 percent of them die. If they have free availability of nicotine or, for the same matter, heroin, the animals survive.
>
> – Nora Volkow, NY Times August 19, 2003

Both in social theory making about drug using women and in biomedical renderings, cocaine – specifically crack cocaine – has occupied the "savage slot."[112] Perceived to be the drug *most* dangerous, *most* racialized, *most* wild and primitive, *most* other, and *most* in need of a colonizing, bioclinical intervention. Political and popular discourses surrounding crack were highly racialized during the late 1980s and 1990s and this legacy continues today.[113] So entrenched is the association of crack use to blackness in the United States that an article was published in the Journal of the American Medical Association (JAMA),using epidemiological statistical methods to refute a biological connection between ethnicity and crack addiction. The article's conclusion reads:

> Findings of race-associated differences are often presented as if a person's race has intrinsic explanatory power. This analysis provides evidence that, given similar social and environmental conditions, crack use does not strongly depend on race-specific (eg, biologic) personal factors. Although the study finding does not refute the previous analysis, it provides evidence that prevalence estimates unadjusted for social environmental risk factors may lead to misunderstanding about the role of race or ethnicity in the epidemiology of crack use. Future research should seek to identify which characteristics of the neighborhood social environment are important and potentially modifiable determinants of drug use.[114]

112 Term attributed to Michel-Rolph Trouillot. Trouillot, Michel-Rolph. (2003) *Global Transformations; Anthropology and the Modern World*. Palgrave. Chapter one: "Anthropology and the Savage Slot: The Poetics and Politics of Otherness. In *Recapturing Anthropology*. Richard G. Fox, ed. Pp. 17–44. Santa Fe: School of American Research.

113 Campbell, *Using Women*. Chapter 7.

114 Marsha Lillie-Blanton; James C. Anthony; Charles R. Schuster. Probing the Meaning of Racial/Ethnic Group Comparisons in Crack Cocaine Smoking *JAMA*. 1993;269(8):993-997.

In other words, blacks have no biological propensity toward crack use and this fact required a corrective examination of the proof of numbers. Potential confusion over the representation of statistical facts about blackness and crack, created a necessity to do statistics better to prove that "neighborhood social environment" plays an important role in who uses crack.

It is interesting that crack could have such a racialized and hyper-sexualized image in the media and in social science writing[115], while at the same time most epidemiological evidence indicates that, frankly, "everybody" smokes crack. In urban health surveillance studies rates of crack-alone and users of other substances are epidemiologically off the map. Multiple epidemiological surveillance studies of a wide range of drug users in urban settings in the United States place frequent (past 30 days prior to interview) crack use at upwards of 50-75%. That is, among persons who report any drug use in the past 30 days, half or more also report smoking crack. My experience of the women living in the daily rent hotels was that I did not interact with a single woman who was not smoking crack, or had a history of serious crack use. Many women also used

In addition, most substance users are poly-substance users. Most drug users of other substances, particularly heroin users, also smoke crack. Although there may be crack smokers who only smoke crack, most also drink alcohol, according to national epidemiological surveys of drug use behavior and my own interviews with medical providers for drug users in San Francisco. Mitch Katz (in Chapter I), the Director of Public Health urged the audience to consider the co-occurrance of substance use disorders, mental illnesses, and physical health problems the way patients do – as existentially inseparable. So too with drug use: it is typically poly-drug use.

115 See Campbell's critique of the ethnographic anthology Crack Pipe as Pimp: An Ethnographic Investigation of Sex-for-Crack Exchanges in *Using Women*, Chapter 8.

Unfortunately in epidemiological research the impact of one drug is often overdetermined and the potential effects of the integration of many substances under recognized.

Unlike Opioids, cigarettes, and alcohol, there is no pharmacological interventions for crack. There is no replacement therapy which appears to effectively assuage withdrawal system the likes seen with methadone, beprenrophine, Wellbutrin, nicotine patch replacement therapy, and naltrexone (ReVia™), acamprosate, tiapride, and disulfiram (Antabuse®) for the treatment of alcohol cravings and withdrawal. Despite ongoing research it appears that crack use and abuse remains unreigned by the convenience of a pharmacological replacement treatment.

Crack is absolutely central and in many ways is a site of origin for current concerns and knowledge production about pregnancy and drug use. The bioclinical literature which examines the risk of addictive drugs to fetal development and child outcomes must be examined within the context of crack exceptionalism. Under the numbers driving this field of scientific inquiry are the nightmare visions of a nation of brown, welfare dependent unruly children who originally and fantastically fueled this line of research in the late 1980's and 1990s. As one health provider I interviewed reminded me, "there isn't a lot of data that shows that cocaine causes birth defects." "There is quite a bit about alcohol." I respond. "Yeah, but it's for the crack baby you have to get qualified data. No one smokes crack who doesn't drink, anyway. But one of the reasons the data about crack and fetal outcomes is so tricky is because many people believe that there are too many other environmental things that might be playing a role. And they can't (statistically) control of all of those things, because things are so out of control (socially)."

IV. Debates over "exposure" and the social qualification of maternal love

There are currently competing discourses about crack cocaine's impact on fetal development and later child growth. One argues that all the epidemiological research on crack was basically fear-mongering, racist predictions of social decay which failed to materialize. Several authors cited here have written about the "myth of the crack baby," being debunked based on analyses of studies completed in late 1990s which did not produce the damaged drug-exposed children that were anticipated.

Certainly the research of today on fetal exposure to crack cocaine is more equivocal than hysterical. The careful avoidance of racially stereotyping is overt in a NIDA summary of recent data. A picture of a blond white boy in a middle class living room forms the background to graphic representations of mentally deficiencies among cocaine-exposed two-year olds. The sample is described as "a group of 415 infants born at a large urban teaching hospital from 1994 through 1996 to mothers from low socio-economic backgrounds who had been identified by the hospital staff as being at high risk of drug abuse." The picture and this description do not match. There is no mention of the race/ethnicity of the mothers or their children; one has to access the paper through Medline to discover that 80% of the sample was "non-white."[116] Even with these caveats, the impact of cocaine exposure was clearly delineated by the author:

> "We believe that cocaine exposure is a neurologic risk factor that may take a poor child who has a lower IQ potential because of maternal and other risk factors and push him or her over the edge to mental retardation," Dr. Singer says. For example, average IQ scores for both cocaine-exposed and unexposed toddlers in the study were well below the average score for the general population. "In effect, cocaine lowered the range of IQ scores and that means more children may require early stimulation and educational programs," she says.[117]

116 Lynn T. Singer, PhD; Robert Arendt, PhD; Sonia Minnes, PhD; Kathleen Farkas, PhD; Ann Salvator, MS; H. Lester Kirchner, PhD; Robert Kliegman, MD (2002) Cognitive and Motor Outcomes of Cocaine-Exposed Infants. *JAMA*. ;287:1952-1960. Table 1 Maternal Characterics.

117 Robert Mathias, (2003) Study Finds Significant Mental Deficits in Toddlers Exposed to Cocaine Before Birth. *NIDA Notes*, Research Findings Vol. 17, No. 5.

A cursory review of the recent epidemiological research reveals that cocaine still holds pride of place. For example in a Medline query using the search words "pregnancy" and "illicit drugs" yields 827 abstracts, over 75% address crack use during pregnancy. But Medline and the NIDA website are not the sources for "truth" or evidence that pregnant addicts sought in my ethnographic study. Category-makers may have multiple new tools and data bases at their disposal to try and answer the specific questions such as: what difference does drug us make during pregnancy, which drugs? How much? When during pregnancy? Women on the street created folk categories[118] as assess their risks and manage their fears.

Kelly: When you said you didn't want to have crack baby, what does that mean?
Cupcake: You seen them commercials on TV? And those babies that are addicted and stuff. And I shit you not, I thought about that kind of thing. Like that is what my baby – because I didn't know that I was pregnant until I went to jail [at 3-4 months pregnant]. And that hit me like, wow, like hard. And I seen them commercials in my head. Like that's, I don't want have a kid like that. You know what I mean? So that's why I got clean. Because I didn't want to have a crack baby. It wasn't like, 'Oh I am gonna be a mom, and it's gonna be great.' No. I just didn't want to have a crack baby. You know. My reality.

- Interview at the in the Metropica Hotel, November 2009

The media frenzy that was produced around the phenomenon of "crack babies" has been well documented[119]. The gravest of accusations which emerged is perhaps the least related to fetal risk per se or controlling fetal risk through abstinence from crack smoking – that crack makes women, especially African-American women, incapable of maternal love. Murphy and Sales write: "The image of poor inner-city African-Americans whose mothering instincts had been destroyed by crack was highly publicized and widely accepted."[120] Campbell asserts that discourses about the effects of addictive drugs on maternal instinct are heavily influenced by women's role as both biological and social reproducers for society. I wish to take the discussion in a slightly different turn, by

118 See Wacquant's discussion of folk categories in urban ethnography in Wacquant, L. (2008) *Urban Outcasts: A Comparative Sociology of Advanced Marginality.* Polity Press.

119 See Campbell for a discussion of drug policy implications of this political discourse. *Using Women*. Chapter 7

120 Murphy and Sales (2001). *Pregnant Drug Users: Scapegoats of the Reagan/Bush and Clinton Era Economics* January 13, 2001.

examining both the social contexts which place limits on the possibility of maternal love and how the expression of those limits might be captured – as in Cupcake's statement above, as recognition of what forms of motherhood might be socially available in her "reality."

Nancy Scheper-Hughes argued persuasively almost two decades ago that maternal love is susceptible to social and economic environments which place limits on its affordability, its price. Maternal love is malleable, flexible and socially reconstructed. Explained ethnographically by Scheper-Hughes, maternal love is not as a universal human form, but rather it was a luxury to which the poor and hunger residents of Bom Jesus in North-eastern Brazil were not privy during Scheper-Hughes' anthropological work there. Arguably, one of the most significant interventions that *Death Without Weeping* makes, is Scheper Hughes' insistence that this fact was imminently obvious – a common sense logic - to the pregnant women of Bom Jesus. It required multiple repetitions and interactions for the Western anthropologist to recognize it, as something other than individuated pathology.[121]

V. Pregnancy in the daily-rent hotels

The reactions that pregnant addicts expressed about their pregnancies were heavily influenced by the bereft material realities that characterized their lives in the daily-rent hotels. Active addiction meant living every moment in relation to substances, and a pregnancy discovery could translate into an additional stress in an already stretched to breaking social world. In a mainstream sense pregnancy necessitates planning for an uncertain future. Among women in the daily-rent hotels, pregnancy often meant adding another uncertainty to a long list of unstable relationships and risky endeavors required to ensure housing and access to substances. Thus pregnancy often

121 Nancy Scheper-Hughes. (2002) *Death Without Weeping: The Violence of Everyday Life in Brazil*. University of California Press.

evoked feelings of ambivalence and fear, and a deferral of action, at least among the women whom I knew were pregnant. Since my role as an info-vulture did not involve systematically testing women for pregnancy in the hotels, I cannot be certain that I was aware of all the pregnancies that occurred. Although, as part of the outreach effort, I did give out pregnancy tests on demand and I was able to interview several women in the ethnography as a result of giving them the test. Still, I am sure there were several women who may have tested positive and terminated the pregnancy early-on. Kitt is the only women who discussed her abortion with me, and she deferred the procedure, due to ambivalence, until relatively late in her pregnancy (20 weeks).

Like the majority of women, Kitt reported that her pregnancy was unplanned. She had "make-up sex" with her husband after they had been fighting. He lives in a different city, and I never met him. Even though Lexi was deeply in love with Pano, as she repeatedly pointed out to me, she was "shocked" to discover she was pregnant. She said that her religion was blocking her from getting an abortion. Her fear over loosing another child, after the death of their daughter, pervaded her emotions about her 2009 pregnancy. Tara was pregnant with her boyfriend's baby and also ambivalent, as was Benz initially. Toward the end of her pregnancy Benz became very invested in entering treatment to stay with her baby and this desire increased after her daughter was born. Benz' husband, the baby's father, was serving time in jail when Benz entered treatment. Both Danell and Dylan got pregnant from tricks during sex exchange. Dylan said simply, "I made a mistake" in reference to her pregnancy. Danell got pregnant by one of her regulars, and has kept her daughter in drug treatment with her.

While Cupcake's pregnancy in 2008 ended with a D&C procedure because it was a "false" pregnancy – a cyst, she was actively trying to get pregnant throughout 2009. Cupcake was very attached to her husband and the two of them had plans to raise their future children outside of San Francisco and get jobs. Multiple arrests for parole

violations have continued to foil those plans. River was a woman I knew briefly in 2007 when she was 7 months pregnant. She was the only woman I met who successfully got housing outside the Mission district, and kept her baby in custody without entering drug treatment or going through a CPS intervention. Cupcake and River remained in consistent proximity to their husbands. This was unusual. Many of the other women had husbands that they referenced, as well as boyfriends and pimps with whom they might be having sex, but few women lived with them. None of these men had much involvement with their pregnancies or subsequent babies, as was demonstrated in Ramona's anger toward Duke after their son was born. Even Pano, who was out of jail the majority of time that Lexi was pregnant in 2009, did not ever mention her pregnancy or the future of the baby she was carrying in my presence. Lexi attributed this omission to Pano's unresolved feelings and fears for the future, both connected to loosing their daughter in 2004.

VI. Biosociality and fetal risk

In Ian Hacking's discussion of the tension between biological explanations for mental illness and constructionist ones, he expands on a phenomenon he had previously referred to as "looping effects" (Hacking, 1995). Looping effects occur when persons who are classified (into a group, say, of schizophrenics) *interact* with what is known about them. They see themselves differently as result of classification and act differently as well. "What is known about a people of a kind may become false because people of that kind have changed by virtue of what they believe about themselves"[122] as members of that kind. We see similarity here between Hacking's looping effects and Rabinow's observations about "biosociality." Rabinow describes groups coalescing

122 Hacking, I. (2000) The Social Construction of What? Page 34.

around physical and genetic variations which cross social, racial, religious, national and professional categories "to experience, share, intervene, and 'understand' their fate."[123]

These resources for biosociality also exist for drug using pregnant women, but rather than being unilaterally supportive, they are fraught. They were all virtual in San Francisco, except for those available to women in drug treatment for whom support group attendance is mandatory. They are also middle class to the extreme, which while not unexpected, is still noteworthy. Enter "pregnancy drug use support" in a google search engine and various sites pop up. One site is bent on the production of knowledge through peer-to-peer discourse. Following one conversation, we see a woman who is concerned about her use of Percocets – a narcotic pain reliever - during pregnancy. Like most entries on this blog, the woman tells a middle class, only mildly stigmatizing narrative about her use of perocets for "migraines." Street drugs and alcohol are never mentioned in *any* postings. The migraine poster gets a get deal of blog support including one woman you claims allegiance: "We can do this together!!" and another man who urges her not to stop using perocets all at once because the detox could send her into preterm labor. "Valerie's" post below offered the only sobering and pointed counterpoint to the overwhelmingly solidarity-producing posts.

By Valerie Sep 26, 2009 12:39PM
I have to play devils advocate.
Maybe your babies weren't born "addicted" or so you thought. Maybe the 15 month old, or 6 months old are smart as a whip and doing great. What you don't know is the after affects. I did foster care for six years for drug exposed infants and kids. They do well until they start missing milestones. My seven year old adopted son was born to a mother who used Percocets and Oxycontin throughout her pregnancy. He has severe panic attacks, is bipolar and as his colon was developing, while she was pregnant, the nerves didn't form right. This has caused his colon to not work, and he takes laxatives twice a day just to poop, and he still suffers and cries when he has too. If your baby is born and has ten fingers and a chubby little cute face, you are kidding yourself if you think you aren't or haven't caused damage. Read some studies, medical literature. Read about Fetal Alcohol syndrome, Infant drug toxicity etc, autism. Just because someone claimed they "took a ton of stuff" and "my baby was fine" doesn't mean anything. If there is a time in your life you need to get educated about a subject, this is it. I don't mean to give anyone a hard

123 Rabinow, P. (1996) Artificiality and Enlightenment: from Sociobiology to Biosociality, in *Essays on the Anthropology of Reason*. Princeton University Press . Page 102.

time, I just wanted to post from the other side, a woman raising the kids from drug addicted mothers. Its a hard job. The kids don't get a fair deal. Good luck.

Valarie urges the concerned mom to "read some studies, medical literature" – to access the evidence of the category makers to find the truth about the potential danger her baby faces. The tone is gentle (with a parting note of "good luck!") but the message is clear. Drug use while pregnant wreaks destruction, whether proximate or distal, both in the child's life and those left to care for him or her. This point was emphasized by Campbell in her analysis of the *Born Hooked* Congressional testimony. She claims the central question that haunted the hearing and produced the policies of "postmodern progressivism" was "the perennial question of who would take care of the kids."[124]

Driving with Dylan San Francisco September 2009
Dylan and I are leaving the Jack-in the Box drive through where I have bought her some tacos. She wanted to get out of the Mission so we have driven to a neighborhood close by. As she has a loud conversation on my cell phone with her pimp about another girl who might work for him,. After she hangs up she informs me: "You need protection. Some girls say they don't. That they work alone. But they are full of shit. You need someone to watch your back. We need to pick him up some chicken, you have money for that?"

Dylan as always is well dressed in casual clothes – jeans and a top. I have never seen her homeless in the three years I have known her. This is the first time we have talked at length. She usually blows me off when I see her. She isn't friendly, all business and puts off an aggressive air, meant to intimidate. It works. Usually she doesn't chat, she is always hustling. She is moving constantly now. Her eyes dart around the car and out the window and back to the car. She turns on my car radio, changes the station to hip-hop and turns it up.

I ask her about her most recent pregnancy. I have heard a lot of stories, from first hand witnesses about this delivery. One told me she hit the doctor, another that she was screaming for crack from the delivery table. She has been criticized for not wanting to look or touch her baby after the baby was born. Dylan doesn't offer much. "It was fine. The hospital was wonderful and they treated me like a queen up there."

"Can you stay in contact with her?" I ask.
"Why would I?" Dylan shoot back. "She is in a better place now. She is gonna have a better life. She don't need to see me."

We drive a bit and park under a freeway pass, but the cops pull up behind and that makes us both nervous, so we drive on.

"Tell me about other pregnancies you have had." I ask.

"The last one…" She means the baby before the one she just had. Unlike most women I know, Dylan does not offer names for her kids. "The doctor couldn't believe he lived. Every time I would

124 Campbell, *Using Women*. Page 185.

smoke crack, I would bleed. It was incredible. I just put my mouth to the pipe and there it went. The doctor said 'I can't believe he made it.' When he was born."

Her description makes my stomach turn. Her tone is mocking, jokeful. She dismisses the crack use and bleeding, like she beat the odds. As if it were a biological game that she was playing with her body, crack, and her baby. A game her doctor is surprised that she won. She appears particularly psychotic to me when she relays this story. I hide my disgust with a question:
"What about just recently [her most recent pregnancy], did you bleed when you smoked."
"No, not at all. It was the strangest thing."

One can interpret this conversation as an attempt on Dylan's part to deliberately reclaim a ethical stance vis-à-vis her child she left at the hospital. Almost all of the pregnant addicts I knew struggled with mixed feelings, if not inwardly, than at least openly and performatively with me, about what their drug use might be doing to their baby. Cupcake worried about having "a crack baby," Benz cried to me about her daughter's methadone detoxification in the hospital, lamenting "No one told me it would be like that. That she would suffer." Ramona expressed regret even while smoking crack at seven months pregnant: "This baby doesn't deserve this." She said. Dylan was a notable exception. She was adamant and unwavering: her daughter was "better off" not seeing Dylan. Not having any contact with Dylan might mean "having a better life." A better life than Dylan could offer right now, and a better life than Dylan had herself.

VII. Hereditary disadvantages

> "If a family stays on the street, if the parents remain addicted, if the parents continue to abuse the children, if the parents continue to neglect their children, then the child does not stand a chance. The child *will* become like the parents because that is all the child knows."
>
> – Martha Ryan, Founder and Director of Homeless Prenatal Project, San Francisco, website video.

The specificity with which the causality of both addiction and mental illness have been linked to mothers has significant socio-historical resonance that haunts current nature and nurture debates. Pregnant homeless women shared concerns about "passing on" psychotic, addictive, or other negative personality traits from women to their

children. Lexi often discussed her son as "hyper," and she fretted about what might have gone on during her pregnancy that contributed to his "too high" energy. Crysanne described her mother's alcoholism and addiction to pills, as well as her grandmother's alcoholism as contributing factors to her turning to the streets and becoming "anxious". Crysanne believed both "bad behavior and bad luck" might be hereditary. When I drove Duke back to the BART station after we dropped off Ramona at residential treatment he shared his concerns about hereditary disadvantages:

Riding with Duke San Francisco December 2009
When I am riding with Duke, Ramona's Baby daddy for Charles, in December 2009, he begins to discuss Duke Jr., the baby Ramona had in 2007 - who was "full of crack."

"Is that the baby Ramona was speakin' about when she said 'I let the other one go'?" I ask repeating a conversation we all had on the way to dropping Ramona off at First Steps [the residential drug treatment facility]. "Yes." He sighs. "We couldn't keep that baby, because he was loaded up with drugs. We couldn't have kept him. We were off the hook [using a lot of crack] at *that* time."
"Did he get adopted?" I ask.
"Yeah." He says. "But anyway I told Ramona, see I have ADHD. I have ADHD, and I told Ramona, with the drugs and me having ADHD, that that baby would probably get that too. I was worried about that because it works like that, through the parents to the kid."

Scientific optimism about the technological ability to bridge connections between mental health disorders and other conditions influenced by heredity abounds in current neuroscientific literature.

> Just as research during the Decade of the Brain (1990-2000) forged the bridge between the mind and the brain, research in the current decade is helping us to understand mental illnesses as brain disorders. As a result, the distinction between disorders of neurology (e.g., Parkinson's and Alzheimer's diseases) and disorders of psychiatry (e.g., schizophrenia and depression) may turn out to be increasingly subtle. That is, the former may result from focal lesions in the brain, whereas the latter arise from abnormal activity in specific brain circuits in the absence of a detectable lesion. As we become more adept at detecting lesions that lead to abnormal function, it is even possible that the distinction between neurological and psychiatric disorders will vanish, leading to a combined discipline of clinical neuroscience.[125]

Concerns about hereditary disadvantages, and the probability of them also took the form of justification for operability – surgical interventions that ensured no future children. Lexi was operated on – given a full hysterectomy – immediately after the

125 Insel, TR & Quirion, T. (2005) Psychiatry as a Clinical Neuroscience Discipline. *JAMA*. 294: 2221-2224.

second loss of a child, a son, in September 2009. The story of the ending of this pregnancy for Lexi included (1) a violent encounter with her partner Pano; (2) her cervix opening at the daily hotel where they stayed; (3) an emergency transport to the hospital in handcuffs as a 5150 (mandatory 72-hour psychiatric lockdown for harm to self or others); (4) the birth of her "deformed" and dead baby, (5) followed immediately by a full hysterectomy. At that point in the telling, I found it very difficult to assess whether or not Lexi could have given adequate informed consent for such a permanent operation. She insisted to me: "They asked me if it was what I wanted and I said 'yes'." Lexi had expressed to me, prior to her son's death and immediately following it that her risk – like her mother's – of the premature opening of her cervix was too high in her assessment (not based on anything she had heard from medical providers, whom she avoided). "I don't know what I would do if I lost another baby. I would probably go crazy." She had told me. Because of her addiction, on-going sex work, and housing instability Lexi never accessed the indicated medical intervention – to suture the cervix closed and remain on "bed rest" from five months gestation to term - during her 2009 pregnancy.

Monica retold a narrative also replete with violence, hereditary worry and medical institutional involvement.

Operability[126] as congenital prevention

I first meet Monica in January, 2007 at the homeless drop in center. She has lived in the residential hotels in the neighborhood of over 15 years. Prior to that she stayed at the Section 8 housing with her Grandmother, after she ran away from foster care. She smokes crack, but not all the time. She began to receive SSI as a child because she was judged " slow…or mentally retarded." "But I have a lot of mental problems too," she says, when she describes her multiple experiences with mandatory 72-hour lock down at the psych ward of the local public hospital. When Monica describes her childhood to me the first time, she matter-a-factly describes her early physical development, abuse in her foster care, her drug use, and suicidality. When Monica begins to enter puberty at age 9, her biologiocal mother, grandmother and her foster mother plan her sterilization.

M: And then, I was a young kid – they tied my tubes…you know, they cut me open, tied my tubes, and…
K: When was that, Monica?
M: I was nine years old…Um hmm (yes). I was just a kid.

126Cohen, L. (2004) Operability, Bioavailability, & Exception. Ong & Collier, eds., *Global Assemblages*. Pp. 79-90. Oxford: Blackwell.

K: Do you know why?
M: They said I was getting promiscuous, like uh, you know, they don't want me having kids at a young age, because I was all – they thought I was already interested in boys, which I was not because I didn't like it – after I got molested, I didn't trust anybody for a long time, you know?
K: What did they tell you about that when you were nine?
M: The [doctors] said that we're doing this because your mother and your grandmother, and your foster mother said you're too promiscuous…and that you wanna know about sex, and they don't want you getting pregnant and aborting your babies to foster care, 'cause they would take 'em away from you, 'cause of your – way you are – you're slow…you have, you're a mentally retarded, so they wouldn't let, allow you to keep your kids, if you had any…And that – every since then, I, I've lost relationships because I don't feel like I'm a whole woman, you know? I've always, you know, wanted to experience what it felt like to have children…And so, even sometimes now, it's harder for me to get into relationships and stay in 'em because of that reason…Um hmm (yes), 'cause, you know, people you meet up with…they want children, they want a big house, they want all these children and, you know, I can't do it, so.

Monica and I spend a lot of time together over the next couple of years. I take pictures of her so she can send them to her mother. "She wants to see how I am doing." Monica says. Sometimes she says her biological mother does not want her to call or write. "She doesn't want to talk to me." Other times Monica claims to be planning a trip to see her. Finally, it late summer of 2009, I go with Monica to pick up her welfare check so she can buy a bus ticket to visit her mother and sister who live several hours north of San Francisco.

When Monica and I run into each other at the drop-in center in October 2009, I ask Monica about her jeans. She has names written on each leg in marker – sharpie she tells me – above her knee on each of her thighs. They are placed so she can glance down and read the names while she is seated. She starts to the read the names to me, five on one leg, four on another. "I had my mother and sister tell me the names of all my brothers and sisters and I wrote them here so I wouldn't forget them." She says. On her recent visit she was introduced to a sister, a sister no one had ever told her she had. "She was nice to me." Monica says about her "new" kin. "She has a job and house. She is doing good." Monica smiles when emphasizing her sister's accomplishments.

Monica's description of her relationship to her mother is not at all unusual. I found most women who still had some access to their mothers would seek out frequent contact with them. In the same sitting many women could retell to me horrible stories of neglect and abuse as children and also emphasize the significance of their mothers – and sometimes their fathers- in their lives. One manifestation of these complex familial relations implicates pregnancy and addiction directly – when mothers, and sometimes grandmothers, aunts, and sisters are called upon to care for and raise the children of pregnant addicts.

VIII. Kin of last resort

> Referring to American ideas, Schneider (1968:23) observed that kinship is whatever the biogenetic relationship is. 'If science discovers new facts about the biogenetic relationship, that is what kinship is and was all along, although it may not have been known at the time.' There are many other ways of defining kin persons but no way of conceptualizing a biogenetic tie between persons that does not presuppose it as a kinship tie. [127]

"Kin of last resort" references relatives who are called upon to take custody of pregnant addicts' babies and children so they are not placed within the foster care system and adopted out to strangers. Accidental or unplanned pregnancies produced forms of familial indebtedness as many of the women in this ethnography – Anita, Lexi, Ramona, Crysanne, and Kitt – had to leverage familial ties due to lost custody of children. The family members called upon to raise women's children are the kin of last resort because their custody of the children often cements members of historically dysfunctional families back together. What many women view as difficult and painful childhood, especially in relation to the mothering they received, can be reproduced as their own children become dependent on the kindness and support of grandmothers, sisters, and aunts recruited into parenting. Crysanne's abusive boyfriend convinced her to leave her children and join him on the street. Her description of leaving her baby has both vengeful and altruistic overtones, which captures the dynamics that I often witnessed between pregnant addicts and kin of last resort. Crysanne said:

> My mother always hated me. So, I left my baby with my mother. I go "You know what? I'm leaving him with you to give you a –" I said it nasty. "To give you a reason to get up in the morning. You're so bored. You're probably gonna die because you have nothing to bitch about. Alright. Now you can worry about what he's going to eat and you can iron his socks and his underwear."

Upon birth, babies of pregnant addicts can enter into legally tenuous relationships with their mothers, the state, and more distal kin until they are reordered into the custody of a foster family, their mother, or a relative. When I spoke to Anita at

127 Marilyn Strathern. Displacing Knowledge: Technology and the Consequences for Kinship. In Ginsburg, F. and Rapp, R. (1995) *Conceiving The New World Order: the Global Politics of Reproduction*. University of California Press.

two months post partum, she was not certain whether her aunt had gained custody of her daughter. She tells me that she thinks her daughter is with the aunt but "I have to find out." Four months later she tells me a story about her aunt and mother trying to engage Anita into treatment so that her daughter will not be permanently adopted outside the family.

Anita's son comes to the hotel **March 2010**

I walk down the hallway of the Chandra Hotel and knock on the door. Anita yells "Who?" in a menacing voice. "It's me, Anita. Kelly." I say. She lets me in.

"Kelly you would not believe it." She says. "My son was here. My three year old. My aunt brought him down here to Mission Street. She knew where to find me. She was trying to use him to convince me to clean-up. You know how she won't let me see him?"

All of Anita's custody rights were revoked at the birth of her son because he had a positive tox screen for crack and opioids. Anita failed to enter treatment and she lost visitation rights as well. Her aunt was awarded custody.

"Yes." I say. "What changed her mind?" I ask.

"It is my daughter. They [CPS] are saying that she [Anita's aunt] can't have her. They told her that I keep having babies, and I never go to treatment. [My aunt] brought my son down here to try and force me to go in. I have to do it [go to treatment] this time or else my daughter will be adopted out. She won't stay in the family. My mother is distraught, she hasn't stopped crying. I have to get to the hearing, I have to talk to the lawyer."

Anita takes a break to smoke some crack. Then she starts the story up again.

"Kelly you would not believe it, she [the aunt] told him that I was his mommy! She told him! And he said 'That is my mommy,' and he pointed at me. It was beautiful." Anita is crying now. "You know how I always buy him stuff but I can never give it to him, because she won't let me see him? [I haven't heard her mention this, but she keeps talking.] "Well I ran back up here in the room and found two books, one with Elmo and one about the sky. And he was so happy to have a present from his mamma."

Kin of last resort can serve to magnify guilt among pregnant addicts even as they represent a saving grace from total child custody loss. Every time Lexi spoke about her mother caring for Lionel she described feeling "sad and guilty" that her mother should have to be caring for her son, especially considering her mother's age and failing health. This was Lexi's heartfelt experience even though her mother had physically abused Lexi and forced Lexi to take care of her sisters and brothers- and their children - at a very young age. Despite this difficult family history, Lexi is the black sheep in the family as a

result of her drug use and forever indebted, and truly thankful, to her sisters and her mothers for giving Lionel "a stable life."

IX. Recirculation of no-longer pregnant women addicts

Lacking custody of their children, women rejoin the street life they had temporarily left without further intervention from the state unless they seek to regain custody. According to the Substance Use and Mental Health Service Administration data, while most pregnant women decrease their intake of addictive substances during pregnancy, most also increase their use after birth.

> The rates of past month illicit drug, alcohol, and tobacco use among recent mothers were higher than the rates for pregnant women and similar to the rates for nonpregnant women (Figure 4).[7] For example, among women aged 15 to 44, the rate of past month illicit drug use for recent mothers (9 percent) was similar to the rate among nonpregnant women (10 percent), with both groups reporting a higher rate of past month illicit drug use than pregnant women (3 percent). The data presented in Figure 4 suggest that women aged 15 to 44 use alcohol, tobacco, and illicit drugs less during pregnancy, *but increase their substance use after giving birth.*[128]

Kim Hopper, and anthropologist who has written extensively on homelessness and mental illness, first coined the term the "institutional circuit"[129] to describe the instability and transcience of homeless men and women as they travel from the street, to transitional hotels, jails, and shelters. Both pregnant addicts and their babies, once born, have institutional circuits. Women traveled the circuit depending on (1) their willingness to disclose their pregnancy to service providers;(2) their interactions with the criminal justice system which may have them pregnancy tested, court-ordered to drug treatment as a diversion to incarceration, or admitted to psychiatric lock-down through a 5150; (3) their access to resources to stay housed and off the street. Their children, once born, can spend time in custody limbo in the hospital, as wards of the state through social services, adopted into foster care, with their mothers in residential drug treatment,

128 The NSDUH (National Survey on Drug Use and Health) Report. Pregnancy and Substance Use. January 2, 2004. Retrieved December 2009. http:///www.oas.samhsa.gov. Empahsize mine.

129 Kim Hooper et al. 1997. Homelessness, Severe Mental Illness, and the Institutional Circuit, *Psychiatric Services* 48:659-65.

or adopted by kin of last resort, those for whom the now-just-an-addict mom can often negotiate some form of contact which would be precluded if all custody was withdrawn.

Hopper uses the sociological construct of "liminality" which reflects the "dicey uncertainty of transitional states" to understand how homelessness is a process of in-between living, not an end in and of itself.[130] To Hopper, the social problem of homelessness is not a question of laziness or addiction (not that many years of unemployment and poverty might not contribute to these phenomena). Rather, homeless persons are those whom are redundant in labor markets lacking support for that redundancy.

> Reframing homelessness as the problem of redundant people, lacking sufficient resources (money or kin) to secure housing, redirects our assessment of the social response to homelessness. It may make better sense to think of "regular access to a conventional dwelling" more as *work* than *residence*, in ways analogous to those used by economists in measuring "regular access to a conventional job."[131]

Hopper enters the debate through a critique of unequal resource distribution under capitalism and the disintegration of extended kin support networks in post-industrial urban centers. This argument concurs in principle with Loic Wacquant's recent explanation of the *hyperghetto* in post-Fordist America. Wacquant's hyperghetto is characterized by unattainable and unsustainable wage labor and the disintegration of familial and neighborhood infrastructures which had characterized, and stabilized, ghettos in the past.[132] Through these overlapping yet divergent sociological reads on urban poverty we can locate the pregnant addict as one who is often seeking, sometimes with encouragement for Child Protective Services agents, to maintain relationships with her family of origin – mothers, sister, aunts - to have kin to raise her children. This child rearing is often taking place at distal locales while the women, the mothers, return to the liminality of the daily-rent hotels. As Cupcake, Lexi, Anita, and

130 Hopper, K. (2003) *Reckoning with Homelessness*. 2003. Cornell University Press. Page 8.

131 Hopper, K. (2003) *Reckoning with Homelessness*. Page 19.

132 Wacquant, L. (2008) *Urban Outcasts: A Comparative Sociology of Advanced Marginality*. Zone Books.

Ramona's stories all demonstrate the custody window slams shut quickly. And it is only conditionally propped open anyway – conditional to her move into treatment, to her finding employment, to her seeking and gaining disability welfare, to her having a place to live.

The stratified reproduction of the pregnant addict illuminates longstanding images of the failed mother – the toxic mom - capable to reproducing morally flawed and intellectually damaged offspring as result of her abhorrent behaviors. Some of the pregnant addicts in this ethnography described partaking in those haunting future imaginaries, fretting over hereditary behavioral flaws which might be passed on to their children. More often though, pregnant addicts in the daily-rent hotels sought to manage the pressures of their everyday lives of addiction and housing instability while deferring plans of action around their pregnancies. Pregnancy fit into the overall uncertainty of daily life, and the on-going, predictable disappointments that many women had experienced from childhood. Women were forced to mend conflicted family dynamics and patch up old wounds if their kin of last resort could be relied upon to save their children from state intervention.

Chapter 4: Info-vulturing in the daily rent hotels

I. Introduction to the info-vulture

Room number 43 Raman Hotel May 2008

Following the blood Chandra Hotel September 2009

I am looking for the stain of the puddle of blood and then I see the faint outline. The way Lexi described it, when her water broke she was gushing blood all over the floor, right next to the bed. We are back from the hospital and Lexi can barely walk. She wants to change the bloody pads in her underwear, but discovers that the blood has already soaked through her jeans. "Shit!" she exclaims. Pulling from my limited gynecological knowledge, I ask what color the blood is to try and determine if it is newer bleeding (bright red) or clots (darker). She indicates it is clots. Because she left the hospital AMA (Against Medical Advice), she also left without the antibiotics that she was supposed to be taking post-surgery. "I have to get to work to pay for this room." She tells me. "Lexi, I don't think you can." I respond. I can't imagine her pulling dates in her condition. She doesn't argue and goes to change her pad. Even if she did spike a fever, she won't return to the hospital. Because she came in on a 5150 psychiatric admit and left AMA, Lexi fears the hospital staff commit her, finishing off her mandatory 72 hour lockdown. Then no one would be at the bus station to meet her six year old son who is arriving, alone, in several hours.

A vulture is not really a bird of prey, not like an eagle or a falcon. The vulture does not actively seek to kill or hurt that which from which it gains sustenance. Rather, a vulture waits, circling. Observant and vigilant, until some other animal, human, object, or accident kills for it. It is only then that the vulture swoops in to benefit from another's violence, to survive off the sick, wounded and dead.

The relationship between the vulture and its food is intimate. As it consumes what is no longer viable, it is said to serve a purpose beyond its own survival. In recognizing the dead as food, its feeding is a demonstration of the necessary disposal of waste and its potential renewal. Vultures do not hesitate to eat each other, all dead being equally food.

So too the info-vulture - the anthropologist in this ethnography. This info-vulture lives not off of flesh, but information (data). She is present, observing social death and its reproduction. Her (professional) survival is predicated of the presence of that death, her intimacy with the socially dead is acute and on-going. She hopes she is serving some purpose beyond the feeding itself. The information she collects disposes experience into narrative, seeking its renewal as it is reconstituted into evidence for something else.

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This chapter relays my experience becoming an info-vulture in the daily-rent hotels. It describes the site of my ethnography, my methods, and the political economic realities of lives in the daily hotels for the women I observed over three years of ethnographic research. First, I explain where my study of everyday life and pregnancy in daily rent hotel rooms adds to and deviates from previous anthropological studies of "the homeless." Second, I describe the specific neighborhood – the Mission District in San Francisco and the specific blocks where I worked. I then examine the circulation of the term "SRO," how it defines certain government policies that have converted private daily hotel stock into publicly managed rooms and buildings for those who gain eligibility[133]. I discuss how I gained access to the daily hotels as ethnographic sites and the nature of my participant observation activities in those sites over time. Lastly, I explore how the

133 The relationship between disability health status and eligibility for specific housing stock will be further explored in Chapter 6. The discussion in this chapter is meant to simply map the complex social geography of public and private housing that existed in my ethnographic domain.

experience of pregnancy impacted women's everyday lives and living arrangements. Throughout the chapter I weave a descriptive analysis of my experience as an ethnographer (generating anthropological evidence) with epidemiological data about pregnancy, housing, and women. I also engage in a critical analysis of how the "info-vulture," creates as well as describes the evidence found within the daily-rent hotels.

II. Location, location, location: ethnographic spaces of habitation

Very few anthropological studies of homelessness and urban poverty have taken daily-rent hotels as their sites of ethnographic engagement. This might be generally accounted for because of difficulty in gaining access. Unless one is willing to check in and rent a room for an extended period of time, one does not have a good reason to be there. This is not financially feasible or necessarily desirable. Those who have engaged in ethnographic work inside low income hotels (see Hooper, 2005) have limited their analysis to city-funded hotels. Hooper investigating homeless men in 1979-1982, for example, focused either on men who were in male-only dormitory and single room hotels run by Social Services Administration or those who were "sleeping rough" (street homeless). Philippe Bourgois and Jeff Schonberg's ethnography, *Righteous Dopefiend* (2009), about homeless heroin addicts, focused on a specific homeless encampment, under a freeway and outside on major commercial city traffic. This ethnography ended with a discussion of the unintended, and poor, outcomes that arrived to many of their ethnographic participants who were able to find housing in government-subsidized hotel rooms.

Several ethnographies of homelessness have been conducted in shelters - settings which have direct bearing on how mental illness among the homeless clientele has been interpolated by staff and contested by anthropologists. Robert Desjarlais (1994) argues that "experience" in shelters is constituted by sensory responses to a

series of interpersonal relations established in the shelter. This experience reflects an attempt to "stay calm" and to self regulate in light of the monotony of everyday life as a homeless person and the political economy of street-based exchanges. Lyon-Callo's (2000) analysis of the medicalization of the homeless implicates the homeless shelter staff in creating an environment in which individual pathology, rather than structural violence, is implicated as the causal agent in homelessness. To Lyon-Callo, the "sheltering industry's" "helping practices" are guilty of reproducing deviant subjectivities. He states:

> Within the dominant medicalized conceptual framework, it becomes common sense to understand the coping strategies of people surviving in homeless shelters as symptoms and evidence of mental illness. These people are thus understood as passive victims of biological disorders rather than situated social agents.[134]

Amir Marvasti's (2003) work, which was shelter-based, sought to use the voices of homeless persons to exemplify how narratives of homeless identities were textually constructed from societal, personal, and historic factors. Catherine Kingfisher (2007) also focused on the narrative construction of the category of homeless. However, she choose to "study up" (Nader, 1969) by examining how the political actors (politicians, service providers, activists) debate the placement and parameters of a new homeless shelter in a small Canadian city. Like Marvasti and Lyon-Callo, Kingfisher is interested in the exploring the ways in which individualizing, medicalizing practices reflect a neoliberal focus and "invite, prompt, or coerce individuals to work on and transform themselves."[135] Similarly, Darin Weinberg (2005) situates his ethnography in two treatment facilities serving dual diagnosis patients – those diagnosed with a mental illness and a substance use disorder. Choosing treatment facilities as ethnographic spaces of habitation gave

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134 Lyon-Callo, V. (2000) Medicalizing Homelessness: the Production of Self-Blame and Self-Governing with Homeless Shelters. *MAQ* 14(3): 328-345. Here I am discussing Lyon-Callo's ethnographic situatedness within a homeless shelter. In Chapter 6, I will engage his argument dichotomizing medico-biological diagnoses of mental illness and political subjectivity.

135 Kingfisher, C. (2007) Discursive constructions of homelessness in a small city the Canadian prairies: Notes on destructuration, individualization, and the production of (raced and gendered) unmarked categories. *American Ethnologist* 34(1): 91-107.

Weinberg the opportunity to address "how putative mental health problems have been *experienced* and *managed* when they have been found to afflict homeless, impoverished, and/or otherwise culturally marginalized members of the community."[136]

While I conducted participant observation at a drop in center program for homeless women and on the street, in local restaurants, on neighborhood walking tours, at methadone clinics and other medical appointments through my three years of field work, I was primarily interested in life in the daily-rent hotels that were privately owned and not managed by governmental agencies or non-profits. The existence of many "unstably" housed women in Mission district in these hotels offered me the opportunity to investigate the micro-economics of a space of habitation which stood in limbo between "sleeping rough," the publicly funded shelters, and government subsidized housing. Privately owned and operated daily-rent hotels have been understudied as ethnographic sites in the United States.[137] When ethnographies are conducted in a "hotel" setting it is often in hotels with governmentally subsidized rooms and on-going social service involvement, in the form of case management, home health visits, etc[138].

Most ethnographies of homelessness do not focus on privately-managed hotels; nor do they focus on women or on pregnant women. In 1989, Anne Christiano and Ida Susser published a paper in the *Journal of Nurse Midwifery* concerning ethnographic research they had conducted with "homeless pregnant women" who lived in a residential hotel. This study, twenty years old now, focused on whether low income Latina and African-American women were aware of their risks for HIV infection. Christiano and Susser's study does not offer a broad analysis of the dynamics of housing and gender but it does address the levels of crowding, illegal drug use and sex work which were

136 Weinberg, D. (2005) *Of Others Inside: Insanity, Addiction, and Belonging in America*. Temple University Press. Page 10.

137There has been some ethnographic research on brothels in Nevada, but although private, they are highly state regulated.

138 See Carr, G. (1996) Ethnography of an HIV Hotel. *JANAC* 7(2): 35-42 for a lengthy description of health service integration for HIV-infected persons in a Single Room Occupancy (SRO) hotel in San Francisco.

occurring in that ethnographic setting. Alisse Waterston's book *Love, Sorrow, and Rage: Destitute Women in a Manhattan Residence* (1999) describes two years of ethnographic engagement with women stigmatized by mental illness and homelessness. Waterston offers a powerful ethnographic engagement with the everyday by documenting women's narratives of "what it is like to live on street and how it feels to lose your mind, about the taste of crack cocaine and the sweetness of friendship."[139]

Tanya Luhrmann's (2008) recent ethnographic engagement with homeless women focused on a daytime drop-in center, mostly serving women, who stayed in publicly-funded shelters in the Uptown neighborhood of Chicago. Both Waterston and Luhrmann's ethnographic engagements with homeless women are most similar to my own, yet neither was ethnographically situated in the world of private owned and managed daily-rent hotels. Maria Epele has conducted such ethnographic work, among Latina injection drug users who often spent nights in daily rent hotels in the Mission district. Epele's compelling work is focused on HIV risk, injection drug use, embodiment, gendered violence and political economy.[140] She does not analyze the hotel rooms as specific sites of production for these practices per se. Her work also diverges from mine in that it does not exist in conversation with larger sources of evidence production (statistical renderings, policy-maker testimony) or focus on pregnant women or mental health. Epele's ethnography does not explore how private verses public, governmental management of hotel rooms and buildings can play a role in the political economy of sex work for women who stay in these settings. This may be a result, in part, of the fact her ethnography was completed in the late 1990s, prior to progressive housing initiatives in

139 Waterston, A. (1999) *Love, Sorrow and Rage: Destitute Women in a Manhattan Residence*. Temple University Press. Page 1.

140 Epele, M. (2002) Excess, Scarcity and Desire among Drug-Using Sex Workers. Reprinted in *Commodifying Bodies*. Scheper-Hughes, N. and Wacquant, L. (eds). Sage Publications. Pages 161-179.; Epele, M.E. (2002) Gender, Violence and HIV. Women Survival in the Streets". *International Journal of Comparative Cross-Cultural Research*. 33 – 54.

which public institutions (such as the San Francisco Department of Public Health and the San Francisco Health and Human Service Agency) assumed the master lease of several previously privately managed buildings in the Mission district, creating a starker contrast between publicly and privately managed hotel rooms and buildings.

During my ethnographic tenure in public and privately managed hotels, there were clear differences apparent between these housing settings. One feature of difference was the practices of illegality and the variability by which they are regulated according to the degree of privatization of each hotel. Related to practices of illegality are the differential metrics by which "success" is evidenced. For the private daily-rent hotels this metric is profit, money. For the publicly funded hotels it is cost, also a form of money, but its evidentiary forms are linked to the outcomes of clients who are housed with the hotels. In publicly managed hotels effectiveness can be measured by "housing tenure" - the percentage of residents who stay housed for at least two years in the same building, or by following indicators of health, such as adherence to prescribed psychotropic and HIV/AIDS medications, and consistency in keeping appointments with case managers and physicians. These numbers are then aggregated across buildings and programs as a whole to support on-going city and state resourcing. Rent in the publicly managed hotels is governmentally-managed, and paid monthly. No such person-based evidentiary markers exist within the world of privately managed hotels. Rooms are rented, with little money lost. That is success.

While the women that I spent time with navigated their daily lives in the privately managed daily-rent hotels, several experiments in supportive housing that included the public take over of previously privately managed rooms and whole buildings were underway in San Francisco[141]. My ethnographic focus remained on the private daily rent hotels because the women I worked with did not gain access to publicly managed

141 More detail in Chapter 7 about these initiatives.

buildings. Not a single one of the pregnant addicts I worked with successfully transitioned to affordable housing, government hotel rooms during the course of my study. The reasons for this are, of course, complex. I will spend much of this chapter and later chapters discussing the myriad of complex circumstances that contributed to this fact. First I describe the social geography of the neighborhood in which I worked, the process by which I gained entrée into the daily rent hotels, and why I remained focused on these sites as specific locations of social suffering and poor health for pregnant addicts.

III. 16th and Mission Street Corridor

The picture below speaks volumes to the changing political economy of the 16th and Mission Corridor that is resultant of federal and state-side initiatives refusing health and social benefits to immigrant families, rising rents and gentrification in the neighborhood, and an associated increase in the criminalization and policing of drug and sex markets that had previously thrived, unchecked, on this corner. The photos of the women were taken by Kari Orvik, a professional photographer. The women who participated in the *Women's Space* program were given the opportunity to have beautiful portraits taken of them. I remember this project. It had a huge impact on the women who participated. They loved being able to put on make-up and have there hair done, and pose for the photos. It was a professional and serious endeavor and it is also fun. Most women had never had a photo portrait of themselves taken. One woman, Monica, who is featured in the picture below, bragged happily in 2007 when we first met about how many people in the neighborhood complemented her on the photo while it was up in the plaza. Once the pictures of four women were chosen for the plaza display, the picture served a purpose to increase visibility about homeless women and the *Women's Space* program. Many of the people who were, and are, gentrifying this neighborhood

have employment downtown, so they utilize this subway stop to get to and from work. In this way public art representing homeless women can serve a political function of both visibility and representation. What is tragic about the photo is that two of the women pictured are now dead. One woman was killed in an extremely sexually violent rape and murder; another woman overdosed and died.

BART Station 16th and Mission. February 2007.

The picture above speaks to how the multiple political economies in this neighborhood can converge, and yet also remain completely distinct from one another. Homeless women can be consumed as art without any knowledge of the violence of their everyday lives. The picture below - its mirror- displays the portraits of four civil and health rights activists, organized in a similar display as the four the women's portraits.

From left to right: Rigoberta Menchu, Nelson Mandela, Caesar Chavez and Audre Lorde. April 2008.

The Mission district consists of three co-habiting and sometimes colliding economies: the drug-sex economy; the gourmet ghetto gentrification economy and the informal and formal sector immigrant labor economy. The first economy, and the primary focus of my ethnographic engagement, is the drug-sex economy. Within the three by three block radius in which I conducted participant observation multiple stretches of open air drug and sex exchange markets exist in abundance, as does the police presence. In 1994, a police station was opened on Valencia Street between 17th and 18th situated directly at the opening of "crack alley" where the highest concentration of crack sales and open drug use occur.

The businesses which serve the everyday needs of persons participating in the drug sex economy (and others) in the neighborhood are check cashing places, TripleX sex video stores, thrift clothing stores, 99 cent stores (there are five within three blocks of 16th and Mission), pawn shops, and liquor/cheap cigarettes low-end corner stores. Many of these businesses occupy the ground floor of buildings which have private daily rent hotels occupying the second and third floors. Many have workers and owners who

are Asian, mostly of Chinese decent. Some of these establishments will allow women to accrue debt. The economic and social relationships these establishments have with homeless persons in the 16th/Mission Street Corridor and with the hotel's management are complex. For example, cheap establishments such as variety stores, liquor stores, 99-cent shops and discount cigarettes shops rely on the a steady stream of consumers among the poor, addicted , and indebted hotel patrons. Some stores which reside underneath daily-rent hotels even serve as the payees for welfare checks of tenants living above.[142] Because cooking is not allowed in most private, daily rent hotel rooms, cheap fast food also does a strong business among persons involved in the drug-sex economy, and many other lower incomes families and persons in the neighborhood.

Pawn Shop on Mission Street between 16th and 17th, daily rate hotels in the background. 2007.

The second economy at work is the "gourmet ghetto" industry of restaurants, bars, and live music that support an "edgy" nightlife in this section of the Mission District, which attracts patrons who live in other neighborhoods. Some blocks, such as Valencia

142 Changes in the payee structure for Social Security Income (SSI) and Social Security Disability Income (SSDI) are discussed in further detail in Chapter 6.

Street which runs parallel to Mission Street one block away has successfully gentrified to offer upscale condos, and day and nighttime businesses that cater to young hipsters and middle and upper class professionals. This economy is not in direct competition with the drug-sex economy. Indeed the gentrification economy is somewhat dependent on the "urban-feel"[143] of the area – to sell its businesses as both hip and exciting in a rock-n-roll, hipster sense. The economic shifts in the 16th Street/Mission Corridor and the associated perception of its new patrons' declining tolerance for the urban poor were reflected in this sidewalk posting:

Spray paint graffiti on sidewalk, 16th Street. It reads "Mission nite time patrons who harass people who live on the street in this anti-poor city are worth less than shit." This sidewalk sign was made in front of the Nisha Hotel, which is situated on the boundary between gentrified Mission and blocks yet to gentrify, October 2008.

It was not uncommon to find several store closures and for rent signs in older stores, which were rapidly "flipped" into higher-end restaurants and condos. The dot.com boomers bought up office space in abandoned industrial spaces to the East of Mission street and Valencia Street – a gentrified street of restaurants and shops- lies one block to the West. The blocks to the South of Mission Street have been gentrifying recently

143 "Urban" in real estate is typically code for and area being crime-ridden and/or populated by people of color.

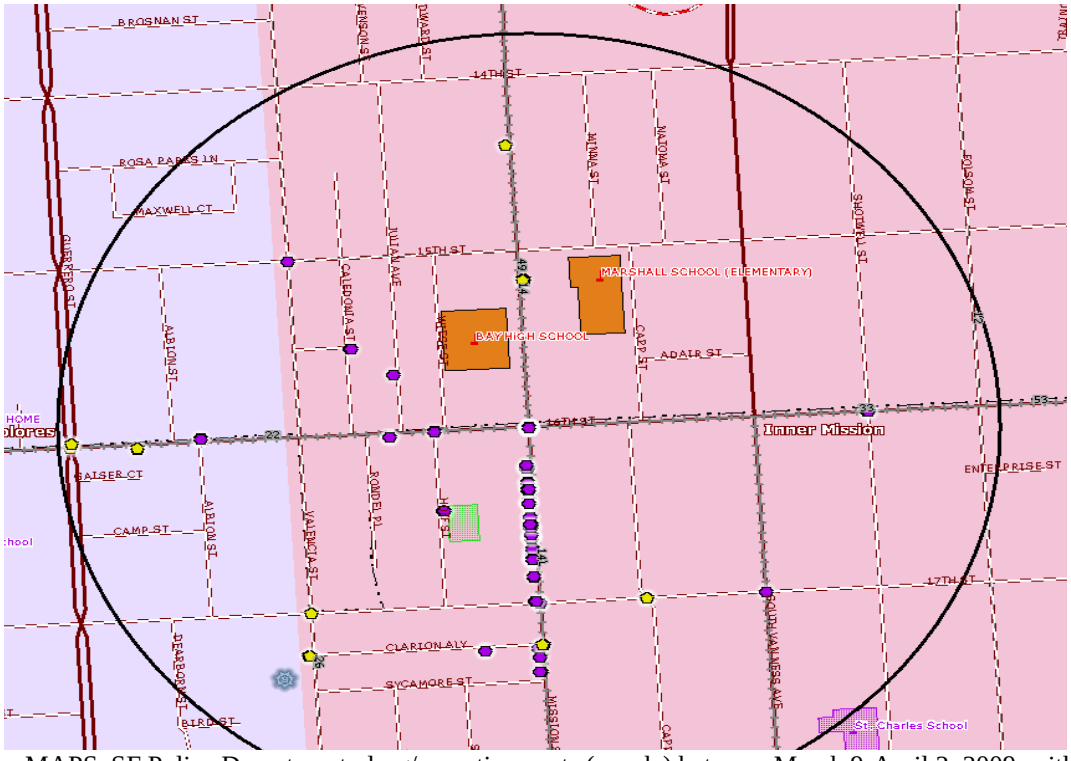
with an expensive, private school for K-8th grade students opening its doors in September, 2008, quickly followed by a string of new restaurants and coffee shops. Homeless drug using women who live in the daily-rent hotels are being squeezed from all directions.

Picture taken from room facing Mission Street, Raman Hotel April, 2009. Notice the 99-cent store across the street has closed and is for rent.

The third economy in the Mission is the formal and informal sector economies of Central American immigrants, primarily from Guatemala, Yucatan Peninsula in Mexico, and El Salvador. These economies are various including some shop keepers and restaurant owners – although those are disappearing as their shops are bought by gentrifying newcomers- informal tamale sellers, taco truck vendors, and stall operators. Some of the immigrant, and migrant, men also rent rooms in the daily hotels, yet I have seen very little direct interaction between them and the women who are in my primary cohort within the hotels themselves. One woman commented to me that she tries "to keep those poor boys from getting eaten alive." in the Raman Hotel. She indicated that they immigrant here from the country and get caught up in day labor and drinking and

drugging in the hotels. She was making a protective, differentiating statement between young immigrant men caught up and the "regulars" who are a constant feature of the drug sex economy within the daily rent hotels.

An examination of the San Francisco Police Department statistics on violent and drug-related crime arrests provides a graphic picture of the concentration of open air drug market activity and the police response. According to the San Francisco Police Department CrimeMAPS website data between March 9, 2009 and April 2, 2009, there were 11 arrests for (non-sexual) assault and 66 arrests for drug/narcotics charges. "Possession" – not sale or intent to sell – accounting for 32/66 of the drug/narcotic arrests. Purple dots on the map below reflect one or more drug/narcotics arrests; yellow dots represent (non-sexual) assault arrests. The daily rent hotels in which I conduct participant observation are indicated on the map by the highest density of purple dots. The police station is indicated by the blue police badge symbol.



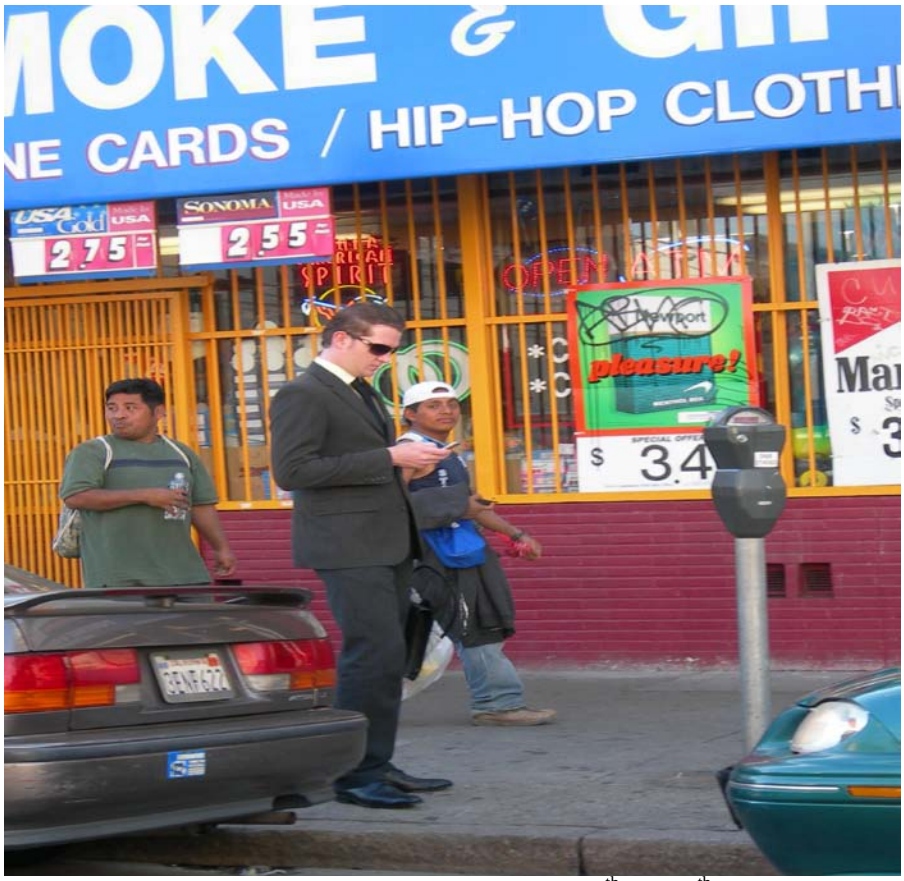
CrimeMAPS, SF Police Department; drug/narcotic arrests (purple) between March 9-April 2, 2009, within 1/8 mile of 16th and Mission Streets (center of map).

Lexi explained to me that she sometimes does not want to be seen out working – doing sex work - during the day because many of the families with small children would walking by might give her judgmental looks. "That is why I try to only work late at night, when the children are asleep." She told me. Many other women also expressed concerns about the children being "exposed" to the drugs sales and prostitution activities on the block. Women would often ask us to move our outreach activities if we were close to entrances of one of several Pentecostal churches in the Corridor which held family services in the evening. On an everyday basis, most immigrant families, tolerated and strategically avoided the drug sex economy, especially shielding their children. Although neighborhood groups are active in business counsels and local schools, I only documented one public protest of the drug sex economy in three years of ethnography.

16th Street Plaza. October 2008. The middle sign reads "Please don't do drugs near our school."

There is a large "young hipster" scene in the Mission, people in the their 20s and early 30s who rent apartments, or even buy houses and condos, in the Mission district because they are relatively cheap and close to many bars and music venues. Anita told

me a story about says how they are “fearless” about the drug dealers that work the corner of 16th and Mission. She said, “One time I seen a dude – one of those new Mission dudes, a hipster - knocked off his bike [by a dealer]. He didn’t run. He turned around and cursed the guy [the dealer] out. I couldn’t believe it. These young people don’t take any shit. Not anymore.” Set apart from the immigrant families, the gentrifying young hipsters and home owners expressed neither outrage nor fear toward the sex workers and drug dealers. For the most part I witnessed dismissal, as they walked by women seeking dates, selling and buying drugs. In many ways the gentrification battle has been won on the street and has been pushed inside; inside the privately owned daily-rent hotels of which most passersby have no awareness or knowledge.



Intersecting economies on Mission Street between 16th and 17th, October 2008

The gentrification has also brought massive police presence to the Mission, and that has come to contain the drug-sex economies to a relatively small area. The policing activity was constant in the 16th/Mission Corridor during my ethnography. Often I would hear the whisper of ”blue ghost” outside of the coffee shop where the majority of open-air drug dealing took place to indicate that a plains clothes or uniformed officer was on the way down the street. Instantly people, would disappear into the hotels or the shops. I knew if I arrived on the corner and no one was around that the police had just been through. I spent half a day watching a sea of sex workers disappear and reappear like the tide as police cruisers would circle or police officers on front and on bikes would patrol. One evening in 2008 an undercover officer approached me during an outreach shift to ask what we were passing out, he then pulled Danell out of line to question her parole status. Two articles highlighted the overall policing strategy, which included a focus on “drug dealing and prostitution,” more officers on the street and the practical and political advantage of using crime monitoring statistics:

> Mission Police Station’s boss Capt. Greg Corrales said that priority number one in his return to the post he held from 2002-2004, is to aggressively combat drug dealing and prostitution.
>
> “When drug arrests are up, all other crimes are down,” said Corrales. “The bottom line is we will make the Mission District safer for all residents and tourists,” declared Corrales in a tone more resembling a politician than a police officer.
>
> On Nov. 16 [2009] Corrales returned to head the Mission Station, swapping places with Capt. Stephen Tacchini, who left to lead the traffic detail.
>
> [Police Chief] Gascón’s overhaul is the department’s first major realignment in decades. It includes the redeployment of approximately 100 of the department’s investigators to the district police stations—eight to the Mission Station.
>
> Corrales believes this disbursement of investigators, a clear priority for Gascón in his first few months in office, will vastly improve each station’s ability to solve crimes in a way that has not been possible with all investigators centrally located at the Hall of Justice.

> Corrales plans to put investigators to work in his war on drugs.[144]
>
> "When you get drug users and drug dealers off the streets, you also get an auto burglar, a thief, you're getting people who are committing a lot of other crimes," said Capt. Greg Corrales of the Mission Police Station. "The whole goal of getting drug dealers off the street is to make the Mission District a safe place for everyone to live."
>
> Those goals were responses to Godown's questioning on their plan to reduce crime in the Mission during Wednesday's CompStat meeting. As a new initiative on coming to office, Police Chief George Gascón implemented CompStat, a crime tracking system that allows police from all 10 districts to follow crime trends and collect suspect profiles from all districts, in October.
>
> The Mission District's latest CompStat numbers show a slight increase in the number of violent crimes from 72 to 75, in the last 28-day cycle – from Dec. 6, 2009 to Jan. 2, 2010, compared to the same period last year.[145]

Everyday, in the 16th/Mission Street Corridor, the streets are populated constantly with drug users, dealers, sex workers, yuppies, Latino families, and tourists. This is the public street life, where the three economies mix and overlap most directly and obviously. The private life of the daily hotels presents a political-economic picture which diverges from this diverse public landscape.

IV. The "SRO" in our political imagination, in name, in actuality

> "SRO" does not mean what we – service providers, policy people - think it means. It is a term that is used in government, for policy. It is not a term that really works for the people who rent the actual rooms."
>
> – Member of the Mission SRO Collaborative, October 2009

What is an "SRO?" SRO is an acronym that stands for Single Room Occupancy. The most direct rendering of this term is just that: only one person per room. There seems to be agreement that a "typical SRO is a single 8x10 foot room with shared toilets and showers down the hallway."[146] From the perspective of the epidemiological categorization, and in governmental language, privately owned daily rent hotel would be

144 Patrick Kolman. New Police Chief Targets Drugs and Prostitution. *Mission Loc@*l. December 15, 2009.

145 Vanessa Carr. Police Set Goals for 2010. *Mission Loc@l*. January 8, 2010.

146 Central City SRO Collaborative, San Francisco. (no date) History of SROs in San Francisco. Accessed on the web January 20, 2010.

included under the term “SRO”. This is, in part, an artifact of history. SROs began as temporary housing for low-wage workers and migratory laborers. While rooms may well have been occupied by more than one person they were not specifically targeting families or even women. These rooms were often rented by single men:

> In San Francisco, SRO tenants included gold prospectors in the mid-19th century, seafarers who spent their months at shore in the hotels of the ‘Barbary Coast,’ fruit and vegetable pickers who would migrate to city residential hotels in the winter months, and laborers who would pick up short term jobs as they came.[147]

Currently the blurring between public and private management of individual hotel rooms and buildings makes the “SRO” terminology problematic. Deeming a hotel, or a hotel room an “SRO” because of its physical characteristics and layout does not reveal the important detail of how it was paid for, either daily, weekly, or monthly. All “SRO” rooms do reflect an equal economic burden on their occupants. When progressive supportive housing movements began to take over the Master lease on “SRO” buildings, and rooms within buildings, and manage them publicly. Because these two managerial types - private verses public- had two divergent markers of success, they were managed differently. Supportive housing SROs did not have any daily or weekly rent, and offered varying degrees of social and physical health services support on site. Success here is evidenced by persons staying housed. Private SROs, running on a breakeven and profit model, measured success by rooms filled. This differentiation helps to explain why I had expected when first approaching the “SRO” hotels to find their rental populations fairly stable. I thought the majority of the rooms – even in the private hotels - would be filled with SSI-entitled or other entitled renters because their access to government subsidy insured rent consistently. This is the reality for publicly funded SRO hotels because of citywide efforts on the part of the department of public health to advocate for SSI

147 Central City SRO Collaborative, San Francisco. (no date) History of SROs in San Francisco, citing Groth, P. (1989) Living Downtown: the History of Residential Hotels in eth United States. UC Press. Page 133-137. Accessed on the web January 20, 2010.

benefits for all homeless clients.[148] The city is happy with entitled clients because they can defer some portion of the rent cost; it is not a net loss. For private hotels, daily renters are exceedingly more profitable. These hotels run as de facto brothels, gouging renters and their visitors for fees, so that the notion of "single" occupancy at any particular moment is comical at best.

What I came to discover through participant observation is that women – like Ramona in the field note below – do not see the daily-rent hotels as "SROs".

Ramona **16th Street** **September 2009**

I meet Ramona in front of the Nisha Hotel. She is starving and eats the sandwich that I brought for my lunch. She thinks the hummus is weird but good. She has never tried hummus before. She is seven months pregnant.
"I got an SRO," She tells me. "You are already in an SRO." I say, indicating the Nisha behind us.
"That dump isn't an SRO, I have to pay daily." She quips annoyed at my obvious ignorance.
"People call it an SRO." I retort. "Well it isn't. If you pay daily it isn't an SRO. If you can pay for two people it isn't an SRO." She barks back. "I got an SRO. A room at the European (Hotel). And I can keep my baby there (after the baby is born)."
"When do you move in?" I ask.
"I don't know, I have to go talk to the case manager, deal with the paperwork. You got anything else to eat?"

Ramona points out that if you pay extra for it you can have more than one person sleep in your room. Typically it is $35 for a single person and $60 for two people, if you are paying a daily rate. This is demonstrative of the fact you are paying daily. If a person has access to a SSI entitlement and they have a monthly rental arrangement, then they not allowed to house another person in their room. This is illegal from a governmental perspective because the SSI benefits is linked to the mental and /or physical health disability of the beneficiary, not her girlfriend, boyfriend, brother, running buddy, etc. Ultimately this links back to the evidentiary forms that come to count here. Disability welfare can not be shared because it is linked to the individual – justified by a mountain of paperwork and not easily granted.[149] For this reason, persons who have housing

148 More elaboration on this point and at its significance to women's mental health in Chapter 6.

149 See Chapter 6 for an in-depth discussion of this process.

benefit entitlements are monitored and hotels – even privately owned ones- are meant to enforce the "single" in single-room occupancy at the risk of loosing their payee status.

So the term "SRO" can reference both privately owned daily rent hotels which are sites of illegal gendered exploitation and publicly governed housing which serve as sites progressive housing policy implementation. Thus, Ramona's protest to me: If she is paying for her room with her SSI, and it was garnered through a governmental case management apparatus, then it is an SRO. If she hustles for the daily rent, it is not. These distinctions are not petty linguistic differentiations. Many women (and men) loose access to entitlements and face eviction if it is discovered that they are harboring another person in their entitlement-subsidized room. Those who have subsidized "SRO" rooms have limited "overnights" – nights in which partners, friends, children, or others are allowed to stay the night without jeopardizing an entitlement benefit and risking the loss of housing.

Throughout this thesis I have chosen to use the term "daily-rent hotels" because that is a term suggested by Ramona as a corrective to me, and it more accurately reflects the economic realities of most of the women – and all of the pregnant addicts – I worked with throughout my ethnography.

V. Daily-rent hotels as spaces of illegality

Evidence for the daily hotels is money: hard, cold cash. You can rent a room only if you have money to pay. Otherwise you are out on the street. Hotels may offer credit to some women, but it eventually has to be paid. And the insecurity of indebtedness produces risk for women in their illegal activities, while they are often constantly harassed to "get outside" – get some dates and pay your rent – but hotel management. The structural violence of daily rent charges by private hotels, and the ways in which the hotel's metric of cash is inextricably bound to a larger economy and the gendered drug-

sex economy was visually represented to me in an edited sign on the Chandra Hotel. The Chandra, like all the hotels in the Mission, tried lowering its daily rates when the national economy tanked in January 2009. The hotels began for the first time since I had begun my ethnography to advertise, not just vacancies, but a cheaper price. Single daily rent hotel rooms that ran as much as $45-50 in January of 2007, had dropped to $35/night one year later. On one of signs someone had changed the lettering, so instead of reading “Daily Rate $35” it read “Daily Rape $35,” poignantly capturing how violating the experience of life in the hotels can be.

Visha Hotel January 2009

All the private and public SROs have gate-keepers, often men in their 20s who sit behind a heavy clear plastic window. They must buzz you in from the door at street level, you climb the stairs and then they interrogate you about why you are there on the first floor landing. These interactions are not overly intimidating, but they often have a hostile feel; and no one is getting by the gate keeper without an explanation. Even the police

who raid the hotels first check with management, often calling to announce their impending arrival. This forewarning allows hotel managers to privilege certain guests with a warning that the police will soon arrive or are on the premises, while leaving other guests “hung out to dry” if they have garnered disfavor with the management. Some of the gate keepers work in multiple hotels. The young male gate keepers at some hotels are on the internet - surfing the net or watching porn - and barely raise their heads in acknowledgement when we arrive to conduct outreach (not the case if I come by myself). At some hotels young children, as young as six or seven years old, may be in charge of the door, but a parent or relative is never very far away. In one hotel it is not unusual to see several kids behind the glass, some on computers, some doing paper and pencil homework assignments, while all the action of the drug economy is unfolding on the landing above and a short distance down the hallway.

Gate Keeper desk, Grey Hotel. The Board to the right of the desk is a long list of hotel rules. August 2008.

The hotel managers and staff seem to know all the women by first name. One reason for this familiarity is because the women are deliberately shuffled between hotels in order to deny them tenancy rights. This is a policy known as a "21-day," as in "I got 21-dayed, so I had to move out for awhile." Technically illegal in San Francisco, the policy is widely practiced. Once a renter has occupied a room for over 30 days they automatically gain residency status and with that status the tenant becomes harder to evict. Hotel managers require that individuals move out for two-three days when they come close to the 30-day limit, usually after about 21-days of renting a room. The "21-day" is also referred to as "musical rooming," in reference to the children's game of musical chairs. In the daily rent version everyone gets displaced and often someone ends up without a room (homeless) and out of the game. If women have a congenial relationship, sometimes hotels management will even offer to store a person's belongings while they are not occupying their room, or make promises to return the tenant to the same room.

Few women that I have spoken with feel it is worth it to fight a 21-day request, often because are fearful of making things worse for themselves. The hotel management can mete out privileges and punishments in overt and subtle ways to express their displeasure about the hassles a woman might be causing them. Suddenly debts are called in, the boyfriend who is just home from prison is unwelcome, the rent increases, or the hot water is off. The logic of a predictable displacement and resettlement – to a new hotel in which the woman must renegotiate the social relationships and quickly become abreast of the drug and sex politics in order to get her needs met – is preferred to the systemic discriminatory punishments which might await a tenant activist.

The relationships between hotel managers and gate keepers and the women renters are inflected with racist, classist commentary that flows in both directions. Hotel

managers have disclosed that: “I no longer rent to black women.” I have seen, many times, hotel management be openly hostile toward women who are very physically sick-yelling at them and kicking them out of the hotel. I have heard many rumors forwarded by women about the owners and the families that manage the hotels for them. These rumors are discussed sometimes to support racist rhetoric, sometimes to underscore the rationale for management’s brutal behavior, sometimes with tones of empathy and solidarity. For example, it is rumored that they owners ship in managers from India, have them trained to be tough by drug users and sex workers in their hotels in Los Angeles and then they come to San Francisco to work. It is rumored that the managers are paid no salary other than visiting fees so they are encouraged to run the hotels like brothels – because they too, are being economically exploited by the owners. It is rumored that the owner of many of the hotels, who many women know and have interacted with, has a very powerful lawyer against whom you can never win an eviction case. It is rumored that all the management families are “low caste” and working as managers in the hotels in San Francisco is a lot better than their lives would have been in India.

The private hotels charge between $35-60 a day to rent a single room. None of the rooms have bathrooms and most look like the two pictured below: stained walls, dirty, broken furniture, chipped and peeling paint, often with blood stains and graffiti on the walls. Most rooms have terrible bed bugs, rats and mice – there are flies everywhere and often garbage in the hallway, along with broken TVs, dirty bed sheets, old mattresses, and other odds and ends.

Floor stained and eaten away from a bedbug infestation. The carpet has been pulled up. Raman Hotel, October, 2009.

Room in the Raman Hotel, March 2009

The hotels make a tremendous amount of money from charging renters daily, and accruing renter debt. The primary source of this income is through charging visitors fees for sex workers. Charging visiting fees, like musical rooming, is illegal in the city of San Francisco; and it is widely practiced in the hotels in which I conduct participant observation. This is how it works: a woman rents a room for the day, paying $50. Every trick she brings into the room has to pay the manager a $10 fee to visit, plus paying for the cost of the transaction. The cost of the transaction can vary by a variety of factors including the price of specific sex acts, how much the sex worker thinks she can charge the trick, the degree of desperation of the sex worker, pressure from pimps to earn a certain amount of money in a night, and how the sex worker is feeling mentally and physically at that moment – dope sick, depressed, energetic, exhausted.

Some quick math reveals that this is an extremely profitable form of gendered economic exploitation on the part of the private hotels. An SSI-benefited tenant will pay between on average $500/month for a room. A sex worker will pay $350/week. Assuming only 5 tricks a night, another $350 in visiting fees is garnered from her labor for the hotel. She keeps whatever money gained from the sex work, minus her rent cost, minus payouts to pimps, minus money for drugs. It easy to see how the relationship between hotel management and women engaged in sex work in their hoetls is a mutually dependent, yet exploitative labor market. This is equally true for women who are dealing drugs out of hotel rooms where visiting fees are charged, although with less consistency.

The everyday economic reality of women in the daily rent hotels is one of perpetual indebtedness.

Message from management to renters Visha Hotel January 2008.

Debts are often called in by hotel management, but different women are able to negotiate different lines of credit with their hotels. Some hotels are known to be more lenient about letting women accrue debt. Other hotels are very strict, still others are apparently arbitrary. For example, on a single floor of a hotel it is not unusual to have one woman struggling to get enough tricks to pay down her hotel debt and avoid a night outside; another woman is unfazed by owing the hotel several hundreds of dollars; and, yet another woman will be calling in the debts others - boyfriends and friends- owe to her to pay down her own debt to the hotel. Hotel management will often "employ" women, to clean bathrooms or work the front desk, and this is sometimes in exchange for paying down debts. Sometimes it appears that women are feeling threatened that they will lose favor in the hotel and perform this labor even when they still are paying $50/day in rent, and not in debt. What I have observed is that women are intimated by hotel management and fearful of their arbitrary actions. I have witnessed heated verbal exchanges, curses and name calling back and forth, but these are more show than

action. Women who overly anger the hotel management end up kicked out. All of their possessions are thrown out for others to rummage through on the street out front.

Picking through a renter's belongings which have been dumped on the street by hotel management Mission Street, December, 2008

VI. "Homelessness" is bad for your health

Noah's cotton fever Daly Hotel February 2008

When we first came up the stairs, we saw Noah at the top gate. She was really sick and begging the hotel manger's wife to let her come up. She said, "I really want to visit [number] 36. I have the ten dollars. I'll pay the fee. Just please let me come in." They wouldn't let her come in and she was really distraught. When we went up and did our outreach, I realized that #36 is Trina's room. Trina's room was far enough away from the front desk that she didn't hear what was going on. Trina has told me that she's got a lawsuit going [against the hotel] because of them trying to raise the rent. Trina has also told me that the management withholds her mail, and won't tell her when she has visitors. I wondered if they won't let Noah up because she wanted to go to Trina's room.

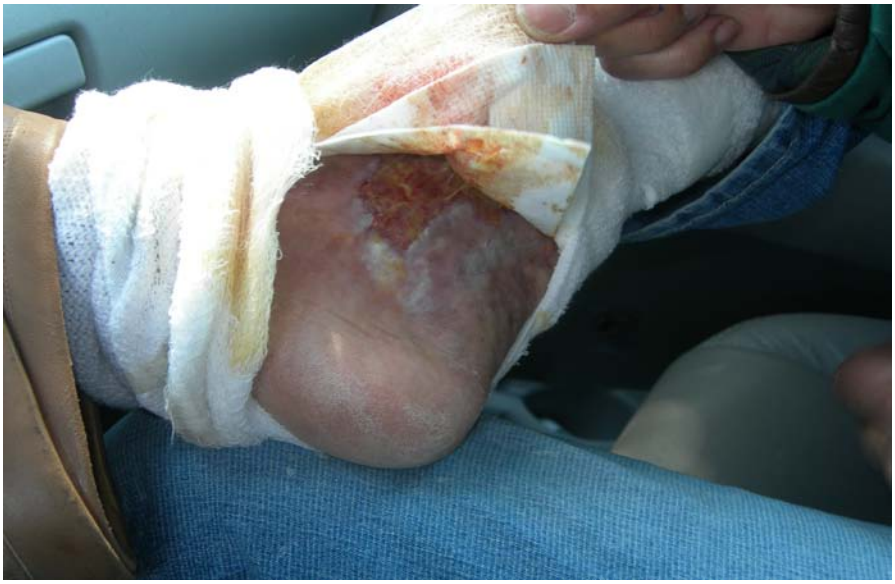
As we are leaving we check in with Noah. She is now on the stairs near the door to the street and she's crying and shaking. She told me she has cotton fever. I asked her if she was thinking about going into the doctor. She said, "No it'll pass." I felt her forehead and she was really hot and she was crying. Then somebody came through the front door and up the stairs next to us. An African-American guy, an older guy, named Marcus. Noah asked if she could pay a fee and stay in Marcus' room for a little while. I think she just needed some time to rest. He ignored her. So she wasn't sure what her plan was gonna be, "probably the street," she said. She only wanted wound care supplies. She wouldn't even take a sandwich she was feeling so sick. It was very sad to leave her crumpled up like that on the hotel stairs. I don't know what ended up happening with her that night.

"Homelessness" is bad for the body and the mind. The research on that is clear across the board. There are no mental of physical health benefits from being homeless, and it is not a neutral experience, outcomes are uniformly bad for homeless persons when compared to their housed counterparts. Yet, epidemiological studies have generally failed to capture the physical and mental health consequences by specific housing type. There are several reasons for this. The first is that definitions of homelessness are often inclusive, seeking to deploy the label "homeless" not just for persons living on the street, or even only in a public shelter, but also include those women who were using daily hotels for part or all of the month, but had no stable housing beyond each day of rental payment. This is not always the case, though. Studies sometimes want to compare the effect of being inside – even in a daily rent hotels – to outside. Then those women who are housed in daily rent hotels become "housed" while women on the street and in shelters become the "homeless". To further blur the categorical lines, some epi studies use the terminology "homeless", "sheltered" and "housed" and sometimes "permanently housed" verses "transitional housed" in then comparison.

During my participant observation in the daily-rent hotels I was routinely called upon to fulfill the role of "doctor." Often the role of street doctor involved being asked advice about whether a condition –frequently an STD or a wound – necessitated a visit to the hospital. Women were reluctant to access care unless it was deemed absolutely necessary, not because they wanted to wait until infections reached the point that they would be guaranteed a hospital stay. Rather, women feared loosing their rooms in the daily-rent hotels, their livelihood (if they were selling drugs or doing sex work), and their possessions should they have to be hospitalized. One woman made this clear to me when I suggested that she might need to go to the wound clinic for an abscess that was

causing a fever: “If I go in [to the hospital] they are going to keep on a [antibiotic] drip for two days. I know it. Who is going to move all this stuff [drugs she needs to sell]?” Another woman ended up in the hospital at the same time as her husband. He had cellulitis and she had a live-threatening asthma attack. She told me that even though they were gone a week from their hotel room, the management would not offer them a discount. “We had to pay $50 everyday!! Even though we have lived her for years!”

Some women sought out doctoring services for temporary treatment, not advice. This involved attempting to clean and bandaging wounds with gauze and medical tape. My aid was often a mere extension of the self-doctoring practices women routinely engaged in to avoid formal, institutions of care, keep working, and maintain housing. Abscesses, the most common wound, were treated by women themselves or by other women, but if this was too difficult or inconvenient I might be called upon. One evening, a woman beckoned my into her room because she was trying to clean a deep bite puncture that she had received on the back of her neck during a drug fight with another woman. For 18 months, Crysanne needed to clean and bandage the severely infected wounds on her ankles which did not heal until she moved out of the hotels.



Crysanne’s infected ankle, outside the Bridgit hotel April 2008

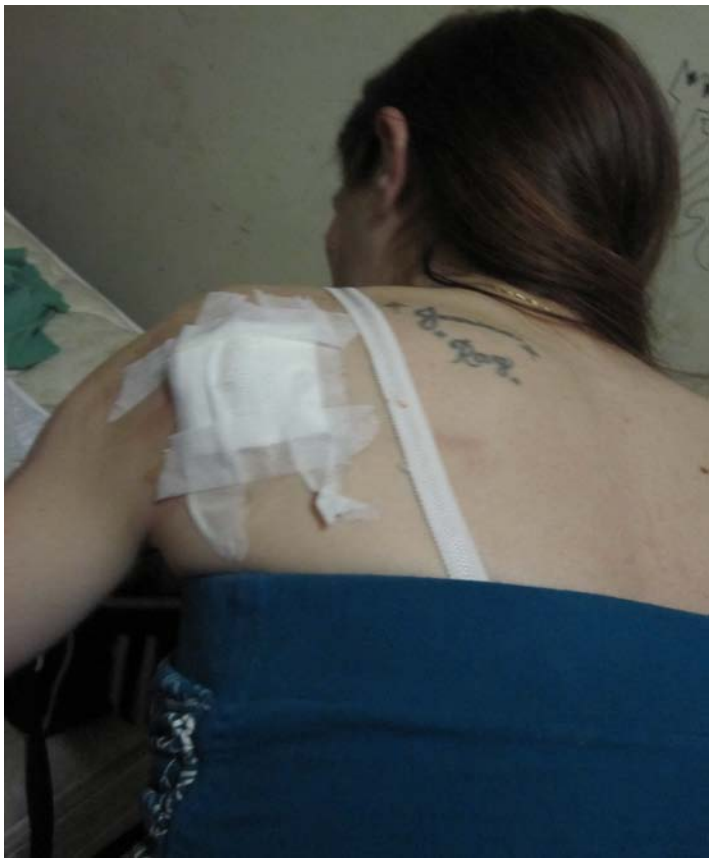
Crysanne's hospital visit September 2008

I saw Crysanne on Mission street. She told me she went to the doctor to try and get some pain medication for her feet.

"The woman I saw was like 25," she frowns. "I'm in my sixties. I have been out here a longtime, taking care of myself. They told me I was going to loose my legs, that they had to operate. Look at me now, I am walking." I am thinking that she is walking today, but tomorrow will she be back on her knees?

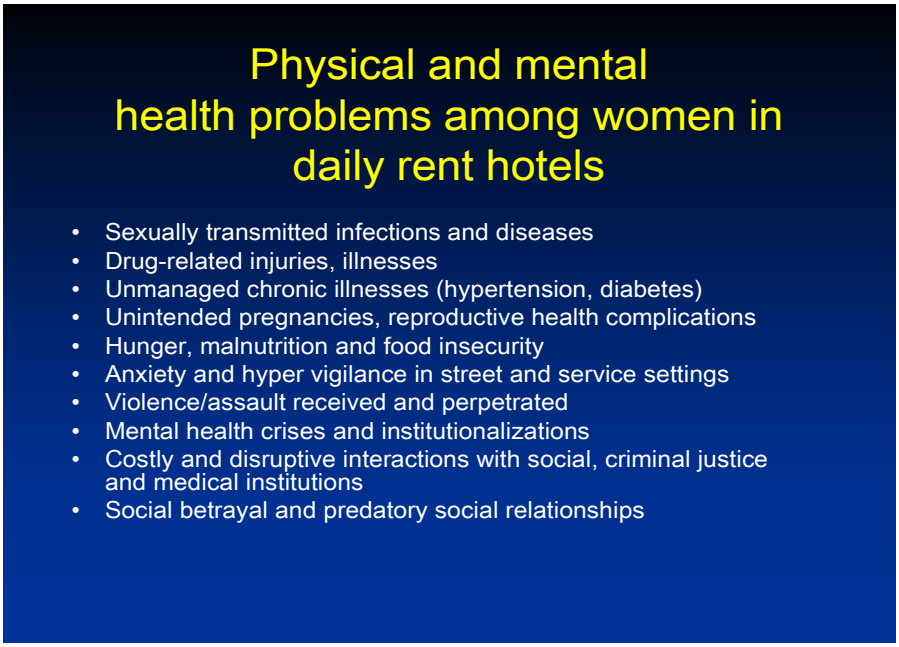
"Getting away from the bugs in those nasty hotels has helped." She says. "Anyway, I tell the girl, the doctor, I say 'You going to give me some of the good medication, the stuff that really heals what I have?' Because they had given it me once, remember I told you. I healed right away. She told me maybe at the end of the visit. And she wouldn't give me pain meds. I just left. I said 'You don't waste the good stuff on people like me, do you?'"

Just before we left for Anita's child custody hearing, an abscess on her back shoulder opened up and started to bleed. I was able to quickly clean and bandage the wound with supplies she had in her hotel room, so she could put on a jacket for the courtroom.



Anita's bandaged abscesss, March 2010, Chandra Hotel

I created to the following slide to summarize the range of health and mental health consequences I have documented among women living in daily rent hotels. This "data" has circulated in a poster I presented at a health disparities conference, at a drug researchers seminar, and at a continuing education accredited quarterly meeting of physicians at a local public hospital.



This next section offers an opportunity to look more in depth into the everyday realities of the negative health consequence of the daily rent hotels, and explore some innovation in their epidemiological measurement.

VII. Consumption and insecurity

Consumption

- the process of taking food into the body through the mouth (as by eating)
- pulmonary tuberculosis: involving the lungs with progressive wasting of the body
- (economics) the utilization of economic goods to satisfy needs or in manufacturing
- the act of consuming something

Insecurity

- the state of being subject to danger or injury
- the anxiety you experience when you feel vulnerable and insecure[150]

150 wordnetweb.princeton.edu/perl/webwn, accessed December, 2009.

The above definitions of consumption offer images of both gain (as through eating, or consuming) and loss (as through disease wasting, or utilizing goods). The experiences of consumption in the hotels seemed to contain these same dualities. The consumption of everything - alcohol, drugs, food - in the daily rent hotels was governed by the sense of both acquisition and loss. Insecurity reigned: even though women rarely appeared emaciated or in the throws of heroin withdrawal.

Lexi's room Nimish Hotel June 2008

Women often described themselves as "starving" and were always "chasing a high," literally down the hallway. Slam. Slam. The doors would close. Women would knock and whisper "Who is it?" Someone would holler form inside, then the doors would open and close again. Sometimes I would view this from outside the room (in other rooms or the hallway) sometimes from inside. Either way, the overall atmosphere was one of tension and low level panic that seemed to pervade the hotel during the waking hours (after noon to midnight or later). An ironic feature of this tense atmosphere was its repetitive nature. So while a low level of chaos came to feel natural, neither I nor the

women I spent time with, ever felt relaxed. It was both expected and unpredictable. The needs of women of food, drugs, water, cigarettes were chaotically met. I never knew, upon meeting a woman where in the cycle of build up and release she may be at that moment.[151]

Despite the whispers and near constant social interaction that characterized many women's daily lives in the hotels, the hotels did not create a communal environment for the consumption of alcohol, drugs, or food per se. Although women and men would often hole up in rooms to use drugs –especially to smoke crack – together, these were unstable arrangements. They often seemed to depend on which random collection of individuals may have landed, or been forced to land, in that particular hallway on that particular day. I can provide a handful of examples to illustrate the random and constantly fluctuating constellations of people, drugs, money and food that is the private hotel life.

> **April 2008**: I arrive to pick up Lexi and find Pano on the stairs. We hang out while she finishes with a (very loud) trick about 10 feet down the hallway. "I am gonna make myself scarce, and get something to eat." Pano tells me sheepishly. "She should be done soon." I wait for about 10 minutes, the trick leaves and we hang out for a bit. Pano returns with food for Lexi, after about 20 minutes. We all watch a movie together in the room, but people interrupt constantly for stuff. A hit. Cigarettes.To convey a message. Whatever.
>
> **September, 2009**: When Ramona buys crack after our interview, we head up to her room for her to get high. After about 15 minutes, she gets a call on her cell. "Remember that guy you saw me talking to downstairs for a minute? Well he wants to come up." She tells me after she hung up. I ask if he is a date, and whether she wants me to disappear for awhile. "No. He is just getting a piece. I can make some money off of him." She is going selling him a piece of crack for a higher price but let him hang out in her room while he smokes it. Which he does a few minutes later.
>
> **October 2009**: Lexi and I return to her room. She opens the door, and a guy is masturbating on her bed to the porno on the TV. "Get the fuck outta here!" She yells. "Don't be like that." He call back walking down the hallway, while doing up his pants. "I don't even like that motherfucka!" she tells me after he has left and we close her door. "He sneaks back in here [into the hotel] because he is 86'd [barred from renting a room]. I try and be nice but that ain't cool!" She says exasperated.

Most women that I keep track of were rarely found in the same daily-rent hotel from week to week. Multiply the number of women (say 50) that regularly rented rooms

151 I elaborate on the temporal constraints of "addict time" in Chapter 5.

in daily-rent hotels that I would frequent by the number of available rooms (about 300). That conveys a sense of the possible combinations of people who could end up on any hallway, any given day. New social geographies were established, dismantled and reestablished throughout out the week, causing moments of tension and solidarity between women users – but overall, creating high levels of insecurity. No one, including the other women on the floor, me, or the hotel management really knew who was going to turn up, with what to offer, or what demands.

An approach in epidemiology that has recently gotten some attention is the construct of "residential transience". Residential transience argues that the disruption of changing housing situation may be as significant a factor in housing-related poor health as the location itself (e.g. public shelter, street, daily-rent hotel). For example, a forced eviction after 21-days which leads to displacement from one daily-rent hotel into another, or a housing downgrade from a daily-rent hotel to street homelessness. This epidemiological framing has its contextual appeal. It matches more closely with the experience of housing disruption on the ground, in my experience. The women cycled through multiple forms of housing throughout the year. As mentioned above the degree of residential transience was extremely high between the daily-rent hotels, which created specific forms of disruption in daily life throughout weeks and months. So women not only followed the "institutional circuit" from jail, treatment, shelter, flophouse (daily-rent hotel), street, and hospital, that Kim Hopper so astutely identified in his ethnographic work. They also followed the daily-rent brothel circuit, moving and being moved from hotel to hotel constantly.

The epidemiological research on residential transience indicates that it increases depressive symptoms especially for women, even after homelessness, as one form of

transience is taken into account.[152] Residential transience has also been linked to injection related HIV risk behaviors, when studied by the same group of researchers at John Hopkins.[153] As "residential transience" is gaining purchase as an epidemiological categorization that may better capture the experience of housing instability and its health effects, one must ask: why? This shift may reflect frustration among category makers that even after years of epidemiological studies of homelessness and its effects, it is still problematic to compare evidence between studies because the construct is unstable. Another possible contribution is the effect of the globalization of public health. Many, many quantitative researchers who specialize in injection drugs use, HIV/AIDS, and urban health issues began to work outside of the United States when injection drug use-related HIV epidemics surfaced in the late 1990s, early 2000s, in places such as Thailand, China, India, Russia, and Eastern Europe. Connections were made between notions of the ill-health effects of "internal displacement" (as WHO concept used a great deal in refugee health) as a result of war, conflict, natural disaster, or political repression and US domestic homelessness. Residential transience offered a different way to measure homelessness – not only by the individual frozen in time by housing type, but by the cumulative experience of displacement, or housing disruption. It offered a more globally informed construct of socio-structural disease risk and environmental stability.[154] One small example of the integration of global public health with my local ethnography of unstably housed women: In 2007 and 2009 I was solicited by two international public

152 "In a sample of drug users and their social network members (n = 1,024), we assessed the relationship between transience (frequently moving in the past 6 months) and depressive symptoms, measured by the CES-D, among men and women. Even after adjusting for homelessness, high levels of depressive symptoms were 2.29 [95%CI = 1.29-4.07] times more likely among transient men compared to nontransient men and 3.30 [95% CI = 1.10-9.90] times more common among transient women compared to nontransient women." Davey-Rothwell, MA, German, D, Latkin, C. (2008) Residential transience and depression: does the relationship exist for men and women? *J of Urban Health* 85(5):707-16.

153 German D, Davey MA, Latkin CA. (2007) Residential transience and HIV risk behaviors among injection drug users. *AIDS Behav*. 6(Suppl):21-30.

154 See Rhodes T, Singer M, Bourgois P, Friedman SR, Strathdee SA. (2005) The social structural production of HIV risk among injecting drug users. *Soc Sci Med* 61(5):1026-44.

health instructors and researchers at UC Berkeley to be a guest lecturer in the *Structural Inequalities and Reproductive Health* course. My task was to discuss my research on US homelessness among women as a form of internal displacement.

The relationship between place and violence has been looked at from an epidemiological framework, comparing both the effects of both housing type and residential transience. Kushel et al (2003),[155] who did research with unstably housed women in San Francisco, found what many women in my ethnography corroborated: being outside is more dangerous than anything that might happen in a hotel. This does not mean that the hotels are safe. No. Hotels are just safer than they would be on the street. Compared to the risk of "abject homelessness" – literally sleeping on the street, camping out under a bridge, or sleeping in a car, the daily rent hotels are imminently safer for women. They offer women a measure of safety from attack and robbery because they conceivably provide a door that a woman can lock, and bathrooms with showers which offer women sex workers the opportunity to clean up and negotiate better paying dates.

Another study tried to examine the relationship between residential transience – moving- and risk for IPV (intimate partner violence) prospectively. This is an epidemiological method that tries to "see what happens" rather than to measure what already happened in the past. They found IPV increased if women moved, but could not determine which came first the violence or the move. Oddly, they recommend screening women for transience as a proxy for violence, because it is easier data to collect, even without a clear understanding of its meaning once collected. [156]

> CONCLUSIONS: The apparent increase in IPV risk after residential change may be a marker of a pre-existing problem or a precursor of subsequent problems. Unlike past research that has considered residential change after abuse or as a simultaneous

155 Kushel, M.B., et al. (2003) No door to lock: victimization among homeless and marginally housed persons. Arch Intern Med 163(20):2492-9.

156 The role of gender and spatial segregation in addressing violence and housing instability among drug using homeless women is further explored in chapter 7.

> exposure, this study focused solely on empirically measuring the risk of IPV after a recent move. This decision has important public health ramifications: determination of IPV exposure is not always possible, whereas soliciting a woman's history of residence may be more feasible. If transience puts a woman at greater risk for victimization by an intimate partner, increased awareness may have a vital role in protecting women who move. [157]

Other evaluative data on the part of San Francisco policy makers also points to not just a place inside, but the type of space inside as a key factor in stabilizing chronically "difficult to house" individuals with co-occurring substance use and mental health problems. One policy maker said to me:

> I am presenting our supportive housing data at a national meeting next week. Here is what I will tell them: 'When we look at our success in keeping housed in our building, what we see is that places like the Marque, which has small, dirty rooms. Case management, but shared bathrooms. The rate of people staying housed there for two years consecutively is 30%. That is horrible. The Zenith, a new building, has case management, same as the Marque. But it is beautiful; every room has its own bathroom. 70% of the tenants stay at least two years." The point is the good stuff is the better investment when it comes to supportive housing. The environment matters. I think it is about trauma. People, who have had so much trauma cannot stabilize, cannot stay housed if they still living in a dump.

Yet another global construct in public health appears to be traveling with epidemiologists from the global South to the inner-city North: "food insecurity." The role of "food insecurity" - what anthropologist often just call "hunger" – has gained momentum as a construct to be measured and assessed among drug using, unstably housed urban poor populations in the United States. This is currently concentrated among especially among HIV infected persons among the US urban poor, perhaps because research in Africa has shown a considerable affect of food insecurity on HIV treatment success and mortality rates.[158] However, pregnant women are also measured for food insecurity in a few studies.

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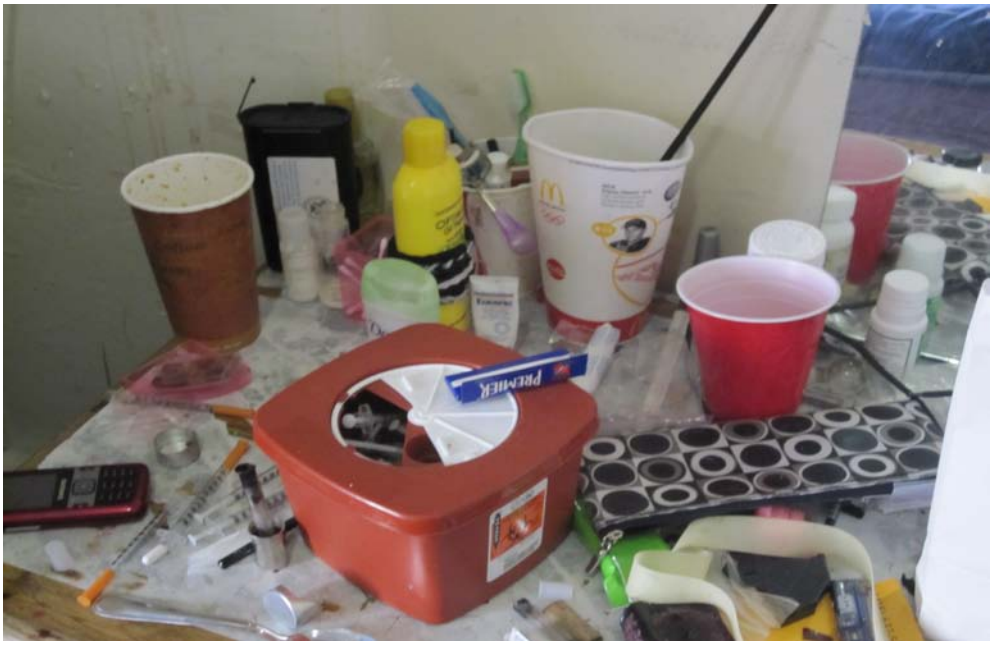
157 Waltermaurer E, McNutt LA, Mattingly MJ. (2006). Examining the effect of residential change on intimate partner violence risk. J Epidemiol Community Health. 60(11):923-7.

158 Weiser SD, Tuller DM, Frongillo EA, Senkungu J, Mukiibi N, Bangsberg DR. (2010) Food insecurity as a barrier to sustained antiretroviral therapy adherence in Uganda. *PLoS One*. 5(4):e10340; Miller CL, Bangsberg DR, Tuller DM, Senkungu J, Kawuma A, Frongillo EA, Weiser SD. (2010) Food Insecurity and Sexual Risk in an HIV Endemic Community in Uganda. *AIDS Behav*. Apr 20. [Epub ahead of print]; 20405316.; Roberts B, Felix Ocaka K, Browne J, Oyok T, Sondorp E. (2009). Factors associated with the health status of internally displaced persons in northern Uganda. *J Epidemiol Community Health*. 63(3):227-32. Kalofonos, I. (2010) "All I Eat is ARVs": Paradoxes of AIDS Treatment Programs in Central Mozambique, *Medical Anthropology Quarterly*, September; 24(3).



Ramona's Room: Cell phone, crack pipe, biohazard bucket and needles. Not much food. Roberts Hotel. August 2009

Research conducted in San Francisco among HIV infected (HIV+) homeless and marginally housed individuals reported that, "among 250 participants, over half (53.6%) were food insecure. Higher odds of food insecurity was associated with being white, low CD4 counts, recent crack use, lack of insurance, and worse physical and mental health."[159] Similar results have been shown among crack smokers who are HIV+ in Atlanta and Miami as well,[160] and among families with young children, especially when the mother is experiencing mental health problems[161]. In a large study of "Prenatal Risk Overview" (PRO) factors that contribute to poor birth outcomes, 1,386 prenatal patients were screened at four community health clinics between November 2005 and April 2007. The results indicate an strong overlap between housing instability, food insecurity, depression, and drug and alcohol use: "The PRO classified 48% at moderate or high risk

159 Weiser SD, Bangsberg DR, Kegeles S, Ragland K, Kushel MB, Frongillo EA. (2009) Food insecurity among homeless and marginally housed individuals living with HIV/AIDS in San Francisco. *AIDS & Behavior* 13(5): 841-8.

160 Vogenthaler NS, Hadley C, Lewis SJ, Rodriguez AE, Metsch LR, Del Rio C. (2010) Food insufficiency among HIV-infected crack-cocaine users in Atlanta and Miami. *Public Health Nutr.* 15:1-7

161 Melchior M, Caspi A, Howard LM, Ambler AP, Bolton H, Mountain N, Moffitt TE. (2009) Mental health context of food insecurity: a representative cohort of families with young children. *Pediatrics.* 124(4):e564-72.

for housing instability; 32% for food insecurity; 75% for lack of social support; 7% for intimate partner violence; 9% for other physical/sexual abuse; 18% for depression; 23% for cigarette use, 23% for alcohol use, and 25% for drug use."[162]

Every ethnographic conversation I conducted with a pregnant addict was prefaced by the offer of food, even if it was just gum. While we also provided food on outreach shifts, I began coming to do fieldwork with tangerines, granola bars, nuts, cookies. Anything I could find that might be easily carried, was placed in my bag with my tape recorder and camera as a headed out for a day of field work, moving with the women from the street, up into their rooms and back out onto the street. My description of the importance of food appeared in a very early field note about an outreach shift:

Outreach **Nisha Hotel** **June, 2007**
We had a feed bag with peanut butter and jelly sandwiches and juice boxes, and chocolate. Ruth told me about how her first thing to try and change in the outreach program was the food that we give out. Then her first night out, when she brought all this health food, and women were like, "I'm coming down (off drugs) and I really need sugar." So she is basically was still trying to figure that out. She told me that kind of was a way of excusing the fact that there's so much sugar in what we give away.

Tylenol advertisement, 16th Street Plaza, April 2008

162 Harrison PA, Sidebottom AC. (2008) Systematic prenatal screening for psychosocial risks. *J Health Care Poor Underserved*. 19(1):258-76.

The above Tylenol advertisement provides a subtle disregard for the degree of food insecurity among people who frequent this corner of 16th and Mission Streets. For Benz, who is 8 months pregnant, making the connection between her hunger, her drug use, and her baby's well-being is a current concern:

Benz Raman Hotel December 2008
Benz is "starving". She asks me for extra food. She is so tiny. Her belly is getting big though. She asks if I want to feel the baby move. I smile; she lifts her shirt a bit. I feel a kick and a roll. "The baby is bouncing around so much today." She tells me. "I haven't even smoked that much (crack)." She takes the prenatal vitamins, and heads back into her room.

The *What to Expect When Your Expecting* website sends me this friendly reminder about eating healthy during pregnancy[163]:

> ## Best Foods to Eat While Pregnant
> *Twelve superstar foods that should headline in your diet*
> At 11 weeks pregnant, these twelve pregnancy power foods pack an amazing amount of nutrients into just a few bites, making them especially effective when efficiency is a priority (as when you're too sick to eat much, when you're gaining weight too fast, or when you're not gaining quickly enough). Put all of the following "it" foods on your A list: (1) Avocados (2) Broccoli (3) Carrots (4) DHA eggs (5) Edamame (6) Lentils (7) Mangoes (8) Nuts (9) Oatmeal (10) Red pepper (11) Spinach (12) Yogurt.

As I opened the email, I reflected. Lexi did order the yoghurt parfait thing at McDonald's once when we were there. Otherwise, I can't recall women in the daily hotels consuming any of this stuff on a regular basis. They can't cook in their rooms and have no refrigeration. That rules out #s 2, 4, 6, 9, 11, and 12. Of course, even without weekly email updates, pregnant women in the 16th/Mission Street corridor get reminders about nutrition during pregnancy. The form it takes is not specific nutritional advice so much as admonishment for not taking responsibility for their children's nutrition, and encouragement to sign up for the federally funded food program. I poster below is one of many directed at poor women in the neighborhood. My interaction with Ramona at the hospital offers a sense of the regularity with which poor women are connected with food securing services.

163 I signed up to the website by entering a date of my last menstrual period. I wanted to see how the email monitoring of a digitally-connected, middle class professional's pregnancy would compare to the pregnant addicts renting rooms in the daily-rent hotels.

Poster by the Women Infants and Children (WIC) Program reads "Everything comes with nutritional information. Except her." Daily rent hotel window can be seen above the billboard. 16th Street, August, 2009.

NICU (Neonatal ICU) w/ Ramona December 2009

At one point Ramona disappeared from the hospital and left me with her newborn son for about 30 minutes. I thought she was out smoking a cigarette. Things are really charged and tense between her and Duke today. I thought maybe they were fighting out of earshot from me and the nurses on the ward. I rock the baby back and forth, singing softly, watching him sleep. At one point the nurse comes over to give him his injection, part of his detox off the methadone. She inserts the needle into the splinted IV. He doesn't wake for it.

Ramona finally returns with a handful of paperwork. "Sorry. I tried to text you, but my cell wouldn't work. I had to get my WIC stuff together, so the baby will be set when he leaves. I didn't have the right form and took forever. How is he doing?" She asks a bit anxiously. I hand him carefully to Ramona. Carefully because he is attached to the DOT wire that monitors his infant abstinence withdrawal symptoms. "He has been sleeping the whole time. The nurse gave him his shot." I tell her reassuringly. "He is so beautiful." I add. "Yeah," She sighs, smiling. She sits with him, totally absorbed for the moment. I step away from them into the hallway to give her some time with her son.

Convenience store across from the public hospital advertising WIC and Wonder Bread.
Mission District December 2009

When all factors are taken together in the epidemiological research - pregnancy, drug use, mental illness, and sex work - it appears that cumulative vulnerability is the hallmark of disease. This abstract describes the point aptly and calls for further attempts "identify and address" the plethora of health and mental problems that are consistently co-occurring:

> Results suggest that as many as one-in-five pregnant heroin- or cocaine-dependent women in treatment have one or more STIs (Sexually Transmitted Infections) that are concurrent with their pregnancy and may contribute to risk for contracting HIV and pregnancy complications; psychiatric co-morbidity and/or sex trade were associated with greater STI risk. Findings underscore the importance of identifying and addressing co-morbid psychiatric disorders and sex trade behaviour in this population.[164]

So what does everyday life look like for unstably housed women who careen across multiple risk categorizations and present with frequent mental and physical health crises? I began to focus on the lives of pregnant addicts in my ethnography for two

164 Cavanaugh, CE ; Hedden, SL; Latimer, WW. (2010) Sexually transmitted infections among pregnant heroin- or cocaine-addicted women in treatment: the significance of psychiatric co-morbidity and sex trade. *Int J STD AIDS* 21: 141 - 142.

reasons. First, pregnancies overlay an external, progressive and time-constrained crisis on the everyday lives on women in the daily rent hotels. Every day becomes one day closer to an inevitable interface with institutional forms of public health governance. I wondered what those interfaces might look like and how women's everyday would be affected and/or unaffected by them. Second, the outcomes of the pregnancies became intertwined directly with housing. If women interfaced "successfully" they could enter residential drug treatment. If they managed to avoid the Child Protective Services (CPS) apparatus – nearly impossible – they could end up more unstably housed because the private daily-rent hotels did not want them there with their babies. The next section describes the rates of pregnancy among homeless women, the number of pregnant women I encountered, and the complex relationship between being pregnant, being housed, and being able to mother.

VIII. Pregnancy (yes) and motherhood (no)

In the introduction of the epidemiological study entitled *Homeless Women: Who is Really at Risk for Unintended Pregnancy?* Gelberg et al. (2008) discuss the risk of pregnancy among homeless women. Gelberg and the associated groups of researchers at UCLA is critically engaged in trying to explore the different modalities of "homelessness" and how it might relate to reproductive health problems and risks of violence of unstably housed women. They produce some of the most thoughtful epidemiological literature on the subject. They open this paper with following statement:

> Homeless women are a high risk group for unintended pregnancy. At any given time, approximately 10% of homeless women are pregnant [Herdon, et al. 2003], a rate twice that of US women of reproductive age, and significantly higher than that of low-income women who are not homeless [Bassuk et al 1996; Bassuk et al, 1996; Robrecht and Anderson 1998]. One recent study found that nearly three-fourths (73%) of pregnancies among homeless women were unintended at the time of conception [Gelberg et al. 2003][165]

165 Gelberg et al. (2008) Homeless Women: Who is Really at Risk for Unintended Pregnancy? *Matern Child Health J.* 12:52-60.

Reading this got me curious. I referred to the table I had been plotting out during my field work. What do my numbers look like? Let's see, I have been tracking about 55 women who regularly circulate in the daily-rent hotels and on the streets in the 16th and Mission Corridor. Some women are post menopausal, several more have disclosed past sterilization to me, five are preoperative transwomen, a handful are lesbian women not having sex with men. So let's knock the number down to 40. *At Any Given time*. OK, let's say the year 2009. In 2009, there were 9 pregnancies that I documented among women living in the hotels. 23%. This is more than twice the 10% listed in Gelberg's introduction above, begging the question: What is going on in the daily rent hotels?

Numbers certainly won't tell the story for me, and they are not my evidentiary modality of choice. Yet, it disconcerting that my instinct was numerically correct. As I continued to see women disclose their pregnancies to me, I found myself saying, "There are a lot of women getting pregnant around here." Among 19 women, there were 21 pregnancies between 2007-2009.

Pregnancy Table 2007-2009

Pseudonym	Race/E	Age	Year	Planned
Ramona	Lat	30s	2007	No
Ramona	Lat	30s	2009	No
Kitt	AA	30s	2007	No
Marta	W	20s	2008	??
Cupcake	W	30s	2008	Yes
Tara	W	20s	2008	??
Scoop	Lat	20s	2008	No
Dylan	W	20s	2009	No
Benz	AA	20s	2009	No
Anita	Lat	30s	2007	No
Anita	Lat	30s	2009	No
Rocky	Lat	20s	2009	No
Lexi	AA	30s	2009	No
Marlena	AA	30s	2009	No
Bella	AA	20s	2009	No
Danell	AA	20s	2009	No
River	W	20s	2007	??
Monique	AA	20s	2007	No
Rebecca	W	20s	2008	No
Luisa	Lat	30s	2008	No
Noah	W	20s	2007	No

The relationship between women's housing status in the daily-rent hotels and their pregnancy changed throughout the course of her pregnancy. Benz had an

excellent relationship with management in the Raman hotel, to the extent that she did some part-time desk work for them (gate keeping) and gave the management advice on how they should let rent rooms and who they should disallow. Even so, she was clearly told by the management that she needed to find another housing arrangement once the baby was born. She had few choices other than to join residential treatment program, which she did after he husband was incarcerated.

A program manager described to me a client of hers. This client, unlike Benz, was active and successful in her outpatient drug treatment program. This made her a poor match for the residential program, but likely to attract CPS attention because of her housing instability. The program manager told me:

> This woman, she is an example of *doing everything right,* she has everything going for her. She has a relationship with a partner he *has a job,* and is looking to get an apartment for them when the baby is born. She has been on methadone for 8 months, all clean urines. She just can't find a place to live. She will probably get a CPS case when the baby is born because she is homeless. Right now she is staying in her partner's hotel room, but she isn't supposed to be there so she has to sneak around.
> "What about residential treatment?" I ask
> "She isn't indicted for residential treatment. She is doing great. She doesn't need 24 hour support and supervision. And when you join residential you can't speak to anyone or see anyone for 30 days. That would not be good for her. She has support. She comes to all her meetings. She is doing everything like she is supposed to. I can't just call the residential program and say "she doesn't really need residential, what she needs is a place to live."

Taken together, it appears that women who are engaged in non-residential treatment may not be able to secure stable housing. Women who are willing to or indicted for (forced into) residential treatment have to endure long delays and oversight in order to regain custody of their newborns. Women who are housed in the daily rent hotels are discouraged to bring their infants there. Rocky provides another example. When I show up at the Raman one night in April 2009, I am surprised to see her. She went to *Next Steps* in January after her baby was born. "Yeah, I am back." She says to me. "I had my son." She shows me the picture, proud and smiling. I congratulate her. "They [*Next Steps*] know I am out here. I called them. They know where I am. They know I am

coming back. I just needed a break." After several months, Rocky had still not returned. If she does not return to treatment she will loose her son. There is no other housing for her.

The 16th and Mission Street Corridor is a site where multiple economies and politics overlay and intersect. Hipster young adults ride a wave of gentrification which began in earnest during the early 2000s dot-com period. Immigrant families work and attend church, and their children go to school, on the same blocks where drug dealers and sex workers are hustling. Middle class commuters regularly pass by pregnant addicts – or their representation in public art form – on their way to and from work in downtown San Francisco. Intensified policing clears the streets temporarily until they refill as sex workers and their paying customer spill back out of the daily-rent hotels when the "blue ghosts" have moved on to haunt another block.

Through info-vulturing in the daily-rent hotels, I was able to see and subsequently make visible the everyday struggles of pregnant addicts as they enfolded before me. Residential transience and food insecurity are two embodied experiences which create disruption, stress, anxiety, and suffering among women who live and work in the daily-rent hotels. Privately managed hotels profit indirectly off of these forms of destabilization. These hotels also engage in specific forms of gendered economic exploitation to directly profit off women involved in sex exchange. All these factors increase women's risk for poor health. Pregnant addicts are placed at increased vulnerability because while pregnancy in tolerated within the daily-rent hotels, bringing children home from the hospital (should a woman maintain custody) is discouraged. Imagining the "SRO" or "homelessness" as they are currently categorized in the majority of epidemiological studies does not capture the complexity of the social worlds that exist within these housing situations. In the next chapter, I will closely examine how the

multiple temporalities that characterize the lives of pregnant addicts further complicate the production of evidence about them for anthropology, epidemiology, and policy.

Chapter 5 Past-future-present

I. Introducing time

Johannes Fabian argued against a "schizogenic" notion of time, one which favors physical time - time as linear, topological progression – in order to mask the importance of the intersubjective power relations at work in the present[166]. These power relations are essential in the cultural work of time-making, because they reveal, through the production of discourse, "the specific way in which actors create and produce beliefs, values, and other means of social life."[167] Fabian's call for attention to the way in which social life is discursively constructed in the present offers an intellectual frame for this chapter.

The relevance of time in relation to modes of evidence production is at issue in this ethnography. I present the multiple temporalities at work in evidence production about pregnant addicts in order to highlight how the present is imbued with future projections (the chance of motherhood, a future baby born tox-negative) and haunted by past ghosts (traumatic childhoods, years of addiction). Social legibility from governmental institutions, which grants material support and service acquisition, is determined by "time served" in treatment and "time clean" while pregnant. In clinical settings, mental illness diagnoses are determined by sets of *current* symptoms which may or may not effectively match onto to time-defined diagnostic criteria made statistically valid through the use of DSM categorizations. For epidemiologic purposes, behaviors within the last 3, 6, and 12 months are statistically analyzed. Ethnographic narratives which produce evidence about past and current experiences of pregnant drug using women stop and start time according to "what happened." The "ethnographic

166 Johannes Fabian (1983) *Time and the Other: How Anthropology Makes Its Object*. New York: Columbia University Press. Page 21.

167 Fabian, J. (1983) *Time and the Other: How Anthropology Makes Its Object*. Page 24.

present" is constructed through witnessing, and making editorial judgments that answer questions about what "times" matter and why.

This chapter addresses the multiple temporalities that bear weight upon pregnant addict's daily life, self care, and interactions with institutions. I question about whether debates about the categorization of the homeless (as mentally ill or addicted) might be better unpacked through a consideration of multiple temporalities. I describe the multiple temporalities that constructed, controlled, and gave meaning to the pregnant women I encountered: addict time, hotel time, pregnancy time, jail time, treatment time, life time and epi-time. I explore the relationship between multiple temporalities for women's meaning-making about their roles as mothers in their everyday lives and for the technocratic adjudication of their mothering potential. Trauma - as rumor, historic event(s), and current influence - is ever present here. Finally, I attempt to outline my own ethnographic present and presence.

II. Not "who is she?" but "when is she…due?"

> Identity acts in man's mind like the deforming mirrors which bewilder passersby in arcades. We must now study the notion of time. Only this can give a measure of coherence to the mass of observations we have lying before us.[168]

Shifting the question from "who" to "when" it is deliberate provocation meant to unhinge some of the bitter pronouncements about the categorization of the homeless as mentally ill or not mentally ill, addicted or not addicted found in many social scientific studies. I initially had trouble locating my irritation with many of the adamant claims that the majority of the homeless are not in fact mentally ill (Snow et al.). Or if they are mentally ill it is certainly because they are made so by shelter workers who transform their poverty into illness (Lyon-Callo, Marvasti). Or that they have to lie about their diagnoses to gain sympathy even though they may or may not be traumatized (Bourgois

168 Leenhardt, M. 1979 (1947). *Do Kamo. Person and Myth in the Melanesian World.* Chicago & London: University of Chicago Press, Page 74.

and Schonberg). Or that the construction of mental illness among the homeless is so politically contingent that notions like “mental illness” and “addiction” might not have utility beyond the bureaucratic control of socially undesirable people (Weinberg). My irritation was not one of disagreement with these studies, I respect them all and the interventions they are making. Rather, it was with the either/or perspective they seemed to feel they needed to settle upon and defend. Either the homeless are being labeled (incorrectly) as mentally ill or they are not. The question always seemed to return to the validity of claims about “who.” Who are they - really?

Leenhardt’s unblinking acceptance of alterity, and its translation, offers a refreshing perspective. In describing the social realities of the Canaque, Leenhardt took as his starting point an open view toward the otherness of experience, its institutional transformations through colonial encounters with Western, Christian views of identity, rationality, and the self in a social world. I do not propose to have achieved such a comprehensive description here. Yet, ethnographic attention upon temporal constraints can help explain why the pregnant women that I encountered were sometimes crazy, sometimes lucid, often depending on the pressures of temporally bound social circumstances. Rather than play pop psychologist seeking to diagnosis women, or deny that crazy things were being said and done by and to women in my ethnography, I began to pay attention to time. How indeed could I make any sense of the “mass of observations in front of me” without describing the quintessential connection between exercises of making temporality rational – of “sense” making on the part of pregnant addicts about their past-future-present. Evidentiary bureaucratic forms seek to confine “who” these women are in order to suggest “what” should be done about their reproduction.

Lastly, the attribution of time is "the measure of coherence" for mental health diagnoses as they travel from symptoms experienced to medically legitimated facts to financially reimbursable forms of social recognition. So to with addiction. "Clean time", matters. Whether an addiction is interpolated as "severe" or "mild" is based largely on frequency and duration of drug use. As one therapist who has over a decade of experience working with homeless, drug using women said to me when I questioned her about the rise of bipolar disorder diagnoses among drug using women, "[The bipolar diagnosis] is mainly a way to get benefits. And really, when is the up (the manic side of bipolar disorder)? I never see the up side with these women. When are they up? Is there an "up" or is that just the drugs?"

Tanya Luhrmann offers a perspective on homeless women's ability to narrate their own lives. She claims that women's descriptions of their history (the past) and their current situations (their present) have narrative holes. Pieces of the story are missing as the cumulative result of years of drug use, perhaps mental illness, and the repeated experience of "social defeat" on the streets.[169] When I interviewed Cupcake during her third pregnancy in 2009, she reflected these same sentiments. I asked about her childhood and she told me "I can't remember too much. I moved so often between the (foster) homes and the juves [institutions for juvenile offenders and runaways]. I couldn't even tell you all the places I have been, the when and the where of it. I was a bad kid, and I got in trouble a lot."

Ramona provided a counter point to a lack of access to memory. During her intake with a counselor she was given a health history, during which she lied, knowingly. She dismissively answered yes to a series of psychiatric symptoms by impatiently saying "Yes. Yes. Yes to all of it!" When the counselor left the room, Ramona turns to me and

169 Luhrmann, TM. (2007) Social defeat and the culture of chronicity: Or, why schizophrenia does so well over there and so badly here. *Culture, Medicine and Psychiatry* 31: 135–172

smiling she says, “Whatever it takes to move things along.” The temporal referent for this interaction with an in-take counselor is the burden of answering a laundry list of questions. It differs significantly from Ramona’s discussion of “her history” being used as a weapon against her gaining custody of her newborn baby (see below). With the in-take counselor the temporal pressures of “treatment time” are in play. Ramona understands the demands of this routine. Answering yes to the majority of the symptoms might translate into benefits or services at a later point. Or maybe it will just get her quicker to her dose of methadone which is why she is there. Then she can go visit her son in the hospital. This classic neurocratic encounter mirrored what Sue Estroff documented so expertly in her ethnography *Making it Crazy*: being “crazy” in one interaction may be beneficial, even necessary.[170]

By exploring multiple temporalities I hope to fill in the picture of what the women were experiencing when many things appear to be happening *at the same time*. I wondered in what ways the everyday physical realities (of hunger, drug withdrawal, pregnancy), the social interactions, and the institutional involvements pulled women into and out of different temporalities -- “times” that forced divergent demands upon them. Most importantly for pregnant addicts, the time is ticking as she moves ever closer to her due date, the birth of her child, and an inevitable collision with institutions of governance.

III. Multiple temporalities

“Addict time”

Addict time is the hourly repetitious cycle of “seeking and scoring” behaviors to access and use drugs of addiction. Every day is essentially the same from the perspective of addict time, paradoxically characterized by crisis (withdrawal) and monotony (seek, score, repeat). Philippe Bourgois and Jeff Schonberg’s ethnography of

170 Estroff, Sue E. (1981) *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community*. Berkeley: University of California Press.

homeless heroin addicts in San Francisco took place over a ten year period. They were able, through this *longue duree* analysis, to observe of the passing of years on informants' reconstructions of their history and current drug use practices. One field note, by Schonberg, captured my attention. Its brief description captures both the ethnographic outsider's experience of the redundancy and monotony of studying addicts and the way in which history intrudes into the addicted present.

> "I've been away for three months and, as usual, nothing whatsoever has changed in the Edgewater scene. Crater and Tina are about to smoke crack…Tina excitedly grabs a large, plastic garbage bag and begins pulling out dolls retrieved from the out factory's dumpster. They are, with one exception, all black, and Tina has christened them with the names of her daughters."
>
> Jeff's Fieldnotes, *Righteous Dopefiend*, Page 206.[171]

My ethnographic experience with actively drug using women also reflected the sense of endless repetition alluded to by Schonberg. Every return to the hotels found women perpetually seeking and scoring drugs. My observations of these behaviors were not accompanied by narratives about attempts to reduce or regulate drug consumption on the part of most women. For example, I completed a long interview with Ramona in 2009 two days after see had left a residential treatment program when 5.5 months pregnant. In the interview she discussed "not being ready" to stay in the residential program. She adamantly insisted that her use of crack cocaine was "purely psychological" and that she could stop at any time. "If I am want to get high, I am going to get high." She said. "It is that simple." Yet, as I watch her leave my car and immediately spend the money I have given her to complete the interview[172], she does not appear to causally *choosing* to smoke crack on that occasion. She is jonesing for crack the minute the money hits her hand. She is yelling at a dealer up the street "I told you I would get it, now hold on!!" He walks away and she is pissed. She approaches

171 Bourgois, P. and Schonberg, J. (2009) *Righteous Dopefiend*. University of California Press.

172 See Chapter 4. I was able through partial support by an ethnographic study of women, housing, and HIV risk to compensate women for longer, life history oriented interviews. Women were given $20 for a completed, taped interview. No monetary incentives were offered for participant observation activities.

another guy, buys the crack and we head upstairs. Back in her room at the Chandra Hotel, Ramona prepares her crack. She rests her spoon is a USCF study flyer for the women's health study I worked for during the time of my ethnographic fieldwork. The flyer was given to her the previous evening (not by me, but another staff person) in hopes of recruiting her into a study about victimization, HIV risk, and housing instability. Ramona, captured at this moment, is not in "epidemiological time." She is arguable unable and definitely uninterested in discussing her drug use behaviors in survey-friendly language. Instead, she wants me to document her into a future imaginary. She invites me to record her progression from this moment of addiction and pregnancy into a future moment of recovery and motherhood: "You can video the whole thing, Kelly. You can tell the story of me and this baby, follow me when I go back into treatment. Watch me get out of this mess."

Ramona preparing to cook her crack before smoking it. Chandra Hotel, August 2009.

Self proclaimed recovering addicts describe "being in my addiction" as a temporal location, a time in which drug seeking and consumption trumped all other

concerns. The power of addict time – the ability of an addiction to distract people away from services that are perceived to help them, was reiterated multiple times by health care providers I interviewed, specifically in relation to pregnancy and mothering among drug using women. It was also the most frequent form of excuse provided by epidemiological survey workers for why participants fail to show up for service appointments at the assigned time: "The drugs got in the way." Read this statement as "the drugs control the time." One health care provider who works regularly with addicted homeless women described the how pregnant addicts who may even be trying not to use drugs have their "time taken away," when they get caught up on the street, pulled back into smoking crack. Cupcake described her new found sobriety from crack in terms of time during her third pregnancy. "I got my time back. I can go to the movies, I can just enjoy life. I *see* things now that I never had time to see before when I was always running around. Always crazy. Never stopping."

Those who serve addict time are also bound by its temporal constraints. Dealers, runners, and other go-betweens lose profit if they are not available to the people seeking their product. Two women I encountered in 2007 explicated this point. The first was a woman with an enormous abscess in the Raman Hotel. She had a high fever and was suffering, but she did not want to go to the hospital. When I questioned her about why she remarked, "If I go to the hospital they will admit me. I am looking a two days at least on an (antibiotic) drip in the bed. I know the drill. If I leave for two days, who is going to move all my stuff (drugs)? I have a lot to move and who is gonna move it when I am in the hospital?" Another woman, a young pregnant dealer whom I knew briefly over a couple of weeks in 2007, was funny and sarcastic with me about going to *Women's Space* on a Thursday night: "Yeah, sure. Maybe I can take some time for off for that."

I am not introducing the notion of "addict time" as a fixed temporal category. Rather, I point to how addiction is documented and experienced in ethnographies of drug users which do not take place in drug treatment facilities, or other institutional settings. The governing limitations of these settings which in effect seek to disrupt or stop "addict time," mask the reality of its temporal constraints on the lives of those who are dependent on substances. Indeed, many recovery programs promote the management of "environmental triggers" known as "people, places or things" which will pull the user struggling with abstinence from drugs or alcohol back into "addict time"- an endless, repetitive cycle of scarcity and (temporary) satisfaction.

"Hotel time"

Hotel time is also daily. It starts at 10 am when a woman can pay from $35-60 for a room in a private daily-rent hotel, and continues until morning check-out, when the same amount must be garnered for the next evening's stay inside. Hotel time also operates on a monthly cycle in that tenants are forcibly evicted prior to 28 consecutive days in a hotel to deny them tenancy rights. Next to addict time, hotel time is the single most frenzy-producing temporality women must respond to on a daily basis. The pressure of hotel time was constant. Women, rarely choosing to stay in shelters for extended periods, or even for one night, were bound by hotel time. Lexi described multiple instances of working late into the night until she could finally earn enough for a room. In this way, addict time and hotel time are co-constitutive. If you are in one temporality you are often stuck in the other as well.

The political economy of entitlements plays a key role in who suffers the ill effects of hotel time. However, the story was not a straightforward one, such as 'having benefits equaled protection from exploitation." Like most daily realities around Mission and 16th, no institutional intervention, whether potentially protective (such as entitlements) or structurally violent (such as police harassment), could completely

explain women's experiences. For example, SSI entitlement access and the disruption of hotel time worked in such a way that the only people who were stable – not evicted monthly and who got a monthly rent charge (as opposed to a daily charge), were on SSI. But, not all people on SSI were paying monthly. Which presented a puzzling conundrum. One the one hand, most drug users that I have encountered do attempt at various points to access SSI benefits. Many are denied, sometimes for years. But the official position of the city-government is to facilitate their move, when medically indicated, from the city and state welfare roles (General Assistance) onto the federal welfare ticket[173]. It would seem according to these logics that most women would be receiving SSI, and that all those who were receiving SSI would secure monthly rent rates. This was not the case. In part because living in addict-time often precluded the ability to negotiate these more stable housing arrangements for women.

The illogic of the decision to continue to make addicts pay for daily hotels perplexes me. Take Ramona's situation. She has been in SSI for several years, due to health conditions. She has never had a monthly deal with a hotel. When she was offered a SSI-subsidized room in an SRO where she could return with her newborn, in a hotel that is full of working poor mothers with young children, not drug users and sex workers, she didn't take it. Is it because she wasn't ready to quit using? Perhaps. But she offered another explanation: she resented the hotel taking part of her SSI benefits. For a private hotel it is not a small part, either. While publicly supported SROs can only take 30% of a person's income, the private hotels take about $650 a month, closer to 60-75% of the SSI-supported monthly income. There isn't a lot of money left over for drugs or food, or anything else at that point. But if she doesn't have a monthly rent deal she pays $1000-1800 for the same room. It doesn't make a lot of sense. And the result of

173 The complex machinations of SSI eligibility and assessment are discussed in detail in Chapter 6.

paying daily is more hustling, more sex work to pay not only for the hotel but also the drugs and food. And it is everyday, all day.

It was under the constraints of addict and hotel time that women found themselves to be pregnant. The vast majority of the women who became pregnant during my ethnography, did not become so intentionally. Instead, the discovery of a pregnancy introduced an additional temporal mode upon those already in play.

"Pregnancy time"

Pregnancy time is nine months, split by trimester. Pregnant women who are homeless and using drugs became biomedical time bombs once they discovered their pregnancy. Time starts to work backwards from projected due date. Women ask themselves: How much time can I keep using before I have to stop? When will it be obvious to others that I am pregnant? How much, and of what substance, is too much? For how long?

Pregnancy diagnosis puts women on a train, whether it will end up in a wreck or arrive at the station unscathed and on time is unknown and highly contingent. However, the clock is ticking and it will end - one way or another. Kitt's 2007 pregnancy was stopped by her decision to have an abortion at 20 weeks. For Cupcake in 2008, an ultrasound at 6 months revealed that her "fetus" was actually only a mass of cells. The baby had not materialized and the pregnancy was terminated with a D&C. Tara's pregnancy ended in late miscarriage at 5.5 months, rumored to be the result of a violent fight between her and her boyfriend. He disapproved of her drinking at the bar while pregnant.

The train/train wreck metaphor of pregnancy time could not have been more clearly embodied than in Lexi's case. Knowing Lexi prior to my ethnographic work, and having known her pregnancy history, made me sensitive to the particular medical issues she faced. Because her cervix had opened mid-pregnancy in 2004 leading to the death

of her baby, we both knew that her pregnancy time probably stopped around 6.5 months. While other women like Dylan, Ramona, Danell, Anita and Benz were able to ride out pregnancy time – still using until late in their pregnancies (7-9 months) -- Lexi was on another schedule. No amount of prodding by me seemed to help Lexi get to prenatal care. She did not want her methadone program to know about her pregnancy, for fear they would place her on pregnancy-linked treatment slot which would cause her to lose her methadone if she lost her baby. A repeat of her experience in 2004. Throughout her pregnancy Lexi vacillated between concern and ambivalence about her pregnancy, with the demand of pregnancy in competition with the demands of drug and alcohol addiction: addict time verses pregnancy time.

One provider conveyed to me the two typical types of drug using women who enter the methadone treatment program. First, there are women whose pregnancy serves as "a wake-up call." These women tend to come into treatment earlier in their pregnancies, or when then first find out. Many heroin using women do not menstruate, or at least not regularly[174], so detection of pregnancy through that traditional means is not available to them. They often discover pregnancy when other more advanced symptoms appear. Regardless, women in this first "group" (according to the provider), become future oriented immediately. Pregnancy time becomes a clock ticking toward a better future, a chance. There is a second group of women, according to the provider, who wait. "They are in denial about the pregnancy. They are using throughout their whole pregnancies." Even as their bodies swell, and other women began to ask about them, they continue with their everyday life, to the extent possible, as if they were not pregnant.

174 Gaulden, EC; Littlefield DC, Putoff, OE, Sievert, AL. (1964). Menstrual abnormalities associated with heroin addiction. *American Journal of Obstetrics and Gynecology*. 90:155-160.

I can recall an interaction with Ramona on the street in front of her hotel. She was seven months pregnant and we were having a debate about whether the hotel she lived in was an SRO or not. A woman came by, someone Ramona knew, but I didn't. She stopped, looked at Ramona's stomach and said "Oh! Are you pregnant?" "No." said Ramona flatly, and stared her down. "But…" the women trailed off. "Oh I just thought…" "Well you thought wrong." Ramona corrected abruptly. This was patently absurd. Ramona was hugely pregnant. Is this an example of the denial, the provider described? Ramona fits the provider's behavioral profile, but her social negotiations on the street are actively protective. When the woman left, I asked, "You didn't want her to know?" "No. Way." She responds. "I don't need her up in my business. Why does she need to know? What good would that do? I don't want no one knowing out here." I witnessed many such public denials, and a general lack of discussion about pregnancy, even among women, such as Dylan, who were hugely pregnant and still hustling on the street days before their babies were born. These denials and omissions allowed women to adequately respond to the demands of addict and hotel time while avoiding acquaintance's intersubjective involvement in their futures, whether they might judge her or wish her well.

"Jail time"

"Jail time" came to women in multiple ways. All the pregnant women that I worked with had interactions with the police over the course of my ethnography. Indeed, the years 2007-2010 marked a period in which the local police chief was replaced by one who targeted "drugs and prostitution" as his main areas of focused resourcing.[175]

Kitt described to me her experience of her time inside jail and her time outside of jail as a way to talk more broadly about her family history, her feelings of failure as a mother, her rage over her life on the street and her drug use. During this extended

175 Patrick Kolman. New Police Chief Targets Drugs and Prostitution. *Mission Loc@l*. December 15, 2009.

conversation she came to represent herself in multiple temporalities – through jail time, and as different people, some of whom can not make an appearance on the street.

Kitt September, 2008

When I am walking down Mission Street, I catch up with Kitt. "How have you been? I haven't seen you for a while."
"I was in jail. I caught a case. Now I am back and my lip is fucked up. It won't heal right. Look at it. Do you think its staph?"

I take a look. Her upper lip is split and swollen. It looks like it might have scabbed over and then she picked it open again. "I don't know. I am not a doctor. I don't think so. But you should go have it looked at if you are worried."

"Yeah." A woman who has walked up to us agrees. "Staph don't do that. Staph's all over."

"I can feel something moving in there. Side to side. Like a worm. It is like there is something in there. Do you think there is, or am I just trippin'?" she asks.

"You might be just trippin. I don't know. I am not a doctor." I say looking at it.

"What happened?" I ask.

"Some girl punched me, split my lip, over some dope. It was payback." She states matter-a-factly.

The next day, I see Kitt again. She says "I went to the doctor, like you said. They told me is was *nothin.* They didn't even give me any cream or anything. They just thought I was a crack head. I spend a bunch a time in the ER for nothin'."

We sit down to talk.

"The thing is," she says, sighing. "I have outgrown it out here. I don't know why I came back. I was in a treatment program in jail. I asked to be in it. I volunteered. And it was good, and when I got out I went to a residential, but I only stayed a night. And I came back out here and I got caught up. I am mad at myself. I am kind of punishing myself for being back out here, you know. And my self esteem is pretty low right now."

Kitt starts crying.

"Where else could you go?" I ask.

"Well, that's the thing. I get lonely. I mean I still got my family. But I feel like if I can't do right by my kids. I got four kids. If I can't do it right with them, then I can't do it at all. I can't go home."

"And it is harder now. I want to do a swap for [jail]time, but I have to have a stable residence to do it. It's hard to prove that. And everyday I am out here I am just uppin' my chances of getting another case, of getting violated. I just did my first date in a week out here last night because I was hoping not to go that route. I have a lot of anger, at these men coming at me with $20 dollars and $10. Because it is so low and I know I am worth more than that. And these white girls out here. It is so much easier for them to get dates."

"Why do you say that?" I ask.
"It's just society. The other day, I am out, and I think I am looking good, I am dressed, you know, dressed up. And this car pulls up and there is a white girl, dirty all curled up in a blanket. And he

goes with her, because she's a white girl. And she is all strung out and not charging nothin'. I'm just, I am too old for this shit."

March 2009, Kitt is back in jail. Back out and then in again in September 2009.

Kitt was a woman who was wholly unsuccessful at avoiding jail time. Perhaps her explanation of her positive experience with treatment in jail provides some explanation for this. Or perhaps the massive increased presence of the police on street, targeting sex workers and drug dealers in the Mission. Kitt's ethnicity plays a role: because she is black she can't get easy dates so perhaps she is taking more risk, which makes her more vulnerable to arrest. Or her violence. Kitt is someone who people pay to beat on other people that owe them money or have slighted them. Her crack use is in part linked to that social and finally profitable role she occasionally plays. Or that fact that many social services coordinate with the jail, so that arrest becomes a key temporal access point for social services for many drug users. As one senior policy official said to me,"Many women get the mental health screening in jail." Pause and a sigh. "God forbid, but we are actually incarcerating women in order to get them hooked into services. Jail time is one way in." All these factors seem to create a perfect storm of recidivism for Kitt, in which jail time became a significant and determining temporality for her.

At Ramona's post partum intake appointment she is waxing philosophical to her old counselor: "You go through a lot of pain and a lot of sorrow [going through treatment]. But it is worth it in the long run." Her counselor does not reply directly to this emotional-motivational confession. Instead she asks knowingly, "How much jail time did you do this time around [during this pregnancy]?" "Not too much." Says Ramona equivocally, shifting gears. "Maybe a month." "Oh, that's good," said the counselor. The counselor knows jail can lead pregnant addicts directly to the treatment program and this is the narrative she is fleshing out. Ramona provides it. "But that was a couple of months ago. And from there I went to *Next Steps.* You know, I was court ordered.

And, you know, I didn't stay." When I interview a program supervisor in the same program, she mentions to me the relationship they have with the jail. "If a pregnant woman is picked up and suspected to be an opiate user, they [the jail] will call us right away. They don't want them [the pregnant women]. They don't want them to miscarry or to go into labor. They don't want the liability. We get about half of our women through the jails…Sometimes we have wondered when we have a lot of jail referrals if there are changes to arrest rates going on out on the streets or something. We ask, "Why did we get six women from the jails this month, when last month we got none?"

Unlike Kitt and Ramona, Cupcake avidly avoided jail time during her second pregnancy in 2008. She was on probation and staying at Brigit Hotel, paying daily, when she called my cell phone to ask me for a letter. She had been stopped by the police who found condoms in the car. A lot of condoms, hundreds of them. The police wanted to violate her probation, based on the condoms being proof of her engaging in sex work. This is not an outrageous accusation, but appears to be a systematic problem in the interaction between suspected sex workers and the police in San Francisco.[176] If the outreach program could provide a letter saying that we distribute the condoms, then she could bring it to her court date. I refer her to the program and they provide the letter. Although her husband got incarcerated, she did not get a violation on her probation. After the trail she tells me about trying to get a job. "I went to the Salvation Army. The woman there was really nice, but she said, 'It hasn't been enough time. Come back when you have a few more months behind you.' She felt like I hadn't had enough time in my probation. It was too risky for her. I can't get anything [no jobs]! I went to McDonalds, I have been everywhere. And with the baby coming, I just want to get work."

176 Lutnick, A. and Cohan, D (2009) Criminalization, legalization or decriminalization of sex work: what female sex workers say in San Francisco, USA. *Reproductive Health Matters.* 17(34):38–46; Klausner, JD. (2008) Decriminalize prostitution: vote yes on Prop. K. *San Franciso Chronicle*. Sept. 7, 2008.

When I interview Cupcake and her husband (now out of jail) in 2009, she is pregnant again. They tell me the story of the arrest with the condoms. It turns out he was picked up initially for solicitation. He was picking her up and they thought he was a date. Then when the police discovered that Cupcake and him were married (they have the same last name and address on their licenses), they searched the car and found the condoms. Cupcake and her husband tell me this story with laughing disbelief: "How could the cops think I was her date??!" Funny. However, he was, and is, her pimp. And she was doing sex work that day. Because of his long-term involvement of the drug economy, he is too well known to the police in the Mission, and thus a target. He can't circulate outside their hotel room, just walking around else the police might "jack him up" on a violation and he will reincarcerated. Since she can't find a another job, it is easier for Cupcake to make money for them as a sex worker, even risking arrest, than for him to get sent back to jail. Neither if them are using drugs at the moment (November, 2009) – she has stopped smoking crack and he never used ("I am addicted to money" he tells me by way of explanation). They plan to move out of state to get away from the probation violation issues with cops in the Mission, and to avoid Cupcake getting pulled back into addict time. Until they do, her husband is on hotel time and Cupcake is facing jail time.

"Treatment time"

"Treatment time" is highly subjective and operates like a revolving door. Women who are drug using and pregnant can get access to drug treatment programs. Women in my study stayed between one night and 18 months in residential treatment programs. There are transitional programs in which a woman can stay with her newborn. If treatment funding is linked to a pregnancy and the pregnancy is discontinued – through elective abortion or pregnancy loss – the treatment ends as well. In this sense the child is receiving treatment and the mother is not – or at least not without the child to justify

her access. Time served in treatment is also a bench mark for worthy motherhood among drug using women as judged by institutions such as Child Protective Services (CPS) who gain custody of most women's children at birth. Benz stopped and restarted her methadone throughout her pregnancy. One time ending up in hospital gave her the impetus to start again. She often apologized to me about not going to methadone, and made it a point to say that she "needs to get back there" every time we would see each other. On the other hand, her crack use is her self expressed biggest concern when it comes to her baby's well-being. There is not formal treatment for crack addiction that parallels drugs replacement therapy (methadone for heroin). For Benz, the treatment time in methadone offers a way to establish a record of making an effort to reduce or stop her drug use during pregnancy. A record that will be shared with CPS later when her custody is at stake.

For women who delay seeking methadone treatment, it becomes an exercise in "putting out the fire." The goal being getting the women as clean a tox screen as possible and the most social services prior to the baby's birth. One provider told me:

> Pregnancy isn't a long time. It may seem like 9 months is long time. But to get women stabilized on methadone, to get them prenatal care, to deal with their housing issues, get them to sign up for Medical, get a psych evaluation and follow-up if they need it, so they can deliver a baby with only methadone onboard and not get a CPS case? It is rarely enough time. If women arrive to us at 7 and half months, eight months, chances are they have all of the issues that will get you tagged by CPS: they have been using throughout their pregnancy, they might have a severe mental health issue, they are in denial about the pregnancy and they are probably unstably housed. At that point we are just barely able to put out the fire – to get them on methadone and off everything else.

For Ramona, this became her strategy once she was arrested and brought to hospital. She told me:

> The police, they came up to me, and said I looked like someone who had a bench warrant. It was such bullshit. I was just sitting there. But then they took me to the hospital. Because I was pregnant they needed to get me medically cleared first before they could take me to jail. Well they [the hospital staff] admit me. And they put me on methadone. And then after a whole day, like at 2 o'clock in the morning, the cop comes in and I say "What the fuck? Am I going to jail or what?" And he says, "No. You cleared. You cleared like an hour ago. You can go." But see I was already on my way at that

> point. I thought, well if I stay, he will be born clean. I only got like two more days, and his tox will be clean. So I stayed. Went into labor two days later and out he came.

Treatment time is not only determined by pregnant women. One service provider described her unhappiness with a social worker who did not jump to the assistance of a mutual client when the pregnant woman expressed interest in residential treatment. Personality and prejudice inform providers' decisions and their technocratic roles offer them the authority to grant or withhold access to drug treatment. The provider I interviewed was able to override the case manager's authority and get the woman into residential treatment. The story was relayed to me as a cautionary tale: when treatment time comes the door better be left open:

> I had a client who was admitted to the hospital. She was having severe medical complications with her pregnancy and needed to be hospitalized. In the hospital she refused a bunch of tests, they said she stuck out of the hospital to use drugs – which will happen. When I meet with her a month or so later she said she was ready to go to residential. I called the social worker to help facilitate. Her response was "That is a waste of time, she won't go." Well, I followed up. I got her a spot and guess what. She just won custody back of her child, she is doing excellent. She is very happy. It goes to show, you can't give up. Don't write people off. If you keep offering 100 times, maybe the 100th time she will take it.

"Life time"

"Life time" relates to how women talk about childhood memories, addiction and mental health problems in their biological and foster families, and legacies of poor parenting. It also encompasses women's narratives of "the life" – often traumatic and violent stories of involvement in the drug sex economies and multiple parasitic relationships with men.

Stories abound about homeless women's lifetimes of trauma. When Cupcake was describing being unable to remember all of the institutions that she had lived in throughout California during her youth, she also mentioned that her and her brother had been dropped off at CPS by their mother at age 2 (Cupcake) and 6 months. She remembers nothing about her. Dylan, has seen her mother twice in her entire life, she was raised by her grandmother and hit the streets at age 15 when her grandmother died.

Kitt ran away from home after her mother excommunicated her from their church after her pregnancy at age 13 and subsequent abortion. Monica also describes tensions with her mother over Monica experiences of sexual molestation in foster care. Anita blames her grandmother – her father's mother – for the death of one of her children and for her father's overdose death. Crysanne describes her extremely violent partner convincing her to "get out on the streets" while beating her up. She left her children under her mothers care, and never returned to parent them.

One day in April, 2009, I spent the afternoon with Pano and Lexi in their room at the Chandra Hotel. At one point, Lexi left the room to talk to her brother. He had just come out of prison and rented a room next door. This made Lexi uncomfortable. While Lexi is absent Pano told me, "You know Kelly, I know Lexi isn't dumb, but she trusts people. And she shouldn't. They take advantage of her." I am thinking that this is how Lexi sometimes describes how he treats her. Pano went on, "You know the reason why she has the bi-polar? And she should be taking her medication? Because she had a rough road. I know she did. When she was young and her mother made her take care of that baby – she lost her own childhood. She lost her church. She lost everything to what her brother did. And it is just sad." Lexi returned and pano and I stopped discussing Lexi's childhood. Later, n September 2009, Lexi tells me the whole story. When her mother was working during the day, Lexi was responsible for the taking care of the kids. At 16 she was fixing dinner and she went upstairs to find her two brothers naked playing "games" with her nine-year old sister. "They all thought it was funny," she told me. When Lexi and her sister got the physicals for school, they were both given blood tests. Lexi's sister's test came back pregnant. Because Lexi's sister was so young and was impregnated by her brother, Lexi was forced by her mother to claim the baby was hers. She was publicly humiliated when she arrived at church with the new baby and excommunicated. The brother who returned from prison to stay next store,

was the same brother who got Lexi's sister pregnant. In 2009, pregnant herself, Lexi was still nervous about his unpredictable behavior, but forced to take him under her wing.

"Epi time"

"Epi time" is short for epidemiological time, it marks the ways in which study respondents are time-frozen into classifications during statistical research in order to bound and thus compare descriptive categories. Bounding time for generalizablility is the hallmark of validity in statistical research. If persons can be said to have the same reported behaviors within a specific timeframe than they can be given a categorical slot. For example, crack smokers are those individuals who report smoking crack cocaine *in the last thirty days*. If we agree upon that understanding of what a crack smoker is, then we can compare other things about those people we have so named "crack smoker" – their ethnicity, gender, housing status, access to drug treatment, arrest history, and on and on. Notice all of the comparative characteristics also require decisional points about time bounding. Even ethnicity and gender can change in the subjective appellation over time. It is not identifying what is fixed, but rather to making fixed what is not, that epidemiology finds as its challenge. And this is a challenge it takes seriously for the most part. I am not here to mock that exercise. Rather, I place it in conversation with the other temporalities that bear weight upon the everyday experience of pregnant addicts.

As I engaged in multi-methodological research during my project, I was able to experience the demands of the clash of temporalities as an "experience near" event. One example came in a staff meeting discussion about the recruitment of a qualitative interview sample. We had a staff meeting with those persons working on the survey development for the epidemiological measures and those who primarily work on the qualitative study. The problem of temporality came up in the survey measure of victimization. The measure is trying to be comprehensive. For women living in social

worlds in which verbal conflicts and verbal abuse are normative and sexual and physical violence are frequent, how do we measure the "degree" of victimization? A measure of "ever" (as in life time) is ridiculous. 100% say "yes." So what kind of violence really "counts" when violence is normative and instrumentally deployed? How does temporally bounding events of violence help or hurt our understanding of its role in women's health?

Kath Weston, in her interesting and challenging philosophical exploration of gender and time describes the "violence of counting," linked to industrialization, in which "fluid social relations" become fixed and social injustice masked by statistical renderings.

> On the far side of paradox, our time travels open with an investigation into the violence of counting. As industrialization took hold in different areas of the world, an 'avalanche of numbers' generated by shining new bureaucracies promised to tame chance by calculating probabilities. First to be aggregated by these technologies were the landless bodies pouring into the cities from the countryside (Hacking, 1991). The king's subjects, poorhouse residents, and the dead, all sorted into closed categories and counted. In the current era of national-states and transnational corporations, number fetishism continues to lend fluid social relations the appearance of fixity and to cloak unjust social arrangements with an aura of the inevitable.[177]

Let us consider the implications of the imposition of epidemiological time on the direct question of violence: our interpretation of the meaning of the measure of victimization we used in our survey. One the one hand, violence against women is being both dissected and temporalized almost to the point of the ridiculous here. It frustrated all of us, to try and imbue meaning from the measure. On the other hand the measure here is inclusive and broad because of the need to document, to make visible through numbers, the extent and nature of victimization American women were experiencing. Measures such as these have helped pave the way not only to further studies of violence against women, especially violence against women during pregnancy, but also to provide safe housing and social services to respond to this, now visible, social problem. Is this a case of using the master's tools to break down the master's house? We did not make up the measure, it is a "validated" measure used in many studies that

177 Kath Weston (2002) *Gender in Real Time: Power and transience in a visual age*. Routledge. Page 23.

originates from [some famous national study of violence against women, find the cite]. So in an apparent biopolitical bait-and-switch, the violence of counting seems to turn on itself.

And strange things can happen when politics and measurement collide. In the process of the same study, we eventually chose our sample, using a current measure of physical violence which most closely mimicked the lived social realities of many of the women I see ethnographically. Once the interview began, what became clear is that reciprocal violence, and women-initiated violence against male partners, was common. We proposed additional epidemiological questions to "capture" this phenomenon if it existed beyond the scope of the small qualitative sample. Our questions were rejected initially by the university's internal review board because asking women about violence they have committed *within the past 6 months* might incriminate them. Odd, because we have pages of questions on other illegal activities including illegal drug use and sex work.

IV. History

A woman's history precedes her. Of the 21 pregnancies that I followed during my ethnographic field work form 2007-2009, only two women were first time mothers. Most women had a history of many past pregnancies – Dylan had her third child, Kit was pregnant with her sixth, Lexi was pregnant with her third, Anita had her fifth, Cupcake with her third, and Ramona her sixth. The most recent pregnancies that I documented were constructed relative to pregnancies past. Anita may a point of mentioning over and over again that it was not until her father died that she had a baby with a positive tox screen for drugs, her first three were born "clean" even though she had used drugs early in those pregnancies. Cupcake discussed how young, and crack addicted she was when her first two daughters were born.

History plays a role in institutional involvements with women and their babies. Ramona used her jail time to get clean of heroin and crack so only methadone appeared on her son's birth tox screen. She was furious that the CPS worker could use her "history" of child custody loss against her in her current custody case. She relayed her anger to me and her old counselor at her methadone intake appointment:

> Ramona is talking rapid fire, angry and adamant. She is describing to Mary - her old counselor –an argument she had with the CPS case worker who came to the hospital when her son was born a few days earlier.
> "His tox screen was clean! You hear what I am saying? The CPS worker is a straight bitch. She said 'We are going on your history.' That's the only reason why I have a case! His tox screen was clean! '*Your history,'* she said. I mean I had been using up until then [just before his birth], but I knew he would only have methadone. She [the CPS] worker said, 'He can come to see you at *First Steps* in three weeks.'
> I said, 'That is not up to you!'
> She [the CPS worker] said 'Well, that is my recommendation.'
> 'Well I don't give a fuck about your recommendations. So what are you gonna do about that. And stay on up out of my business! And by the way I have custody of my other daughter (DeLoni)."
> She said 'You have custody! What do you mean?'
> I said 'None of your damn business! I don't have a CPS case so you don't need to know about that!'
> Oh, I went off on her bad, Mary." Ramona stops talking for a minute.
>
> The counselor (Mary) asks, "Which CPS worker did you go off on about what kid?" This is damage control. Mary does not recognize the worker's name when Ramona says it.
> "Which kid?" Mary asks again.
> Ramona responds, 'About my son, about the one I just had.'
> "And how old is that baby?" asks Mary – she did not know that Ramona had been pregnant recently, so she is trying to catch up.
> 'Five days old. I just had got discharged yesterday out of the hospital! And DeLoni, remember DeLoni was on six. She was on six DTO (Detoxification Treatment for Opioid dependency).[178] He is only on 2.5. So he is doing really good, you know what I mean? But that [CPS] worker is a straight bitch. How can they go on my *history* when his tox screen was *clean*?"

For the pregnant addicts in this ethnography history played a role in how they perceive themselves as mothers. Decisions about current pregnancies were weighed against the outcomes of past pregnancies. Lexi feared a repeat of her 2004 daughter's death during her 2009 pregnancy. When history did repeat itself, and her baby died in 2009, she got a hysterectomy. Speaking of her living son (age 7) for whom her mother had custody, she said, "I thank God I have one child, I had one child in the past. One I

178 These numbers refer to the scale of the assessment of neonatal abstinence syndrome.

can focus on him, I have one I can still be a mother to." The past can unmake the present and remake the future.

V. The current trauma of past children lost

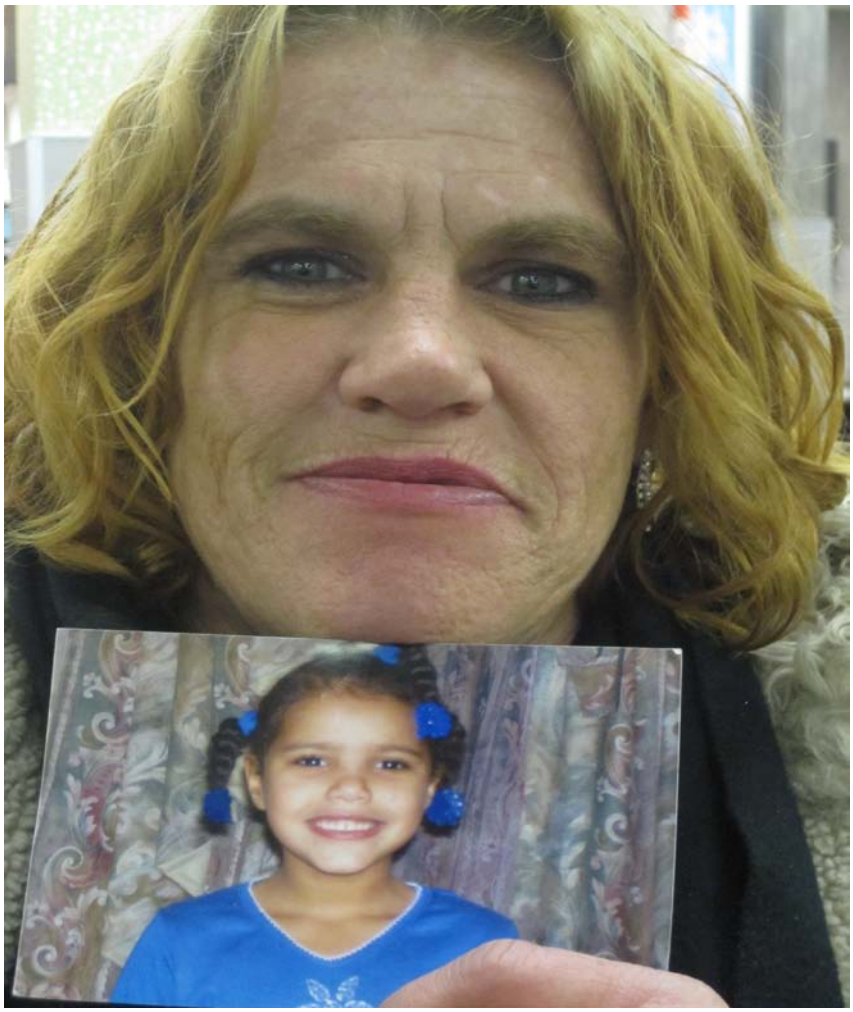
The trauma of the loss of children was so acute in women's lives that many could not to even speak of it. They begin to talk about what happened with the loss of custody and then clam up, or start to cry, before saying "let's talk about something else." The loss of children to the system is the ultimate source of shame, and mark of failure. On-going sex work, drug addiction, arrests, poverty – circumstances that stigmatize drug using women into social death - simply don't compare.

> The tree, planted the day the child is born, in the hole where they bury the umbilical cord, may indeed have a reality similar to the reality of the child's life. The Caledonian custom of sending a stranger away from the village with the words, 'Your Tree is not here," is persuasive evidence that the tree confers social and civic authority on a man.[179]

This passage by Leenhardt caught my attention because of its powerful reference to symbolic children. In Leenhardt's analysis of the social world of the Canaque, trees are not technically a symbol, in the sense of being a representation of the child. The tree is in fact the child himself. And later the man described in the example as either welcome to be present or sent away from a social location based on the reference to the anthropomorphized tree ("Your tree is not here"). The pregnant addicts and drug using mothers I engaged with ethnographically did not consider their mementos of their lost children to be the same as the child him or herself. However, the mementos were very alive material representations of what they could no longer care for – at least during their "addict time." The child who can not be here – right now – *is* very much *here* in the photo. One telling example was provided by Ramona. One our way to the hospital to visit her newborn, prior to checking into residential treatment, we stop at

179 Leenhardt, M. 1979 (1947). *Do Kamo. Person and Myth in the Melanesian World*. Chicago & London: University of Chicago Press. Page 19.

McDonalds. “Take a picture of me and DeLoni” she asks me. I am a bit confused by this request at first. DeLoni isn’t here. Then she pulls out a picture of DeLoni, her daughter now seven years old, who lives with a relative in another part of the state. She holds it very close to her face. “Make sure it is just us.” She says. I take the picture and she wants to see it. I show her and she frowns. “No that is not what I meant. Just us, our faces.” I take another picture. “No that’s not right.” She says viewing the second picture. “I want it to look like she is here. With me.” I finally get it. She wants the picture to create the illusion that her daughter is there in McDonald’s. She wants to document her and her daughter in the same place, *at the same time*. Which they cannot be. “My camera won’t do the trick. I can’t get that close.” I say.



Ramona and DeLoni McDonald’s, Mission Street December 2009

One of my first encounters of living mementos of children lost crystallized its on-going traumatization in the lives of women who carry them. This happened very early on in my fieldwork. I had heard stories, narratives from women, about the experiences of loosing their children and their feelings of failing as mothers, over and over and over again during the hundreds of qualitative interviews I had done with drug using women since 1995. So prevalent was the narrative that my anecdotal recollection is of having done very few qualitative interviews with a drug using woman that did not include this narrative. The routine appearance of child-loss-trauma narratives could be largely attributable to what Judith Butler call the "symbolic violence" of interviews of this type[180], especially when they take place in institutional settings. Women conform to the unwritten "rules" of confession with institutional representatives who expect this trauma narrative and the associated retributional interactions it produces: sympathy on the part of the interviewer and the relief of moral burden on the part of the respondent.

The narrative is one thing. Seeing the symbol so mater-a-factly enlivened before you in an ethnographic setting is an entirely different, and greatly more emotional experience. This next example carries both aspects. The construction of the stigmatized mother-failure on the part of a drug using woman who interprets my nervous smiling as judgment and an enlivened memento, traumatically, and literally, attached to her body.

The picture frame **Mission Street** **June 2007**

I didn't feel strange doing outreach, even though it was my first night. I integrated really well. People were friendly. One woman – I did have a bad reaction with a woman who was embarrassed. This is important, and I forgot it the first time. She was somebody we met on the street. Ruth didn't know her previously; she was really whacked out on speed, or crack and she kind of singled me out as somebody who was laughing at her. I was smiling – Ruth and I talked about it later -- I was smiling at her because I felt really, really awkward that she was so embarrassed of how high she was. She wanted stuff from us, but she was definitely embarrassed to have us see her in "that way". And then she opened her coat and showed me a picture of her daughter. It was in a frame that she was carrying around with her, in her hand the

180 Butler, J. (2005) *Giving an Account of Oneself*. Fordham University Press.

whole time we are talking. “I always keep her here.” She said, cradling the picture carefully. She didn’t hand it to me, for a closer look. She never let go of it.

It was such a sad gesture, a physical, material connection for her to a life that she wasn’t living anymore. And, she sort of, in a quiet voice, said, “You know, it’s not a, it’s not a good time, for me to be with her, right now. This isn’t me”…which is something I’ve heard a lot. Women don’t want their kids to see them, when they’re high, or when they’re out on the street, when they’re working (doing sex work), and they describe it in a way of saying, “this isn’t me.” Which is a real statement about what drug use, and the associated sacrifices that come with it, can do to change who you are and who you think you are, your subjectivity. Especially how you can be as a mom, and fail as a mom, and what are okay ways to show up for your kids. So after all that, she says “I know you are laughing at me.” Not in a harsh way, but in a more embarrassed way, and I was mortified. I said “No, not at all.” But what else could I say, “I am sorry you are so embarrassed? You shouldn’t feel bad?” That would all sound like bullshit, plus I just met her. It is very painful to see women who are so low, and kind of wearing their shame in a litany of excuses, and the picture in the frame just put me over. Like that is all she has left of being a mother is to carry around the picture. I am sure she could see it in my eyes, my sadness about that. So it was a bit awkward, and she shuffled off.

When Allan Young describes the construction of the diagnosis of PTSD, he outlines the importance that time and event played in distinguishing PTSD as differentiated mental illness from other mental illness that shared the same or extremely similar symptoms. I will discuss the problematic aspects of mental illness diagnosis of mental illness among drug users in further detail in Chapter 6. However, I would like to raise PTSD specifically in relation to traumatic events and intrusive memory in the discussion of the multiple temporalities of women addicts. Young writes:

> PTSD is a disease of time. The disorder’s distinctive pathology is that it permits the past (memory) to relive itself in the present, in the form of intrusive images and thoughts and in the patient’s compulsion to replay old events. The space occupied by PTSD in the *DSM-III* classificatory system depends on this temporal-causal relation: etiological event → symptoms. Without it, PTSD’s symptoms are indistinguishable from syndromes that belong to other classifications. The relation has practical implications also, since it is the basis on which PTSD qualifies as a “service-connected” disability within the Veterans Administration Medical System. (A service-connected designation is a precondition for getting access to treatment and compensation). [T]here are numerous clinical cases that resemble PTSD in every respect except that times runs in the wrong direction, that is, from present back to the past… [and] there is no effective way to distinguish these [two types of] cases…PTSD knowledge workers have responded…by developing technologies that provide the disorder’s otherwise invisible pathogenic process with a visible presence.[181]

The importance of the specificity of the social and political context that produced PTSD is directly recognizable in the unique relation that PTSD diagnosis has to time.

181 Young, A. (1995) *The Harmony of Illusions: Inventing Post Traumatic Stress Disorder*. Princeton University Press, Page 7.

This relation also reveals larger tensions between the clinical recognition of psycho-social suffering as experiences of trauma and the scientific need to isolate the trauma as occurring from an isolated set of time-delimited social events which simultaneously produce legitimate and illegitimate forms of PTSD. If homeless women have both traumatic events in their past and their current everyday life is filled with traumatic violence, how can the trauma be temporally bound? Lexi's description of the night she gave up custody of her son, and met the father of her next two children reflects the duality of the traumatic event and the everyday violence of the life of a drug using sex worker. She told me:

> The night I gave up Lionel. I was a wreck. I had called my sister, and asked her to come pick him up. Cause I had relapsed and I knew I would lose him to system. I was just sitting on the ground. On the curb at 16th and Mission. Just loaded, and crying my eyes out. I felt dead. Then Pano comes up, and he asks me if I have place to stay. He's being so nice. I didn't even care at this point. I don't remember nothin. I was just so distraught. And then when I woke up the next morning I was in his [hotel] room. And I still had my clothes on! I couldn't believe it! He didn't even try anything. He didn't take advantage. Cause I think he knew. He knew how blown away I was behind loosing Lionel.

The expected trauma of waking up naked after sex she doesn't remember with a stranger in a hotel room is surprisingly (in Lexi's telling) trumped by the recognition of her vulnerability as a drug using mother who has just lost custody of her child.

The trauma of child loss that many, many drug using women experience is by its very nature on-going. There is the trauma of the moment of loss intruding upon the present, and there is, in many cases, the imagined future, of regaining custody and getting another shot a mothering a specific child. This possibility was reflected in a Anita's unrealistic description of getting herself "together" to be able to regain custody of her daughter, during the same encounter in which it is painfully clear that at that moment, her life is, by physical and economic necessity, directed toward managing her raging heroin addiction and getting enough dates to pay for a hotel room.

VI. Rumors of pregnancy, time, and (social) death

Veena Das seems to experience the political and social ramifications of the partition of India and Pakistan as an intellectual well that demands continual return. Rumor is one way the events of violence are constructed in the language, so words can be expressed about them. She writes:

> I begin with outlining the incident and then show how language and event constituted each other, gathering the past and making it present in a contracted form. I am not making an argument that language itself had the power to *make* these grievous events out of nothing, but rather that memories that may have lain inert came to life in the form of rumors. Enmeshed into local histories of conflict, such rumors became part and parcel of scenes of devastating local violence.[182]

I raise Das' analysis of rumor, language and event as a way to help understand my own ethnographic present with the pregnant addicts I came to know and try to understand. Pregnancy can be construed as an "event" in Das' sense. Through the construction of speech about, and the silence or denial of pregnancy, one can see the proliferations of meanings that women attach to their past, future and present. The way in which the pressures and characteristics of all the modes of temporality intersect is reflected in field note I recorded in March of 2008. The note also reveals a narrative of rumor – talk about an event on the street – which is revelatory of the both the speakers and the subject.

Marta's Death **March, 2008**

There are many versions of Marta's death. I will just offer a few here. The fact that there are many indicates both how much it matters (because people talked a lot about it) and how stories travel and change on the street. Different people have different understandings of blame and responsibility. There are logics about safety, protection, and exploitation that operate locally, and in unexpected ways.

Marta was someone I knew fairly well from doing outreach in the low income single room occupancy hotels for over a year. Tall and strong, and equally strong-willed, Marta was typically pretty well-dressed and put together, on her game. She was in her early 20s.

Every Tuesday the outreach team, usually three of us, trolls through the hallway of the SRO hotels announcing "condom ladies!!" We give safer sex and injection supplies to women who open there doors or who happen to be around in the hallway. We talk and laugh in the hallways, catch up, assess, refer, and share stories.

182 Veena Das (2007) *Life and Words: Violence and the descent into the ordinary*. University of California Press, Page 109

One Tuesday, we arrive at the Nisha Hotel and climb the second set of stairs. At the end of the hallway Marta's boyfriend Axel is screaming at her "I don't care how bad you feel you need to get out there and work!" He wants Marta to get up and out on the street and start turning tricks to make money for the night.

Axel has a cane and he is menacing, threatening to beat her up. Despite how often I hear stories from women about being beaten up and abused by their boyfriends, and the number of black eyes I see, it is actually rare to come across a couple in the midst of violent conflict on the outreach shift. This is probably because of the time of day we do outreach (6-8 on Tuesdays). Marta was lying on her bed, looking unwell, feverish and in a tucked, fetal position.

We try to get her a shelter bed, but the DV shelter that does 24 hour intake is full. Besides they don't take women who can't be clean and sober, and Marta has a large heroin habit. She also has a huge, visible abscess on her right arm. Perhaps this is causing her fever?

Axel threatens again and then storms out, "I am going to get something to eat! Get to work!" This is not a "call the police situation." Axel is in violation of his parole, and getting him arrested is not what Marta wants at all. It brings other problems: the need for her to do even more sex work, without him offering protection.

Unable to offer her a bed, we briefly discuss a safety plan, which she dismisses "He's fine. I am just sick. He will calm down." We say we will check back at the end of the night if we can find a place.

The next week when we return we learn that Marta is in the hospital in a coma. She is dead within 24 hours of our hearing the news. While we are searching for another woman, also for a DV bed for that evening, we start asking people if they know what happened to Marta. In the following week, I ask many more women that I regularly see on the street and in the hotels.

What we know is that Marta was pregnant. We also know that when Axel left "to get something to eat," the police arrested him on the violation and he was taken into custody for 48 hours. Because Axel never returned, Marta was forced to leave her room and search for money (to pay for the room) and heroin to stave off withdrawal and because she was in abdominal pain.

Marta went to the Bottoms, a homeless encampment. There, according to one story, she was hanging out with a couple guys. One of the guys, Winslow, returned to the hotels and said, "I just left Marta down in the Bottoms with CJ, she isn't looking good, we couldn't wake her up. I hope CJ don't try nothin'." Winslow was worried that CJ might try and rape Marta while she was in such a deep heroin nod.

It turned out the "nod" was a coma. I never heard who called the ambulance or how she got to the hospital.

I have heard that Marta died from:

(1) "That nasty abscess."

(2) "She was pregnant and after her miscarriage she wasn't right" [this story also includes theories about a botched abortion, and a potential ectopic pregnancy] Various people believe different things about whether Marta knew she was pregnant or not.

(3) "She got staph." She did in fact get a staph infection. I had heard that from a service provider who spoke to the hospital. It was said that "she went septic," meaning the staph could not be controlled and it killed her. It isn't clear if the staph was a result of the hospitalization or prior to it. She was in a coma for one week.

Despite the violent threats, most folks on the street believe that if Axel had not been violated on his parole, Marta would still be alive.

When I attend the funeral, Axel is crying and crying, staring at the altar made in Marta's memory at the local homeless drop-in. He is so distraught he has to leave the small gathering and stumble out onto the street and disappear for a while.

VII. My ethnographic present/presence

It became clear to me that multiple temporalities played a significant role in how women lived their everyday lives over the course of their pregnancies. These multiple times exerted differential pressures on women, as they sought to survive (stay housed and fed) and as they attempted to engage in or avoid future planning. Constitutions of the past, the future and the present also defined institutional relationships, with the police and jails, with drug treatment representatives, with CPS workers, and psychiatrists. When a women entered treatment active in her addiction and late in her pregnancy the intervention became one of damage control prior to delivery.

My ethnographic present consisted of both witnessing and reconstruction, as the note about Marta's death indicates. This is not only an outcome of doing anthropology as "homework," as Brakette Williams has referred to ethnographic engagements anthropologist's conduct between other daily activities in their hometowns[183]. I was, during my fieldwork, decidedly housed and distracted by coursework requirements, work requirements, parenting responsibilities, and (minimally) a social life outside of anthropology. During my three years of fieldwork I was not there *all the time*, living in the village so to speak. Yet, the temporalities that came to bear upon the women I worked with emerged despite my lack of constant observation and despite the many events I did not see nor hear about.

183 Williams, Brackette (1995) The Public I/Eye: Conducting Fieldwork to Do Homework on Homelessness and Begging in Two U.S. Cities. *Current Anthropology* 36(1): 25-51.

My own ethnographic present and presence is temporally bounded – by events such as pregnancy outcomes, deaths, institutionalizations. It is also unbound. The women's everyday lives continue to unfold in relation to and in spite of these many temporalities and their associated events. I am still, and always, "in the field". As I write this, I pause to call the residential drug treatment facility where Ramona is housed. I leave a message. Another message. Her case manager is either too busy or is actively avoiding me. The initial phase of treatment is very delicate and the risk of leaving treatment to relapse is high. This is common sense knowledge that has been institutionalized into no contact policies on the part of treatment centers like *First Steps*. Anyone who is not a treatment professional – a case manager or counselor from the program or its affiliates is considered a threat to the woman's abstinence. So for the time being, and at this moment, I don't know how that story will unfold.

Fabian (1983) demands that anthropology focus phenomenological attention toward the discursive relations between subjects who are engaged in knowledge production in the present – during their encounters. Such attention could counter "a persistent and systematic tendency to place the referent of anthropology in a time other than the present of the producer of anthropological discourse."[184] As an info-vulture conducting participant observation in a setting of social death, I take seriously the provocation to self-reflexively examine the role of time and multiple temporalities in evidence production, including evidence produced by me. In this chapter I have described how multiple temporalities overlap and collide in the everyday lives of pregnant addicts. Each form of time references a construction of the present through discourse. Narratives of addict time, hotel time and pregnancy time reflect and project the everyday realities of social suffering among pregnant addicts. Yet they also

184 Fabian, J. (1983) *Time and the Other: How Anthropology Makes Its Object* Page 31.

reference women's pasts, often haunted by experiences of their own mothers failing to mother them, and their own histories of past pregnancies and children lost to the state. Institutional experiences with jail, treatment, and public health research reconstitute the temporal frame, offering "opportunities" for service access that are legitimated through "time spent" – time spent in treatment (institutional success), time spent in jail (institutional failure).

Narratives that circulate about traumatic childhood experiences (Lexi) and death (Marta) carry the power of rumor on the street as loved ones and acquaintances try to make sense of tragic behavior and events. For many pregnant addicts these same narratives transform into time-dependent diagnoses – bipolar disorder or PTSD - when the symptoms of the trauma continue to linger long enough to repeatedly disrupt the present. The ethnographic present here is attuned to these multiple temporalities in order to trace their origins and chart their roles in the reproduction of social death.

Chapter 6: Pregnancy, disability, and new configurations of madness

I. Introduction

This chapter is organized around the concepts of disability, economy, mental illness, and pregnancy as they are relevant to drug using women. First I explore the notion of "disability" as "a moving target" which is constituted through the responsive management of three relevant constructs: (1) the complexity of differentiation between preexisting mental health conditions and those induced by substance use; (2) the experience of trauma, mania, and despair that constitute the social suffering among women in the daily rent hotels; (3) the added physical, mental, and social "disability" that pregnancy often brings to women addicts. These constructs – of diagnosis, suffering, and reproductive biology – combine in a moral economy of "disability." Its assessment plays a central role in bureaucratic interactions with women substances users in general and pregnant addicts specifically. I trace the historic changes in the welfare entitlement structure which gave rise to the "neurocrat." The neurocrat is an advocate-cum-bureaucrat. The one responsible for the documentation that distinguishes mental illness from addiction and enables health claims to become economic claims as they travel from the clinic to governmental bodies. Neurocrats help grant monetary attribution to drug users whose diagnoses meet beneficiary criteria.

Where a drug user might land on the spectrum - from mentally ill and disabled to functional and just poor - is highly contingent in this setting. Among the women in the private daily-rent hotels, few had a diagnosis of schizophrenia or showed outward signs of schizophrenic behavior. Ethnography in the private hotels did not offer nightmare visions of the asylum: women muttering, randomly yelling at people not seemingly present, lost in psychotic revelry or staring blankly, socially disconnected. To be sure, spending time in the private hotels in the early and later evening was to experience a high degree of tension and hyper vigilance among and between women and men.

Women yelling at people who were very much present, despair complaints about hotel management, manic and not-so-manic laughter, and frenzy. The routinized chaos of the drug-sex economy was omnipresent and I felt an overall inability to predict the dynamics of constantly emerging and dissolving social configurations at any given hour.[185] Coming to the hotels in the morning or in the middle of the day was like a being in the eye of the tornado. Standing in a hallway was quiet, many women still passed out from nights of smoking crack and turning tricks, a few quietly working on the acquisition of money to ensure the hotel room for that night. The hyper vigilance, depression, and mania that I regularly witnessed in the everyday interactions and social worlds of women in the daily rent hotels matched the mental health diagnoses women gave to themselves and were diagnosed with by medical professionals – PTSD and bi-polar disorder, but they were decidedly not schizophrenic.

These are the "new configurations of madness." While PTSD and bipolar disorder are not "new", these diagnoses have an emergent, and currently shifting, social history among homeless women. Trauma, sorrow, rage and mania seem to provide a moral compass for the emotional experience of gendered abuse, institutional interaction and everyday housing instability among women. They also open up doors to social legibility. The politico-scientific trajectories of these diagnoses parallel this social history. PTSD, for example, is one compensatory avenue by which advocates and care providers can create a space of social recognition and gain stabilizing economic and housing benefits for women. The prevalence of PTSD is well evidenced in epidemiological studies and the manifestation of symptoms is unequivocal to most providers who interact with women addicts on a regular basis. The up and down that evidences bipolar disorder maps directly onto the social experience of chronic stimulant abuse. PTSD and bipolar disorder both have slippery scientific pathways: they are both

185 See Chapter 4 for a more detailed ethnographic description of the everyday life in the private daily-rent hotels.

difficult to diagnose in the presence of active stimulant use. Yet, newly minted atypical anti-psychotic medications have created an increase in these diagnoses among the homeless, in part as a result of a full court press from pharmaceutical companies to utilize these 'broad spectrum' medications.

PTSD and bi-polar disorder are tricky diagnoses to document among active substance users and tricky experiences with which to live, without substances. This chapter ends with a discussion of the "neurocratic pregnancy." I describe the social, governmental, and medical management of pregnancies among women who are unstably housed, with complicated histories of neglect and abuse in childhood, actively using stimulants (crack, mostly), who are assumed to have or have been diagnosed with depression, bi-polar disorder and/or PTSD. First, we need to dissect disability, because the assessment of "disability" plays a key role in how the social and scientific renderings of the everyday experience of substance using women – the trauma, sorrow, rage, and mania – become legitimized.

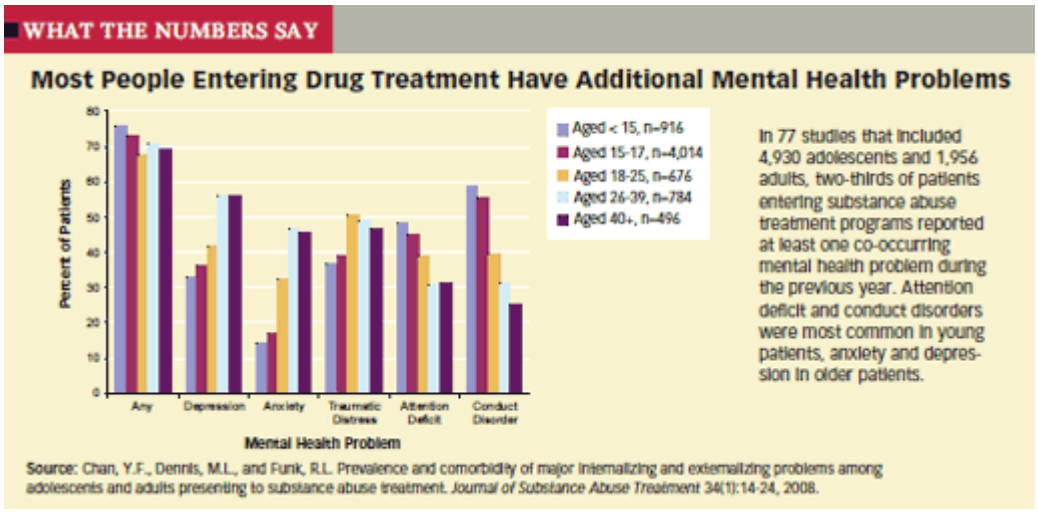
II. "Disability": the target that moved

> Drug addiction also has an impact on a wide variety of illnesses. Smoking and alcohol are linked with a higher incidence and prevalence of certain cancers. Marijuana too. The co-morbidity of depression and smoking is close to 90 percent. Do you know what percentage of schizophrenic patients take cigarettes or take drugs? Eighty-five. Look at heart disease, the No. 1 killer. What is one of the highest risk factors? Smoking.
>
> - Nora Volkow, *NY Times* August 19, 2003

> Of the people in supportive housing in San Francisco, 93% have a major mental illness that we can name. That is very, very high. 80% use cocaine, speed, or heroin every thirty days, or get drunk to the point of unconsciousness. There are no more disabled people in this country.
>
> - SF Health Official, November 2009

If all the category-makers can agree upon one fact, it is this: co-morbidity is the name of the game when it comes to substance users who are unstably housed. Nora Volkow, the Director of the national Institute of Drug Abuse and a neuro-psychologist,

makes the point with the general statistics about the overlap of a wide variety of substance use behaviors (smoking cigarettes and marijuana, drinking alcohol) and mental health conditions (depression, schizophrenia) and physical health problems (heart disease, cancer). She crisscrosses incidence and outcome to paint a synchronistic picture of the added vulnerability of drug addiction. Indeed, national studies conducted on adolescents and adults entering drug treatment that over 70% report a co-occurring mental health problem.



The San Francisco health official quoted above describes the population in supportive housing as the "most disabled in the country" to make a related but separate point. One physical or mental illness may be clinically relevant at an individual level, but co-morbidity with multiple, overlapping conditions is one route to housing. Both of the quotes above are made by officials whose job it is to create and implement programs that pay attention to cost. Why is drug addiction a problem? Not because of the emotional and financial cost to the individual addict or his/her family that is wrought by substance use. No, because the related health and mental conditions that are documented to travel along with substance abuse *when you are poor,* cost society a fortune.

On the global stage, assessing the "global burden of disease" attributable to illicit drug use and mental disorders is currently being produced through an evidence-gathering partnership between several major universities in the United States (Harvard University, John Hopkins University, University of Washington) the University of Queensland in Australia and the World Health Organization. This meta-analysis, not yet completed as of 2010, will include "epidemiological reviews of all diseases, injuries and risk factors and estimates of mortality and cause of death for all countries in the world"[186] in which mental illness and illicit drug use play a role. At the local level San Francisco Department of Public Health directly funded the generation of epidemiologic and clinical data from the largest public hospital about "frequent flyers"- homeless and marginally housed persons, often with substance use problems and mental health issues who monopolize public resources through frequent trips to the emergency rooms and preventable hospitalizations.[187]

The fiscal burden of the urban poor's health and mental health problems propelled the public health officials in San Francisco to investigate the mass movement of this population from city and state funded welfare entitlements onto the federal welfare roles. The history of that local policy evolution relates to drug users in a very specific way. It began in the late 1990's with fiery national debates about the worthy and unworthy poor. In 1996 the United States Congress approved a set of welfare reform policies, the Contract with America Advancement Act, which were approved by then President Bill Clinton. Many reforms were included in Public Law 104-121, but chief among them from the perspective of San Francisco urban health was the decision to

186 Degenhardt, L., Whiteford, H., Hall, W., & Vos, T. (2009). Estimation burden of disease attributable to illicit drug use and mental disorders: What is "Global Burden of Disease 2005" and why does it matter? *Addiction.* 104(9): 1466-1471. Also see Prince, M., Patel, V, Saxena, S, Maj, M. Maselko, J, Phillips, M, et al. (2007) No health without mental health. *Lancet.* 370:859-77.

187 See Shumway M, Boccellari A, O'Brien K, Okin RL. (2008) Cost-effectiveness of clinical case management for ED frequent users: results of a randomized trial. *Am J Emerg Med*. 26(2):155-64.

deny access to Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) for those individuals who claimed drug and alcohol dependence as their primary disabling diagnosis.

Briefly, SSDI is a federal entitlement program supported by the Social Security tax deposit withdrawals from working persons' monthly paychecks. SSDI does not pay short-term benefits or for partial disability and you need to have a work history to claim benefits, the duration of which depends on your age (called the "duration of work test"). SSI, which is much more commonly claimed among drug-using urban poor persons, does not have a "duration of work test" requirement to claim benefits. You do not have to have any work history, but you have to be over 65 years of age, blind, *or* disabled. To meet criteria you also must prove a limited income (the dollar amount changes yearly, but it was $1000 or less per year in 2010), limited resources, citizenship, and residency. The residency requirements become complex for women in active addiction with documented mental health disorders. They must find a local agency, individual, or even a private daily-rent hotel manager whom can be assigned status of "representative payee" (rep payee) through the Social Security Administration. Rep payees agree to sign for SSI checks, pay bills and sometimes rent, and disperse the money to beneficiaries. SSI, also a federal entitlement, is paid for through the general fund.

Several political-economic developments led to the change in SSI and SSDI eligibility criteria. First, the number of persons applying for SSI under a drug and alcohol dependency category had increased exponentially from 1989–1995 (16,100 to 130, 924),[188] so the sheer federal payout had increased substantially. Second, the political climate during this same period supported broad measures of criminalization of substance users (mandatory sentencing laws, restrictions on housing and job training for

188 Barber, 1996. For a more in-depth discussion of the social and policy history of SSI and its relationship to larger criminalization movements as part of the War on Drugs see Bluthenthal, et al, 1999.

persons with drug-related offenses) which amounted to "zero tolerance" for any public support programs serving persons with drug and alcohol dependence issues. The nail in the disability coffin arrived with multiple national media stories reinforcing the suspicion that drug addicts were using federal welfare dollars to buy drugs.[189] A physician offered clinical evidence of the added harm of federal entitlements for substance users in the public media[190] and in a peer-reviewed public health journal.[191] One epidemiological study found that SSI entitlement enrollment was associated with increased drug use.[192]

Thus after January 1997, the complex relationship between addiction and poverty was reconstituted from a disabling medical condition (addiction as a disease) to a immoral, malingering set of criminal behaviors (using welfare funds to buy drugs). To some medical providers the fact that some drug addicts and alcoholics might choose to spend money on substances rather than on a place a live proved the point that addiction was, in fact, a compulsive, progressively detrimental disease that overtook the minds and bodies of addicts. Not so for the general public. Nor for congressional policy makers. It was argued that SSI benefits were enabling, not helping to stop addiction. Addicts could work; they just chose to spend the government's money on alcohol and drugs instead.

Thus, a person could no longer claim disability based on the medical evidence of addiction. One could however, reapply under another diagnosis if it were adequately documented and win back SSI entitlements. As the Social Security Administration's website describes, "substance addiction disorders", known as code 12.09, are is no longer causative, but rather referential disorders. Addiction does not satisfy evidentiary criteria:

189 See Dorgan, 1993; Fitzgerald, 1994; Rust, 1994; Seligman, 1994; Walsh, 1994; Weaver,1994.

190 Satel SL. Hooked: Addicts on welfare. *New Republic*. May 30, 1994.

191 Satel SL. When disability benefits make patients sicker. *New England J Med* 1995;333:794–6.

192 Shaner A, Eckman TC, Roberts LJ, Wilkins JN, Tucker DE, Tsuang JW, Mintz J. (1995) Disability income, cocaine use, and repeated hospitalization among schizophrenic cocaine abusers: A government-sponsored revolving door? *New England J Med*. 333:777-83.

> The structure of the listing for substance addiction disorders, 12.09, is also different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.[193]

One epidemiological article makes the case that although most health providers, be they physicians or drug treatment counselors, recognized that in addiction to a substance use disorder, many addicts had additional mental health problems: depression, trauma, schizophrenia, mania, etc. However, *documenting* and distinguishing between those issues was not necessarily a clinical priority prior to the SSI cut off. After the change in eligibility it became both a clinical reality and political necessity to document other physically conditions and/or qualifying psychiatric conditions to regain access to this benefit. A Policy Brief from the National Poverty Center reported that "by April, 1999, only 35.5% of former [drug and alcohol dependent] recipients had requalified for SSI under other medical conditions, most often a psychiatric disorder."[194] With the changes to disability entitlement eligibility, the neurocrat was born.

III. Going mental: the rise of the neurocrat

Who is the neurocrat? It is the person who amasses an assemblage of evidentiary documentation – clinical diagnoses, medical history, employment history (or lack thereof), proof of poverty, and other certifying paperwork – that must be collated to claim federal disability benefits for homeless, poor people. What is significantly different about neurocratic practices as opposed to other forms of beneficiary advocacy (which are certainty not new or specific to 21st century San Francisco), is that neurocrats must evidence serious mental illness *in exception of* substance use. Since 1997, SSI and SSDI disability documentation has included a box in which neurocrats must testify

193 http://www.socialsecurity.gov/disability/professionals/bluebook/12.0-MentalDisorders-Adult.htm accessed February 2010.

194 Schmidt, L. (2004) Effects of Welfare Reform on the Supplemental Security Income (SSI) Program. National Poverty Center Policy Brief #4.

(evidenced through the accompanying documentation) that the individual in question is suffering from a mental illness that is not induced by their substance use.

Neurocratic practices have become formally institutionalized into city policy over time. I remember in the fall of 1996 working at the women's needle exchange program in the Mission[195] when women would arrive in a panic clutching letters of denial from the Social Security Administration (SSA), worried about what would happen to their housing and their ability to meet their basic needs when they were kicked off SSI in January, 1997. The effort to get people re-enrolled was frenzied at that time. We tried to reassure people, hook them up to benefits counseling or case management. The impression on the street at that time, however, was that unless you had an HIV positive diagnosis with many associated health complication, or AIDS, you weren't getting your disability benefits back.[196] By 1998, however, a concerted effort to move all the persons potentially eligible for SSI and SSDI onto (or back onto) the federal rolls became an organized political effort on the part of the San Francisco Department of Public Health (SFDPH). I interviewed Deputy Director of Community Programs at SFDPH who authored the cost benefit report in 2004 that sealed the "SSI advocacy" programs' on-going support. The report discovered that were over 5,000 San Franciscans potentially eligible through mental health disability for SSI who were not receiving those benefits. She remarked:

> The policy climate has shifted significantly since we began the SSI advocacy program in 2002. Because at that time the Director of Public Health was like 'Get these people off my back! Somehow, fix this!' Because the [SSI] advocates were pissed off. The clinicians were pissed off. The Human Services Agency was agitated, and the Social Security Administration was agitated. So I brought all these people together to discuss even 'What is SSI?' and sort it out because it is very, very complicated. It is like acronym hell. Have you ever seen an award letter sent to a client? How could anyone understand

195 Myself (as a UCSF-funded HIV/AIDS qualitative researcher) and group of activists, service providers, sex workers, epidemiologists and doctors started the first women-only needle exchange program in San Francisco's Mission District in 1995. I served as the program's volunteer site coordinator from 1995-1997.

196 See Crane, J., Quirk, K. & van der Straten, A. (2002). "Come back when you're dying": The commodification of AIDS among California's urban poor. Social Science & Medicine, 55, 1115-1127.

> that? So it is extremely complicated and it made more complicated because it is very legalistic and you have two bureaucracies involved it.

There are many complex moral, social, and scientific reasons (which I expand on below) as to why neurocratic futures became so common among drug users in San Francisco in the late 1990s and early 2000s and continue to be so. But the driving force was to reduce costs – health care costs. In 1998, the San Francisco Department of Public Health (SFDPH) adopted a "single standard of care" as its mental health policy, meaning that the uninsured would have the same level of access to mental health care as the insured.[197] In the state of California when SSI is awarded, Medi-Cal (California's version of Medicaid) is also granted. Therefore hospital-based and other health care cost and cost for mental health services could be billable by the city. If the persons receiving those services were attached to a federal disability program. The unrecooped profit for the city of not getting those 5000 eligible persons onto to SSI amounted to 27 million dollars, and "costs matter, money talks" in city government. According to the Deputy Director,

> Most of the resistance was in the treatment community…So we had to begin the cultural shift with our treatment community. We had to figure out 'What are the issues?' 'What is in the way of disabled people getting on disability?' Because it is their right to get on disability. The Department [she names her supervisors] wanted them to get on disability because of the benefits. The fact that we would get reimbursement for our services, that they can have access to housing, better housing. But that is very philosophical. Getting down here [lowers her hand to the desk] where the advocates actually needed to work was a huge barrier.

The SFDPH study assessed the barriers among patients and their providers. It found that would-be recipients could not independently manage the complex paperwork successfully to "win" SSI cases. Medical and mental health providers concerns were both practical (the paper work takes too much time) and moral (hand outs do not equal health):

197 http://www.sfgov.org/site/uploadfiles/mental_helath/archive/m061098.doc

> The workgroup identified that to reach such a goal, the recommendations would have to address the SFDPH clinical staff's real and perceived problems with not only the application process, but the entitlement itself:
> - The process is complicated, time-consuming, and often futile;
> - Advocates try to tell me who is disabled and how to diagnose my clients;
> - The benefit is contrary to the "recovery model," it is a permanent label, and the money "enables" clients with their substance addictions.[198]

A pilot program was developed in which non-clinical staff would amass the evidence and complete the paperwork needed to make a good case for a would-be recipient. The outcomes of the study changed the practices of SSI advocacy, and they way in which 'success' was measured.

> We attached advocates to specific clinics. They did education, they assessed the issues and we found 100 people whom we could agree should be on SSI. The dynamic was shifted. Instead of serving the client, the advocate was now serving the clinic and the clinician. They [the advocates] were making it easier for the clinician to get their client onto SSI. We were measuring not just client satisfaction but satisfaction with the referral source (the advocacy). It really shifted the conversation, now the advocates were serving the clinician, not [the advocate saying to the clinician] 'My client, you give me what I need. Now the advocate amasses all the proof and the clinician can say if they agree or don't agree. Now they [the clinicians] have now just turned the whole process over.

Because most persons not receiving SSI in the assessment were mentally ill from the perspective of the county, resources went into this newly instantiated neurocratic endeavor. As the author of the report explained to me in an interview: "Most of our clients are dual disordered [substance use and mental illness] or *at least* dually disordered. We are able to purchase about one million dollars worth of SSI advocacy services because we found that the return on that investment to our mental health services was 5 to 1." Relationships built between clinicians and the advocates that now provide training about disability and complete the bureaucratic paperwork has highlighted the benefits to the individual (housing stability) and to the city (reimbursable health and mental health care). "I think organically, and by training, and through relationships [between advocates and clinicians] who might qualify for SSI has changed [since 1997]. Because it has been proven, the success rate (of winning cases) has

198 City and County of Sam Francisco, Department of Public Health. (revised 2008) Return on Investment: How SSI Advocacy Became a Standard of Practice in San Francisco.

shown that even though they have a substance using issue, that we are able to get them SSI, if we frame it a certain way."

Accompanying forms of fiscal management for persons receiving SSI were put in place to mitigate the concerns that clinicians had over their drug using patients being granted large amounts of cash every month. First, a "representative payee" is required of persons with substance use and mental health disorders. This individual can be designated by the SSI beneficiary or can be assigned through a non-profit social service agency that does financial management, case management, and sometimes offers transitional and permanent housing. In this scenario, the drug using beneficiary is not in complete financial control of their welfare entitlement. Often rent is paid and sometimes other basic needs are taken care of, or the payee only gives the individual a nominal amount of the remaining check per month for expenses. Representative payee services can cost beneficiaries fees, but the mental health system created a program to offer the service free of charge to encourage their utilization. Rep payee services were put into place to prevent the misuse of entitlements on drugs/alcohol or other purchases. In the world of the daily rent hotels this amounts to private hotel managers serving as payees, who may also be gauging women for higher rents (than in publicly funded SSI supported rooms). Another scenario is to have the liquor stores or convenient store, which sells expensive unhealthy food and cigarette, serve as payee. Second, lump sum retroactive SSI payments have been discontinued in favor spreading out retroactive payments in smaller amounts. In the past, once SSI was granted, if the disability could be proven to have existed for months or years prior to the granting date, back payments were issued. This could amount to tens of thousands of dollars and could trigger recovering drug addicts to return to drug use and/or lead to reckless spending among active users. I have seen both in my ethnographic experience. Women returning to

their old neighborhoods with money burning a hole in their pockets, women describing "burning through" large checks in one week, or even a week-end.

Even as these polices have been applied, and sometimes ended up poorly regulated, the overall shift toward embracing addiction as a disabling organic disease within the mental health field in San Francisco is partially responsible for the lessening of clinician resistance. The Deputy Director said,

> With harm reduction and the integration of the mental health and substance use treatment services, I think there is more knowledge. Specifically in relation to SSI there is an understanding that if you can get someone housed (as a benefit of entitlement advocacy) you can work on those [mental health and substance use] issues much more effectively than if they are not housed. And it (a substance use disorder) does not mean that automatically do not qualify for SSI.

One physician I interviewed explains the emphasis on distinguishing the substance use disorder from the mental health condition. "The advocates write the [SSI] letters for us about our patients. And they [the advocates] have been clear that the letter must say that the mental health issue is not caused by the substance use. They feel that this is very important. We have to check a box on the form attesting to that for the SSI application." I as discuss below, that testimony is difficult in many cases, particularly for those mental health conditions that tend to be attached to homeless women – bi-polar disorder and PTSD. First however, a further investigation into neurocratic practices is necessary to capture the "on the ground" management of evidence that constitutes mental health disability. How is unproductive madness made visible? In the spirit of the dual, triple, quadruple diagnoses that are constantly invoked about the homeless, drug using people by advocates, bureaucrats, physicians, even anthropologists – we begin by addressing the hierarchy of health verses mental health which served as a catalyst for the development of neurocratic expertise.

A strong case for SSI benefits due to mental illness disability was certainly not the only route to SSI qualification, physical health conditions, such as HIV/AIDS, also

count. Yet, by mid 2000s an HIV diagnosis alone was not enough. Initially documentation of an HIV diagnosis was sufficient to prove a disability case for SSI. Those persons who had an HIV diagnosis and drug and alcohol dependence as their disability conditions quickly reenrolled in SSI after the drug and alcohol dependence cut off point in 1997. However, with the advent and subsequent mass roll out of protease inhibitors in 1996 and then even more effective medications in the following years, the HIV eligibility shifted. HIV transformed into being perceived (by the SSA administration) as a chronic illness, which may or may not be disabling. When a national conference of HIV prevention and care service providers came to San Francisco in fall of 2009, I attended a strategy-based 3-hour training session in which a benefits professional informed everyone in the audience about the "how to" win SSI and SSDI cases. The name of the session was direct: "How to win an SSI case when HIV is not the primary disability." The trainer numerically justified his expertise: "My average for getting a disability case approved is 3 months. Where nationally it takes an average of 1-3 *years* and 70% of cases are initially denied."

The room was packed with social workers and benefits counselors from all over the country. As the presenter whipped through slide and slide on his PowerPoint and cracked canned jokes right on cue, you could tell he was an absolute pro. "I give 100s of these trainings a year," he mentioned at one point. The trainer perceived his role to be that of revealing the socio-cultural logics of SSA disability, laying bare the definitions and details that matter. To that end he was direct about the lack of value-added to maintaining any politicized perspective on the illness experience when entering into the process of pitching an SSI case. He said:

> Now the definition of disability is that 'an individual… we have already changed now to page number 4…[He reads from the handout] The definition of disability is that 'an individual is unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment of impairments,' OK. Page number 4. [He

> continues to read] 'The result of that impairment has lasted or is expected to last for 12 months or is expected to result in death.'
>
> Now I have been working in HIV/AIDS back from *years* ago. Back when people were dying, you know, within a year or two. When I was diagnosed I thought I would be dead in a year and I dealt with that impending doom by going shopping. [audience laughs] I charged up a whole house full of furniture, which was way too expensive and took me a long time to get rid of. [Pause] You don't want people making decision based on the *emotions* of what they *think* it is going to be. We want them to make the decision with *knowledge*. And when you deal with Social Security you have to realize that, even though we know that HIV/AIDS could result in death, they [Social Security] have never acknowledged that portion of it. I have never seen them acknowledge that. [Pause] OK. When you have someone who is dealing with a form of cancer [pause]. They *will* acknowledge that. If you have someone dealing with another life threatening illness. They will acknowledge *that*. I am just telling you what is. I am not telling you it is right or wrong, good or bad. I am not going to tell you how to politically change things. I am just going to tell you what is, so you are successful [at winning SSI/SSDI cases].
>
> [He continues] You see, benefits are very much like a dysfunctional family. Don't make any common sense. Never have. Never will. It is just the way they are run. You know, they are made by law makers who mean well. And they create law, after law, after law, after law, after law. And then what you've got is what we have today as a benefits system. And the consumer goes to access that system and they go 'whoa.' And the sad thing is that so many people who should be able to access Social Security wind up with what I call a diagnosis of 'Post Traumatic Benefits Syndrome.'

If you didn't have a mental illness before, you might get one trying to get your disability approved.

The trainer shares with us the fact that the Social Security Administration has diseases that constitute "listing levels of impairment" in "the Blue Book" which is published on the SSA website. The Blue Book, which ironically shares the same name as the nationally recognized guide for pricing a used car, is a "living document" of "medical conditions that automatically qualify someone if they have meet step number one (not making more than $1000/year) and step two (their condition is severe enough that they cannot perform their "regular work"). "If you find a listing level of impairment for your consumer, whether it is HIV or not, then you are automatically granted." Neurocratic practices involve a shift away from the clinical recognition of a disease. This new instantiation is materialized by applying a numeric code, making it "clear" and "concrete" that everyone is speaking the same language about the body and the mind. The trainer pulls up the website and begins to guide the audience through the Blue

Book, evoking bureaucratic logics of categorical evidence. He also offers advice about the work culture of SSI case auditors in order to help outwit the overwrought government paper-slave into not feeling hassled and harassed when your consumer's case comes across his or her desk.

> Notice the numbering when you are in the Blue Book. They have a numbering system. When I do a case I use *their* number system, because I want their [the SSA worker's] job to be *so* easy, that when they see my case they say, "This one is gonna be a piece of cake. I am gonna go ahead and start working on this right now." Think about it. If you get a situation presented to you that is straight forward or one that is really complicated and messy, and you have a choice of what you are gonna work on today, which one are you gonna go for first? [We answer, "The easy one."] Most people will go for the easy one. So you want to make your case so clear, so concrete that they say, "Wow, they are even using our terminology. I can't wait to get the medical records and see if this case is gonna get granted." So become familiar in the Blue Book, which is the book of automatic qualifiers that social security has for all disabilities, that at step 3, in the sequential evaluation process, is gonna get somebody granted.

As the training wore on it became increasingly clear that the task of enabling social stability – and ultimately health and mental insurance coverage - was an exercise in opposing rationality onto a politically irrational system. The politics of recognition that needed to be learned and deployed by benefits advocates became a method of reconstituting the experience of poverty, joblessness, despair, and poor health into legible diagnoses within a mentally unstable benefits system. Drawing out the trainer's analogy, benefits advocacy was an exercise in moving poor women substance users from one dysfunctional family – their families of origin, their home life in the daily rent hotels - into another "dysfunctional family" – an SSI home. It would be a mistake to assume this a only a lateral move, however. Moving on to SSI might not solve all the problems that women drug users face, and have faced. But it does, more often than not, give them some financial stability and increase the likelihood that they get inside, in better housing, and for a longer period of time.

Neurocratic claims, those without a visible injury or obvious physical disability, prove to be a unique testing ground for SSI advocacy. Without irony and perhaps not by coincidence, when it came to mental health diagnoses and claims – the benefits trainer

chose “bi-polar syndrome” as his case example. “They [bipolar “cases”] can be a challenge (laughter) and they [the SSI cases] are really hard to get granted,” he states. Unless there is “really, really good evidence and really, really good supportive documentation about the hospitalizations.” He continues, “And it is not uncommon with people with bipolar syndrome to minimize as much as they possibly can with their medical providers, so the medical records many times aren’t really true depictions of how truly disabled they really are, because many of them have shame around that disability.” Emotional and social experience are now reentering the arena of evidence production and the neurocrat role is to make visible what a patient may be reluctant to attest to and a provider may not document. Ultimately the lack of a clear biologic marker makes these cases difficult to win:

> So bi-polar conditions are some of the hardest cases to get granted not because Social Security is trying to deny them, it’s because the evidence is something that is via…there is no test you can do for bi-polar condition. You can’t do a certain test. Now I have some of my bi-polar people who are so impaired, and bi-polar is just one of their disabilities so that I can throw out – I mean not throw out, but I can have a neuro-psych eval done, which is a comprehensive two-day test. And through the neuro-pysch eval I have one bi-polar client whose got probably three other disabilities on top of it, and we had no medical evidence to work with. She wouldn’t see the doctor, she is deathly afraid to see the doctor. I did the neuro-psych eval and I got so many disabilities I got her granted right away. So sometimes getting a neuro-psych eval is the way to get the cases. The trick is knowing when to use a neuro-psych eval or not. It’s really difficult. You need to know that there is something *cognitively* going on that is going to be captured in the array of tests that a neuro-psychologist does.

Without a clear biological marker to “test” for a mental health condition, it might be more instrumental to find qualifying assessments (like a neuropsychological evaluation) which could detect additional disabilities. Clinician experts emphasized that that among their patients – homeless and marginally housed persons in San Francisco – close to 100% of their patients were dually or triply diagnosed. Most often this means (1) a substance use disorder; (2) a mental illness – frequently an Axis I disorder[199]. The third diagnosis

199 The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability: Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, phobias, and schizophrenia. Common Axis II disorders include personality disorders: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial

is often a physical problem which will also be acceptable in a SSI beneficiary audit such as HIV/AIDS, epilepsy, cancer, arthritis, lupus, or chronic liver disease. Clinicians are well aware of the disjunction between their clinical tasks and the neurocratic documentation necessary for reimbursing their services and stabilizing their patients. One clinician said:

> Doc: There are two different directions, unfortunately, that we have to go. When they show up in our clinics [city mental health clinics] we need to emphasize their psychiatric disorder, as the primary problem, and that's so that we get paid. But *clinically* their primary issue may be alcohol use, and that is what I spend my time working on them with. Even though they also have a mood disorder. That may be secondary to their alcoholism.
>
> Kelly: How do you determine what is secondary and what is primary?
>
> Doc: Anyone who gets referred to me, 99% have an Axis I disorder and a substance use problem. So when they show up I know they have a stimulant problem and a mental illness that is separate from that. And you really can't say that one is worse than the other, one caused the other. You need to manage both of them aggressively. And when they co-occur, your treatment for either one is a step-up. It is easier to treat depression in someone who is not using substances. It is easier to treat alcoholism who someone who is not depressed. When you have them both together it is just that much more difficult. So my approach is, it's more counseling, it's more group therapy, it's more time with me, it's more medications, higher doses. Sometimes it impacts what medications I give them, because there are some medications which may make their substance use disorder worse. And some medications that might make the substance use disorder better. Sometimes you get a two for one deal.

The neurocrat translates one form of clinical reality – the documentation of diagnoses - into a materially legitimate social categorization that leverages material gains, both the drug users and for the city itself. SSI-advocacy generated, neurocratic evidence has not cancelled out the clinical, DSM categorization it has multiplied its significance. It has pushed physicians and psychiatrists toward a new ways to document mental disability. Disability for the drug using urban poor population in San Francisco is a diagnosis of intersecting poor health and poverty. Our trainer speaks of building bridges.

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personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, and mental retardation.

> You've got your DSM, what is it? like 12 now? [Everyone laughs. "DSM-IV" we answer back]. 4. Is it 4 now? They keep changing it. So you have got your DSM. And you have got your way that you describe it [bi-polar disorder]. Well, you see they [SSA] don't use that. Because there was a little group of attorneys who got together and decided that they are going to create a blue book. And *that's* how they are going to determine disability and they got medical people involved with [pause] lawyers. And that's why you have to learn how your normal way of describing something is actually described by Social Security. Period. You make that bridge, and you are going to get cases won.

Nicholas Rose speaks of new "technologies of truth" – ways of counting, categorizing, and making visible - which have given birth to our "neurochemical selves." He identifies the broad changes in our conception of the human that the assemblages of truth technologies have created in the wake of emergent biological psychiatry:

> The new style of thought in biological psychiatry not only establishes what counts as an explanation, it establishes what there is to explain. The deep psychological space that opened in the twentieth century has flattened out. In this new account of personhood, psychiatry no longer distinguishes between organic and functional disorders. It no longer concerns itself with the mind and the psyche…This is a shift in human ontology – in the kinds of persons we take ourselves to be. It entails a new way of seeing, judging, and acting on human normality and abnormality. It enables us to be governed in new ways. And it enables us to govern ourselves differently.[200]

The neurocrat in this ethnographic setting serves as a of the go-between. The neurocrat is dependent upon the veracity of technologies of truth that privilege medical evidence above all other forms. Yet, the neurocrat also produces evidence in the translation of clinico-medical diagnoses and symptom terminologies into entitlement legibility. What is particularly fascinating about the neurocrat is that the job of the neurocrat is not to identify labor, to reveal a potentially productive poor. Rather the role of the neurocrat is to make the madness of poverty legible. The neurocrat constitution of madness of urban poverty cripples the potential for the beneficiary to productively participate in society while at the same time legitimizing the government's role to compensate individuals for inflicting the wound. One medical provider explained to me the mechanism for getting on SSI in San Francisco: "They walk in to the GA (General Assistance) office and on the bottom of that form there is a box that says 'Can't do

200 Rose, N. (2007) *The Politics of Life Itself: Biomedicine, power and subjectivity in the Twenty-first century*. Princeton University Press. Page 192.

workfare.[201]' – forever! (laughs). Check that off, and then they are referred to SSI advocacy." Another physician shared her attempts to avoid SSA hair splitting about the causality of disability, to avoid neurocratic debates about the worthy and unworthy mentally ill. In clinic she asks herself one question: "Would I hire this person?" She says, "I consider the physical and mental health of the patient *in front of me*, and I ask myself, honestly: 'Can this person *currently* do a job, any job, for 8 hours a day, 5 days a week?' The answer is often, 'No.' The question for me, is –and it should be for everyone because this is about *work*, being *able* to work: 'Can this person work? Would I have them work for me?" L astly, I spoke with a psychiatrist about bi-polar disorder and SSI eligibility. She was dismissive, "SSI. [sighs] SSI is a bureaucratic exercise, it is over here [she motions away from her with her hand]. It is important. It stabilizes people, it might keep them housed. It doesn't heal anyone. What *I* am concerned about is the patient."

Neurocratic possibilities for social legibility have emerged since drug and alcohol dependence were both discontinued as medical conditions which afforded persons federally-funded disability benefits in January, 1997. This change necessitated increased focus on the documentation of mental health disorders among drug users. It changed the practices of evidence production and documentation between patients and providers. Mental health diagnoses institutionalized the desperation of traumatized homeless women. But it also got them inside.

Neurocratic practices embody the discontinuity between the governance of addiction and mental illness and its emergent rendering in science and public health, as an organically-based, co-influencing medical condition. In the world of the neurocrat, because of SSI laws and policies, addiction cannot *count* as a disease. Addiction *can*

201 Workfare is another form of city welfare in which welfare is linked to doing menial work or being in job training programs, also a result of late 1990s welfare reforms. See Wacquant, L. (2009) *Punishing the poor: the neoliberal government of social insecurity*. Duke University Press for a more in-depth discussion of US welfare policies of the mid 1990s.

not be the disease that is making someone crazy, even if a cadre of experts acknowledge and "know" that it is. As I discuss on later sections, neurocratic logics create the on-going separation of clinical and bureaucratic reality for both "patients" – homeless and poor persons seeking disability aid - and their physical and psychiatric care givers. Because of emergent understandings of the addicted brain, psychopharmacological treatments for 'a broad spectrum' of mental health diagnoses, and the presentation of symptoms that overlap between mental illness and active substance use, accurate psychiatric diagnoses are extremely difficult from a clinical perspective. Difficult, but absolutely essential to leverage the further social benefits afforded by access to federal disability entitlements.

For women in my ethnographic scene, two specific mental health diagnoses circulated most commonly: bipolar disorder and PTSD. Prior to exploring the specificity of what neurocratic practices enable and don't enable in the everyday lives of pregnant addicts, I will describe two overlapping constellations in the social worlds of substance using women which require further explication: (1) street psychiatrics and (2) new configurations of madness. The story of neurocratic futures in relation to the pregnancy addict are bound to "street psychiatrics": everyday assessments individual women make about their history, their mental health, and their reasons for using or trying to stop using drugs. The trauma and mania form "new configurations of madness" which characterize their social worlds and legitimate their biomedicalized governance.

IV. Street psychiatrics: self medication and self diagnosis

Monica and I are walking down Mission Street on a sunny afternoon in June, 2008. We come across a poster on a building for lease, one of the many businesses that will most likely transition into a high end restaurant or bar. The poster catches my attention so I pause to read it and take a picture. The fine print claims that psychotropic

medications actually cause the mental illnesses that are visible in brain scans, because all the scans are taken of people on medications. “Look! Kids! This is your brain on psych meds!” reads the caption playing off the anti-drug campaigns of the 1980s which implied a user’s brain became fried (like an egg in frying pan) as a result of drug use.

Poster between 16th and 17th on Mission Street. June 2008.

I ask Monica what she thinks about it. “Hm.” She says “I don’t know. I stopped taking mine [her psych medications]. They were giving me really bad dreams. I didn’t feel right. They made me sleep all the time and then the dreams came.” Both Monica’s trips to the psychiatric emergency room have been the result of 5150 arrests[202] after sexual assaults. Remembering these incidents, Monica described herself as “so traumatized, so out of my mind” that being in the psychiatric lock-down on a 72-hour hold felt like a “relief.” A psychiatrist I interviewed backed up Monica’s experience. For a crack smoker - traumatized and hysterical in a mental health crisis - the focus of the Psych ER was temporary stabilization and release:

202 “5150” is the police code for a mandatory arrest, followed by a 72-manadory lock-down, psychiatric hospitalization for harm to self or harm to another. I discuss the politics and utilization of 5150 further in Chapter 7.

> [The mental health system's] excuse is always that it is the substance use. We blame the substance use, and don't look further that it. And PES [Psych Emergency Services] is designed for that. The most common presentation that they deal with, the most common presentation is intoxication with a stimulant. So all they do is give them a benzodiazepine [tranquilizer], let them sit around for ten hours until they clear [the drugs]. And they often look a lot better and they are no longer suicidal and they send them out the door. It doesn't mean that they don't have other [mental health] problems. It means that the acute syndrome has passed. And with crack, it lasts not very long at all. As soon as they [the doctor and patient] can develop a coherent plan, they kick them [the patients] out. And they don't look beyond their crack use, and that is unfortunate because there is a lot underneath. Trauma. PTSD is ubiquitous [among crack smoking women]. And part of it is that we don't have a lot of offer them, unless they have something else [a mental health problem]. You can't come into the psych emergency room and say to me 'My primary issue is that I am a prostitute and a crack addict,' and expect me to have any good answers for you. Or a place to put you. Or treatment. And that's sad. Because there is nothing. Its like 'Oh OK, here's some condoms.' I mean, that is where we are at as far as an intervention.

Although Monica has been on SSI disability for a mental health condition [not a mental illness] since she was a child and experiences a range of serious mental health symptoms, she has no consistent psychiatric care or follow-up. Monica is not perturbed by this and doesn't consider herself particularly in need. Her SSI benefit keeps her stably housed and she doesn't want to be on medications, "I can't live. I sleep too much." She tells me that crack use makes her symptoms – paranoia, panic attacks, anxiety – much worse. But she tries to control that on her own.

May offered a different picture. She was much more threatened by the accusation that she might need mental health medications. When I see her in 2007 she is seeking new housing. Having accepted a room in hotel in another neighborhood, she felt frightened. She attributed her constant crack smoking to her need to stay up all night because she was so concerned about her safety. Her case manager recommended a psych evaluation for paranoia but she rejected the idea anything was wrong with her mind: "I am smoking crack all night because I am terrified. My place is scary. I am afraid someone is going to break in. I don't feel safe. I can't get out easily because of my knees. I feel trapped. And [names outreach worker from city mental health] wants me

to go on medication, he thinks I am paranoid. I told him 'I messed up my knees, not my head.'"

May smartly identifies the clash between what makes her visible to health care providers and a very expensive patient (her injury and impending surgery) and what makes her more manageable to persons seeking to place her into housing (psych meds). Despite her rant, within several months May has successfully transferred back into the neighborhood and tells me she is content with her new housing funded through a city program, for which her SSI pays for 30% of the rent. One day she approached me looking very worried. She was tweaking out and convinced that a guy in car across the street was following her. She had me watch the guy in his car for a half an hour until he finally drove away. She is usually low key and this was the first time I had seen her acting really paranoid. When I hang out wit her later that week in her new room, she says she is still worried about people breaking in and banging down her door.

Cupcake told me that going through the process of getting on SSI, or any other form of welfare would force her to be under the control of 'authority figures' too much. She said "I have a problem with authority, you know. I don't like rules. That why I was always in trouble, always in jail. But I qualify (for SSI). I qualify for sure because of all my childhood experiences, and because of my behavioral problems. Shit, why do you think I got involved with crack in the first place? But we [my husband and I] feel like if we went that route (and got on SSI) we would never get out of here." A future - being drug-free from crack and having a child that she could remain in her custody - does not include neurocratic disability. Her husband concurs, "Even though I spent a lot of time inside [in jail and prison], I always worked. I was always able to work to make my money. Even if it was hustling. I never took no handout."

Kitt connects her speed and crack use to her past and to her current emotional and financial needs. Her first pregnancy happened the first time she got high on speed.

She had sex with a gas station attendant for the drugs when she was 13 and ended up pregnant as a result. She pays child support for her five children who are under a relatives care out of her SSI check. Even with a discounted monthly rate, facilitated through SSI, she does not feel it would be financially manageable for her. One day we hung out together for about 45 minutes, a much longer time than the usual intermittent chats that characterize ethnography with women actively engaged in the drug sex economy. She discussed her family history, her pregnancies, her self-medication with crack and speed, and her mental health history one subject right on top of the other.

Kitt **Mission Street** **September 2008**

It turns out Kitt can't really go home. Her mother wouldn't accept her, and she would need to get her own place. Kitt has been in and out of juvenile detention since she started running away at age 13. This is the same year she first got pregnant and started using speed.

When she got out of jail last week, Kitt was told by a local service agency that they could get her an SRO room in the Tenderloin for $470 a month. This is considerably less than the $50/night which she would pay privately. However, because she pays child support out of her SSI check, that would only leave her $100 left over.

She doesn't feel she could survive with her drug habit and basic needs on that amount of money.

Kitt was diagnosed with bi-polar disorder at age 19. She was 5150'd[203] after what she called a "speed psychosis" and is currently off her medications. She likes speed because it calms her down. "It makes me feel peaceful and sociable. Crack helps me feel angry, helps me act out about this lifestyle. This life that I am living down here. I get to fight on crack, and beat up other people, be tough and stay tough. But there are really two people inside me. One is really quiet and shy. But she can't show up out here."

Although trauma is understood to be a ubiquitous experience among homeless women, and PTSD to be a normative diagnosis reflecting that experience, the repetition of trauma exposure can create a dynamic in which women don't seek mental health care. Even if they did, they cannot enter the system as stimulant users and access social support programs (treatment, counseling) unless they have been given a diagnosis and/or are willing to accept one. Thus, many providers theorize and many women report, that they engage in street psychiatric practices. They self diagnose and

203 „5150„ is the police code for a mandatory arrest, followed by a 72-manadory lock-down, psychiatric hospitalization for harm to self or harm to another.

'self medicating' with stimulants, pain killers, alcohol, and other substances as a form of psychotropic treatment which keeps them productive and can temporarily stave off feelings of panic, anxiety, and despair. One provider told me "I don't blame (women) for using stimulants. The mania is functional. It allows you to hustle, to get your work down. Smoke crack and it puts everything on hold, so you can be focused and energized to do what you need to do. Whether is it turn tricks or hustle up money in some other way." Another provider rejects the term "self-medication." He told me, "Oh I know plenty of women who 'self-medicate,' who have experienced and do experience terrible trauma and abuse. But I don't like the term, 'self-medication'. I am a physician and I expect that when you talk about 'medication' you are speaking about something that will improve health, or relieve symptoms. I have never seen crack do that. I have never seen it work. It always makes everything worse."

In the next section, I discuss in further detail how bipolar disorder and PTSD are problematic to diagnosis from a psychiatric perspective among drug users and yet have come to diagnostically embody the social experience of women who live and work in the daily rent hotels.

V. New configurations of madness: bipolar disorder and PTSD

> Nearly 10% of participants in an urban general medicine clinic screened positive for lifetime bi-polar disorder. This is one the highest reported lifetime estimates of the rates of bipolar disorder in primary care. Past primary care studies have estimated the rate of bipolar disorders between .07% and 1.2%. [Studies done in 1985, 1988, 1997]…The high estimated prevalence in this clinical setting (99.8%) may be related to the low socioeconomic status of the population. In a national study [Hirschfield, et al. 2003] lifetime prevalence of bipolar disorder was highest (5.7%).[204]

How are we meant to interpret the findings from this study, published in the *Journal of the American Medical Association*? Does poverty make you crazy? Are the poor more likely to be labeled as such? Following Foucault, there has been a strong

204 Das AK, Olfson M, Gameroff MJ, Pilowsky DJ, Blanco C, Feder A, Gross R, Neria Y, Lantigua R, Shea S, Weissman MM. (2005) Screening for bipolar disorder in a primary care practice. *JAMA*. 293(8):956-63.

argument made in the social scientific literature about the homeless that the behaviors needed to survive in street settings – social withdrawal, aggression, hyper vigilance, theft, and rage – are medicalized in to mental health diagnoses for the better social management of these populations. I don't disagree with this broad assessment. Yet, it is the micropractices of behavioral assessment and mental health diagnosis on the part of homeless women and their institutional interlocutors that I find more revealing of the co-constitution of power and control. I am curious about specific configurations of mental illness – mania and trauma, not all forms of "crazy," per se. I am interested in the biological psychiatric categories of these experiences as bipolar disorder and PTSD. Their translation from experience and behavior in the everyday (what I evidence as an anthropologist) into their manifestation as disease trough neurocratic practices and clinical care shape this messy terrain.

Bipolar disorder on drugs: making sense of mania

The two anthropological engagements with bipolar disorder that I find most productive are very different from each other. Andrew Lakoff addresses bipolar disorder as an emergent biological category in Argentina which is unevenly displacing psychoanalytic orientations toward mental illness. He presents a brilliant analysis of political economy and expertise on the stage of global psychiatric categorization and practice. He does not however offer any ethnographic nuance into the experience of bipolar disorder. Thus the illness category, as is often the case in science studies analyses, is attributionally rich and existentially poor. Emily Martin, in her recent study of bipolar disorder, offers the antidote. Martin gives a diverse account of the experience of bipolar diagnosis, management and treatment from the inside out. However, Martin links mania to American success, markets which swing from up to down unpredictably and with grave consequences. She makes connections between mania, productivity and

success. However, in my ethnographic setting, bipolar disorder is specifically linked to the *lack of* productivity, to institutionalized recognition of an individual as a lost cause to be supported and warehoused by the state. The construction of women who live in the daily rent hotels as poor, addicts *and* disabled is key to this differential social pathway.

This brings me to a larger compliant about the anthropological literature of homeless and mental illness that this chapter is meant to address directly. In my ethnographic setting, all the women were wrestling with trauma, mania, depression, *and* drug addiction in varied forms, often exacerbated by pregnancy. Many recent ethnographic analyses of poverty and homeless that I find very compelling (Luhrmann, Wacquant, Lyon-Callo, Hopper) do not address drugs or addiction in a way that is reflective of its destructive individual and interpersonal effects. They soft pedal it. Drug use is seen simply as one inevitable outcome of a neoliberal form of governance that creates poverty and social suffering, or as an understandable individual coping mechanism. The physical and psychological impacts that drugs can and do make are under reported, and not well understood. The experiences and costs of illegal drugs are mostly footnoted, or mentioned in passing. If the complexity of drug use and abuse is taken ethnographically seriously (see Bourgois and Schonberg, 2009; Bourgois, 1995), mental health issues are often under-theorized.

Ethnographies which background or foreground drug addiction often fail to respond to the fact that our operating cultural understandings of our "neurochemical selves" which are expanding in relation to addiction. This emergent overlap demands equal critique of biomedical and social narratives. As a social scientist one must remain critical but not closed to the multiple evidentiary forms as they circulate. One might do better to analyze – and criticize - these perspectives in their limited ability to only present one picture, tell one story, among many being told. Arthur Kleinman discussed a future

convergence that is relevant to the anthropology of homelessness, mental illness, and addiction. At a recent Society of Medical Anthropology conference, he stated:

> The question for anthropology and psychiatry then will not be on the classical order of the normal and the abnormal. But rather will involve a much deeper phenomenology of the forms of social suffering, an epidemiology of the causes and consequences of social suffering, and the implementation science of policies and programs for the subset of social suffering which is represented by psychiatric disorder as well as for psychiatric conditions that are not tied to social suffering. Either/or thinking will weaken, just as a more complex and sophisticated understanding of both societal and biological processes will advance the understanding that normality as well as disease embodies social suffering.[205]

Attention toward the convergence of multiple representations of biology and social suffering occurred in relation to both bipolar disorder and PTSD. My curiosity about the diagnosis of bipolar disorder among women drug users first emerged in 2004. At that time I had been a qualitative researcher with drug using women for almost tens years and had conducted and/or analyzed hundreds of life history interviews. When I began a study in 2004, I noticed something. As I was discussing women's lives, drug use, and everyday experience almost all the women I was studying reported that they were "bipolar". This was interesting to me because it was different from how I was used to women discussing themselves and their emotional experiences of health or mental health. Prior to those 2004 interviews, I often heard "recovery rhetoric," narratives of regret about drug use, sadness and despair over the inability to change drug use behaviors, difficult family histories and current social and housing problems. No diagnoses, at least not for mental health. All of a sudden (from my perspective) everyone was bipolar. This trend has continued both in my ethnographic work with women in daily rent hotels and in more "classic" public health setting where I have interviewed drug using women one time only. The majority of women I speak with report a bipolar diagnosis. I began wondering, what has changed? One aspect that I already discussed which contributes to the change was the development neurocratic advocacy

[205] http://www.yale.edu/macmillan/smaconference/video/index.html Accessed February, 2010

on the part of San Francisco city officials to staunch the loss of revenues caused by the changes in eligibility criteria and to re-engage those who were dually and triply diagnosed (i.e. almost everyone from their perspective) back into systems of care. Another change arrived in the form of new medications – atypical anti-psychotics - which could treat a 'broad spectrum' of mental health symptoms. These pharmaceuticals can be used even of a clear diagnoses of mental illness is confounded by active stimulant use. Finally, both bipolar disorder and PTSD reflect a medically and institutionally valid avenue to transform the mania, depression, trauma and rage of homeless drug using women into recognizable and legitimate social suffering.

I asked an exploratory question on email to a list of psychiatrists and physicians that are attached to the San Francisco Department of Pubic Health: "Have you seen any changes in the diagnosis of bipolar disorder among the homeless since the late 1990s." It generated some interesting responses. One physician said "No." Another said that he had noticed more people self-diagnosing bipolar disorder, especially stimulant users who "identified with the symptoms." A third physician indicated an unequivocal "Yes". When giving reasons why he stated:

> I think that most of us have seen an increase in bipolar diagnoses in patients with primary personality disorders and substance use disorders (both common in the homeless populations). This has been related to a confluence of factors.
>
> 1. More clinician / research focus on the "bipolar II" diagnosis which has had softer criteria than "bipolar I" and is prone to overdiagnosis.
>
> 2. New indications for the treatment of Bipolar Disorder using brand name psychotropic drugs (lamictal, zyprexa, risperidone, abilify, seroquel, geodon). This has led to an all out campaign by the pharmaceutical manufacturers to over-emphasize bipolar disorder.
>
> 3. The de-emphasizing of psychotherapy and the emphasizing of medication management. Psychotropic medications have limited efficacy in either personality disorders or substance use related mood instability. On the other hand, psychotropic medications can have a tremendous benefit in the treatment of bipolar disorder. As the old saying goes, if the only tool that you have is a hammer...everything looks like a nail.

Another clinician concurred:

> Doc: The increase in the diagnosis of bipolar disorder is due to the pharmaceutical industry, because now there is 'plethora of treatments for bipolar disorder.' Physicians are much more likely to diagnosis people with bipolar disorder because the think that will help.
>
> Kelly: The medications will help?
>
> Doc: No. The label (bipolar) will help because they can put a medication on it.

Atypical antipsychotics have morphed from treatments for schizophrenia to treatments for most, if not all, mental health symptoms typically occurring in a population of urban poor substance users. From a treatment perspective, the fact that these medications do not decrease feelings of pleasure (anhedonia) or cause sedation makes them ideal of people who already crave stimulants.

> Doc: These are medications that don't cause anhedonia, don't cause sedation, they tend to be a little more activating and one of those drugs is abilify, it's a newer antipsychotic drug. The newer antipsychotics are very broad spectrum. They work for just about every serious mental illness. They work for depression, they work for schizophrenia, they are mood stabilizers for bipolar. Some of them have anti-obsessional components. If they [a patient] have a mental illness and you give them a medication from that class it [the medication] is probably going to benefit it [the mental illness] to some degree. That is what we have found over time. They were first launched to treat schizophrenia only, and then bipolar, and now augmentation of depression, anxiety, insomnia. PTSD. It's everybody. It is just going to keep going.

This is fortunate from a pharmacological perspective. If an individual actually has bipolar symptoms (mania as well as depression) and is treated only with an SSRI anti-depressant drug, they may be "pushed" into mania, and they may experience an increase craving for stimulants. So in that case, their pharmacologically managed recovery from mental illness symptoms is essentially working against their recovery from stimulant abuse.

> Doc: An example would be someone with schizophrenia who uses meth (methamaphetamine). If you give them Haldol, which is an older antipsychotic medication, it may increase their cravings for stimulants. Because one of the side effects is that it causes anhedonia, when you don't feel any pleasure. Which can also be a symptom of depression.
>
> Kelly: So the experience would be that they feel like they are coming down (off of meth)?

Doc: Or withdrawing. Not just coming down, but crashing completely. And that is often a persistent feeling that they try to escape. Chronic meth use burns out the part of their brain that experiences pleasure. So without meth they have no pleasure. And I am giving them a drug that prevents them from experiencing *any* pleasure. Because they burnt that circuit through meth use, and even through recovery I am giving them a medication that will make that worse….For every symptom that lead them to use in the first place, there is a (psychopharmacologic) medication that might make that worse. So I have to be very careful not to do that. And even sedating medications that don't cause anhedonia can worsen their cravings for meth.

Emily Martin points out that in France, in the mid 19th century, manic depression was known as "la folie circulaire" (circular insanity) by the Alienists who were meant to diagnosis and treat it. She writes: "Falret described this is 1854 as an illness in which 'this succession of mania and melancholia manifests itself with continuity and in a manner almost regular."[206] Among the women living in the daily rent hotels, "addict time" worked in much the same way.[207] Addict time was marked by the continuous repetition of the embodied experience of withdrawal and intoxication. As Ramona pointed out to me, "Listen. Here's me with my bipolar, right? And I am racing, and I am paranoid. I am uncomfortable and pissed, really angry. I am depressed. And here's you coming down off crack. We *act the same*. It looks *just the same*. How you gonna say that you *know*. You can't tell the difference." One physician went so far as to call bipolar disorder a "garbage diagnosis," especially for stimulant users.

Doc: [Bi-polar disorder] has a tendency to be a garbage diagnosis. When you don't know what else it is, especially when they are on stimulants.

Kelly: So you have a woman who is crack smoking…

Doc: You can't ever assess them adequately, so [doctors] have a tendency to come out with a label of bipolar disorder. And no one is doing them any favors because it is bad a diagnosis to have and the treatment…one of the reasons that antipsychotics are so popular, is because antipsychotics actually do pretty well across all three diagnoses, especially the newer the more activating antipsychotics. So I don't know, "Give them some Abilify [an atypical antipsychotic medication]." "Oh look they are doing better." What I am saying is getting the diagnosis right in those settings is very important, and very hard in someone who has not stopped using stimulants, or is still feeling the effects of stimulants. People who are two-years years out of speed use can still have the effects of them because of the impact of amphetamines on the brain.

206 Martin, Emily. (2007) *Bipolar Expeditions: Mania and Depression in American Culture*. Princeton: Princeton University Press, Page 46,

207 See Chapter 4 for a lengthy description of "addict time."

Kelly: How do you mean?

Doc: They will continue to kick, or tweek (their bodies). They are agitated, and that is not their baseline (how their nervous system would be working without the stimulant use history). So they will come across as bipolar or psychotic. You (the doctor) just don't get what is going on, to try and figure out what medicines will help them.

An individual may appear mentally ill when the residue of chronic speed use is still impacting their brain. A person may be using stimulants and have crack-induced manic episodes. These diagnostic quandaries are clinically challenging and become legally important to differentiate for neurocratic purposes. Yet, there seems to be widely used newer pharmaceuticals that can both treat and mask their differences. Unfortunately these medications are not without physical side effects. One provider commented on the irony of stabilizing someone's mental health while introducing physical health risks. His discussion of cardiovascular risk echoes Nora Volkow's comment on the co-morbidity between substance use and poor mental and physical health outcomes: "The co-morbidity of depression and smoking is close to 90 percent. Do you know what percentage of schizophrenic patients take cigarettes or take drugs? Eighty-five. Look at heart disease, the No. 1 killer. What is one of the highest risk factors? Smoking."[208] The provider said:

> There are significant risks with the newer class of medications. They cause metabolic complications. Weight gain. Diabetes. High Cholestrol. We are talking about a population that tends to die early, significantly earlier. And from a cardiovascular cause. And now we have [atypical antipsychotic] medications that cause cardiovascular disease. So it is a bit risky. Twenty ears ago we were giving them Haldon and they had all these movement disorders. You could see that this person was being medicated on an antipsychotic. They looked like it. They had the facial grimacing, the shuffling walk, the blank face. But they weren't overweight and they didn't have diabetes. Now, we give them the new case of medications, and they have bellies that are 50 inches around, their cholesterol is through the roof, their blood sugars are out of control and they are dying from heart attacks. At least they run that risk.

208 Duenwald, M. (2003) A CONVERSATION WITH: NORA VOLKOW; A Scientist's Lifetime of Study Into the Mysteries of Addiction. New York Times, August 19, 2003.

If bipolar disorder has become increasing attached to the everyday realities of women living and hustling in the daily rent hotels, PTSD has become instantiated as the diagnosis which captures the familial and social history of those same women and their current experiences of violence and abuse.

Trauma is the new black

> "Trauma is the major signifier of our age. It is our normal means of relating present suffering to past violence."
>
> - Fassin and Rechtman (2009)

> "99% of my patients in supportive housing have PTSD. With the women it is 100%."
>
> - Clinician, San Francisco, 2010.

In *The Empire of Trauma: An Inquiry into the Condition of Victimhood*, Didier Fassin and Richard Rechtman describe trauma as "one signifier for a plurality of ills signified."[209] Fassin and Rechtman provide an anthropological investigation into the "historical construction and the political uses of trauma" by uncovering the scientific genealogy of its diagnoses as well as trauma's "moral genealogy." Being attuned to the moral genealogy allows Fassin and Rechtman to understand how the veracity attached to the concept of trauma could be utterly transformed in two decades so that what was viewed with suspicion of malingering is now a normative and expected response to the collective and individual violence pervasive in modernity

> Most historians suggest that changes in collective sensibilities – i.e., in the way in which trauma and more particularly the victims of trauma are depicted – come about as a result of scientific developments. But in fact the direction of the causal relationship is far from one way. There is a moral genealogy running parallel to the scientific development. It derives from the collective process by which a society defines its values and norms, and embodies them in individual subjects.[210]

This line of inquiry – the scientific and the moral is of particular utility to questions of evidence about pregnancy and addiction, as new configurations of the addicted and the mentally ill publicly circulate and influence forms of clinical and regulatory

209 Fassin and Rechtman (2009). *The Empire of Trauma: An Inquiry into the Condition of Victimhood*, Princeton University Press. Preface.

210 Fassin and Rechtman, *Empire of Trauma*, Page 30.

governance. The pregnant addict sits squarely upon this nexus. It is at the intersection of accepted truths about her, as the embodiment of a traumatic past and at constant risk for everyday violence and her as a person in need of a diagnosis, a traumatic/manic rendering to make her socially legible that marks her relationships with institutions. The naturalized combination of physical health rendering with the necessary linguistic enabling of a traumatic history to grant social recognition through service access was constantly referenced among service providers I interviewed. One physician with over a decade of experience treating women drug users provided a view into this clinical reality when I asked her about "trauma."

Kelly: I wanted to ask you about trauma.

Doc: What kind of trauma? There is the trauma that shows up in ER, most often as a result of a motor vehicle accident. There is the violent, intended trauma, like 'I got beat up,' or 'I broke my leg because I jumped out of a building.' Then there is sexual trauma, which a lot of my patients have had. There is emotional trauma, which is usually attached to all of those above. So trauma is like a very non-specific word. When I hear that word, I always have to think in my mind: 'what is the person who is using that word referring to?'

Kelly: What do you see as a cumulative effect…

Doc: The cumulative effect of trauma is *huge*. And not just with the women, the men too. And some of it is just living where we live. In a city where there is a lot of everyday violence in the streets, and there is a lot of poverty. There is a lot of desperation, in certain segments of the patient populations. So there is a lot of trauma. More, I suspect then you would see in other places or other social strata.

Kelly: How does knowing that affect your approach to those patients?

Doc: [Pause] I want to think that it doesn't. But it often helps to extenuate those things when I am trying to get services for them. [Laughs quietly]. You kind of play on that compassion-producing response. In trying to get someone into a program, or to get them a service. Yeah. Or to get them, say, an appointment with a specialist. It helps to kind of provide more context for, [to explain to the other service provider] 'Why am I trying to reschedule this patient for the fifth time when they have missed all their referral appointments with you?' 'Why should you even bother to set some time aside for this patient who has consistently no-showed?'

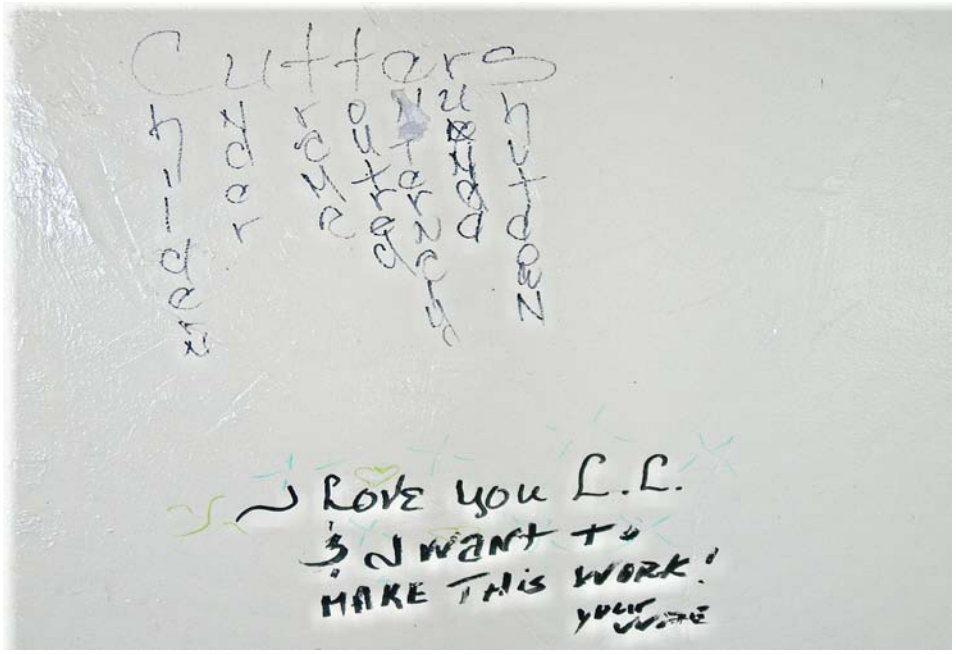
Kelly: How do you convey that?

Doc: There is this really abbreviated language that physicians use to get their points across. We talk about people being 'status post trauma' or 'sexual assault childhood'. 'Sexual assault, CSA (child sexual abuse).' When we give their

> history, we usually describe people using these one-liners: '47-year old, male-to-female transgender, HIV+, CD4 count X, Viral load X, on antiretrovirals, with significant history of childhood sexual trauma, recent rape. It is all this comma, comma, comma.

"Comma, comma, comma." This phrase particularly caught my attention because it mirrored the way in which Tara had spoken about herself. Tara was a young woman I had met in early 2008 when she was pregnant, about 6 months along. She liked to go to one particular bar near 16th and Mission Streets and would often show up in Monica's hotel room because of fights with her violent boyfriend. Monica called Tara her "daughter," and Monica was her "mom". Monica had a couple of "street daughters," younger women whom Monica relied on, and whom she could mother, because her sterilization at a young age had disallowed the possibility of her having her own birth children. Tara and Monica had a kinship bond which helped ground Tara in her relationships with men and provided someone in the neighborhood that would keep track of her. Tara's own parents had introduced her to speed, through injection, at age 12. She had also experience "a lot of abuse, not nice stuff." I had heard from Monica that Tara lost her baby because her boyfriend beat her up after she had come home drunk one night from the bar. "She knew she shouldn't have been drinking. He didn't like her drinking with the baby." Monica said to me. "But I don't like that man, anyway." I was never able to confirm with Tara about the details of her late pregnancy loss. One day in 2009 I ran into Tara on the street. She was explaining to another guy that she is homeless now because she finally left her "asshole" boyfriend. He wouldn't stop beating her up. She said, "I just want to go home. But I can't go back and live with my folks. And they won't help me get an apartment. They don't even want me in the same city. And my boyfriend, fuck him." She sighs and looks at over me half smiling, head-cocked: "Trauma, trauma, trauma." She says. Comma, comma, comma; trauma, trauma, trauma. Indeed, haunted childhoods and current relationship conflicts around love and

loss were written on the walls of the daily rent hotels. The picture below offers one example.



Graffiti on the wall in the Daya Hotel room. January 2008.

"Cutters" is a slang name for people, mostly women and teenage girls, who intentionally cut their arms and other parts of their body. Here the tenant has created an acronym: Children Under Trama (sic) Toutred (sic) Enternaly (sic) Runed (sic) Shutdown. Below the Cutters acronym there is a plea for reconciliation: "I love you L. L. and I want to make this work."

The common sense understanding expressed by both women who are living in the daily-rent hotels and their medical/mental health providers is that any marginally housed woman who is using drugs will have a history of trauma, typically adult and childhood physical and sexual abuse, and perhaps an additional mental health condition. One physician who also does epidemiological studies at the local public hospital said, "When we first tried to publish our data on PTSD symptoms among homeless women, the reviewers keep sending the papers back because they didn't believe our numbers.

They said, 'They couldn't be that high. The prevalence of these symptoms could not be that high.' But it was."

Allan Young most famously analyzed the interconnection between the development of the scientific diagnosis of PTSD and the specificity of its social history. He described how the need for scientific validity in psychological assessment created a technique of diagnostic measure, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* which established rigid criteria for what is "true" in terms of mental health diagnosis. In an active effort to ally criticism about the "soft" science of psychology and create institutional credibility for psychiatric diagnoses, the *DSM III* was revised using the following claims:

> (1) Mental disorders are best understood by analogy with physical diseases"…(2)The classification of mental disorders demands careful observation of visible phenomena…(3) Empirical research will eventually show that the serious mental disorders have organic and biochemical origins.[211]

The scientification of PTSD had the same parentage[212] as the "DSMIII Revolution"[213], functionally sidelining psychoanalytic clinical criteria, and introducing multiple forms of statistical validity (face, predictive, and independent)[214] which were consciously "indifferent to vagaries of content and context."[215] This is a diagnostic manifestation of what Fleck refers to as the false assumption of a determinative logic between conceptualization and evidence.[216]

While it is not the ethnographer's role to reach a final judgment about what is "real" and what is "true" about the experience and diagnosis of PTSD, the clinical-level hairsplitting has dissipated in relation unstable housed drug using women. They all meet the diagnostic criteria for symptoms in screening; they all tell narratives of childhood and

211 Allen Young (2001) *The Harmony of Illusions: Inventing Post Traumatic Stress Disorder*. Princeton University Press. Page 96.

212 Literally, in the form of psychiatrist Roger Spitzer, who was instrumental in the development of DSMIII and in PTSD as a disease recognized within it.

213 Allen Young, *The Harmony of Illusions: Inventing Post Traumatic Stress Disorder*, Page 89.

214 See Young's discussion in *The Harmony of Illusions: Inventing Post Traumatic Stress Disorder*, Page 104-5.

215 Allen Young, *The Harmony of Illusions: Inventing Post Traumatic Stress Disorder*, Page 101.

216 Ludwik Fleck (1935) *Genesis and Development of a Scientific Fact.* University of Chicago Press Page 28.

adult exposure to trauma and violence. However, there are concrete material social consequences inherent in a PTSD diagnosis and it is important to recognize the subtle circularity at work here. Lawrence Cohen has theorized that the high occurrence of family debt in Indian neighborhoods with many poor kidney sellers is not merely a result of a "naturalized states of poverty". Indebtedness does not only produce the circumstances under which selling a kidney becomes the only option for survival, but neighborhoods full of kidney sellers also produce a thriving debtor's economy[217]. Similarly, PTSD is produced and deployed in response to specific social and political circumstances - the traumatizing effect of childhood abuse and adult homelessness which results in social death. Yet the need to legitimatize claims of "service-connected" trauma subsumes and reconstitutes the conditions under which traumatic dysfunction can be claimed, and appropriate medical and social services can be requested. PTSD is produced of and by its social etiology and its intimate links to social benefits cannot be easily disentangled. The site of diagnosis provides the terrain upon which these epistemological shifts are realized in both ethical and financial terms.

What trauma does and is made to do among women in the daily rent hotels provides another ethnographic rendering of the Fassin and Rechtman's claim: "Trauma is not confined to the psychiatric vocabulary; it is embedded in everyday usage." Where my ethnographic rendering differs from the examples offered in *The Empire of Trauma* and also in Veena Das' work on social suffering in the aftermath of the partition is in the complex relationship between event and the construction of trauma in my ethnographic setting. This is not because "trauma," so conceptualized, is individually idiosyncratic

217 Lawrence Cohen, Where It Hurts: Indian Material for an Ethics of Organ Transplantation. *Daedalus*; Fall 1999. Cohen states: "The argument here is that the decision to sell may be set for debtors by their lenders, who advance money through an embodied calculus of collateral value. In other words, the aggressiveness with which moneylenders call in debts may correlate with whether a debtor lives in an area that has become a kidney zone. If so, the decision whether or not to sell is a response not simply to some naturalized state of poverty, but to a debt crisis that might not have happened if the option to sell where not present." Page 152.

among the women, and not a collective experience. As Fassin and Rechtman point out the "politics of trauma" require a bridging of the individual and collective:

> The politics of trauma [are defined by the fact that] the collective event supplies the substance of the trauma which will be articulated in individual experience; in return individual suffering bears witness to the traumatic aspect of the collective dramas.[218]

The ethnographic difference in my work centers around a qualitative and temporal economy of scale. It becomes difficult to attempt to distinguish and bound the sheer magnitude of the trauma-inducing events that unstably housed women have experienced and are experiencing. The "comma, comma, comma" of cumulative suffering in this setting over-determines the naturalization of trauma while also euphemizing the collective emotional response to it. Things are simply always on fire, in glowing embers or at full blaze. It becomes difficult for the physicians, the outreach workers, the anthropologists, or the pregnant addicts to account for the impact of specific traumatic events. In short, it never ends. Or it appears not to. Like a perverse orgy of misfortune. One provider claimed that the reason stimulant (crack) using women would not receive mental health treatment is because the mental health system is not set up to meet their needs. On the other hand, the mental health system does recognize – in accordance with all health providers I interviewed – that women's everyday lives create or exacerbate emotional traumas. The result, in his opinion, is self-medicalization with substances.

> Doc: If they walk into a mental health clinic they are not going to feel comfortable. They may or may not have a mental illness. If you walk in with schizophrenia, there is a group for you! If you walk in and you are a crack addict, there is no group for you.
> Kelly: What about for PTSD?
> Doc: We aren't the VA. We aren't prepared for it. At the VA it's the first question, everyone gets screened for it. We don't do a good job with trauma. Perhaps if there is a sexual assault that enters into the ER, [services exist] to put you in position [to get mental health follow-up]. But that is different than someone who is essentially raped every night, or assaulted in some other ways on a daily basis. The chronicity of it is much more damaging. Kind of like a combat vet. And it is much more [pyschotropically] treatment resistant as well. It is also doesn't bring them in for treatment because it is repetitive. It's like, 'OK this is my life. I life on the street. Yeah people are going to beat me up and take

218 Fassin and Rechtman, *Empire of Trauma*. Page 18.

> my money. Happens all the time. Happens to every one around me. Why should I seek treatment for it? I am just drink instead. Or smoke crack.' I think that is one of the most common forms of self-medication is for PTSD,'

The ability to diagnose a mania or depression that is not substance induced becomes difficult for physicians and psychiatrist if the woman never has any periods of abstinence from drugs or alcohol. The ability to map the effects of individual childhood traumas, to draw lines into the present, when present traumas continue is also extremely difficult. Even category makers – whose evidence is based upon the external bounding of time into segments made meaningful by epidemiologists - have struggled with the conceptualization of trauma. A section for our larger epidemiological grant proposal captures the epidemiological point of view:

> In a review of theory and empirical evidence, Sharon Wasco highlighted the limitations of current trauma response models, with a particular focus on the use of PTSD and the exclusion of other important factors, to characterize experiences of victimized women (Wasco, 2003). Wasco pointed to two problems with trauma response theories. The first problem is that traditional ideas of trauma are too narrow to capture the complexities of women's experiences of violence in a valid and reliable way. For instance, many trauma models highlight the violent aspects of an assault and do not address the cultural, social, and relational context in which violence, particularly sexual violence, occurs. In addition, many trauma frameworks treat an assault as a single event (Jenkins, 1997); however, the traumatic event may not be the only source of harm to a victim, rather a myriad of social problems that start well before and continue long after the assault itself are often contributing factors (Smith, Smith, and Earp, 1999; Saxe & Wolfe, 1999). Moreover, central concepts supporting trauma theory may not apply to ethnic minorities and other marginalized groups (Gilfus, 1999), a crucial point for this study regarding indigent women, over half of whom are women of color. In particular, issues such as racism and oppression often preclude some persons from perceiving the world in the same way that middle-class white persons do (Gilfus, 1999; Root,1992; Root, 1996) and thus lead to different responses to trauma. The second problem with trauma response theories is that emphasizing particular symptoms may recognize and therefore legitimize one sociocultural manifestation of distress and exclude others (Fine, 1992). For instance, the symptoms that diagnose PTSD may capture only a small portion of rape-related distress and may document an ethnocentric concept of distress that legitimize only one cultural expression of pain. Wasco uses rape as an example but contends that a more inclusive understanding of harm has broader value in understanding many types of interpersonal violence as well as stressful life events.[219]

Women's connection to traumatic events and their acceptance of a diagnostic label is influenced by their current social desperation. Poverty and on-going vulnerability continually informs the acceptance into the category. One example from

219 Grant Proposal submission, Shelter, Health care, And Drug use. (NIH/NIDA, R01DA015605; Principal Investigator, Elise Riley, PhD).

Lexi can illustrate this point. In 2004, when we first met Lexi had recently lost a baby under tragic, emergency circumstances. Her daughter was born prematurely when Lexi was 6.5 months pregnant. Her cervix had opened up. The hospital officials were unable to resuscitate the baby when she was born. Lexi always felt, and still does feel, that the providers had not done enough to save her baby because she was drug user and she was black. A case manager insisted she apply for disability because of "PTSD" after her baby died. She resisted having her trauma "connected with the welfare," through a PTSD claim for benfits while still recognizing that she was, indeed, traumatized. In 2008, I accompany Lexi to an appointment to try and get her Section 8 housing reinstated. She had applied while in jail, when pregnant with her son (now age 7). "I couldn't believe it when my sister called me and told me I got the letter. It took *that* long." She told me. We drive out of the county to her appointment. When she was in jail she filled out applications for every county in the Bay Area and this one is the one that came through. "I am going to get my housing figured out and I am going to have [her son] move back here." She tells me on the drive. "We can finally be back together." Lexi is excited. When we get to the appointment the official ask her a bunch of questions. One is about disability. I notice Lexi emphasizes that she has PTSD. The official looks up and nods, making a note of it. Lexi has to mail back more paper work, but she doesn't. I ask about why several times and she is dismissive about it saying "Yeah, I got get that stuff together."

Soon Pano is back out of jail and I realize she doesn't want to live so far away from the Mission. Pano is only briefly out of jail, though, just long enough, according to Lexi, to get into a money-related conflict with daily rent hotel management. Lexi ends up facing eviction from her room for non-payment of rent. She tries to fight the eviction by using the advocacy services available to "SRO tenants." During an attempt to "stay" her eviction, the case worker asks her if she has any "disabilities." Knowing that saying yes

with increase the chances of getting more time to fight the eviction, she says "Yes. PTSD." The eviction worker makes a note of it. She is evicted anyways and spends 8 months street homeless, after which Pano returns form jail and she becomes pregnant shortly afterward.

Fassin and Rechtman conclude their analysis of the conceptualization and circulation of trauma by saying, "[W]e believe that the truth about trauma lies not in the psyche, the mind, or the brain, but in the moral economy of contemporary society.[220]" In Lexi's case, her PTSD diagnosis did and didn't matter. It served to make her a legible "victim," a person rendered more vulnerable in the eyes of governmental housing agencies than someone without such a diagnosis. On the other hand, it did not instrumentally translate into some form of psychiatric care or social support that could stabilize her housing or income. In early 2010, when I speak to Lexi, she is trying not to smoke crack or drink alcohol – and has received her first clean urine at her methadone program in four years. She says to me, "I am finally getting housing. I am getting on SSI. But I am doing it all myself. I went to the SSA office on my own, cause I can't get anyone to help me. Now I just need a psychiatrist. Everything else is in place, because they (SSA) has a record of my PTSD from way back in 2004! I just need a psychiatrist but I don't know where to get one." Lexi is surprised that her case has just been sitting there, at the SSI office, for six years.

VI. Neurocratic pregnancies

> 100% [of the pregnant women here] have a treatable mental health issue. Most will report either PTSD or bipolar disorder, but they have not been clinically assessed for those disorders. They are familiar with the symptoms. They have friends who have these diagnoses. They look at their own histories, especially the severe, just horrible, histories of trauma that these women have gone through, and these disorders seem like a fit.
>
> - Provider in a drug treatment program for pregnant addicts

220 Fassin and Rechtman, *Empire of Trauma*. Page 276

Craving pickles during pregnancy is fine. Craving crack is not. This social reality is extremely problematic for pregnant addicts if one is to "treat" addiction as a brain disease. Not only would pregnancy status have no causal bearing on the "learned addictive behaviors," the stress of a pregnancy within the context of the daily-rent hotels may in fact increase drug use. According to a neurobiologist of addiction I interviewed, stress triggers organic mechanisms in the brain that can reverse abstinence, particularly in environments where people have used drugs in the past:

> It's in the brain. It is all in the brain. And there is no question that if you read the literature everybody agrees that stress can reinstate drug taking in animals that have had that behavior extinguished, or who are abstinent. So stress will do it [initiate drug taking]. Sometimes a small dose of the drug will do it. Sometimes going into an environment where you have previously had the drug will stimulant you to take the drug again.

The catch-22 situation continues in relation to emotional well-being. Moods that swing from angry to happy to deeply sad are normal in pregnancy. They are perceived to be the results of hormonal fluctuations. PTSD, bi-polar disorder, and the medications often used to manage those conditions are problematic during pregnancy. 10-20% of pregnant women experience depression during pregnancy, 10-15% report post-partum depression.[221] Women who are depressed prior to getting pregnant run an increased risk of post-partum depression.[222] Among women who have a bipolar diagnoses prior to pregnancy, 25-50% experience a severe affective puerperal (post-partum) psychotic episode.[223] These juxtapositions push upon the boundaries of rational behavior for pregnant women. Can scientific discourses that link craving, addiction, and impulsivity to brain function influence our understandings of women's seemingly self-destructive

221 Wisner KL, Perel JM, Findling RL. (1996) Antidepressant treatment during breast-feeding. *Am J Psychiatry* 153:1132-1137; Greden JF (2001) Treatment of Recurrent Depression *Review of Psychiatry.* Eds. J.M. Oldham and M.B. Riba. Vol. 20., American Psychiatric Publishing, Inc.: Washington, D.C.

222 Wisner KL, Perel JM, Findling RL. (1996) Antidepressant treatment during breast-feeding. *Am J Psychiatry* 1996;153:1132-1137.

223 Jones, I. & Smith, S. (2009) Puerperal psychosis: identifying and caring for women at risk. Advances in Psychiatric Treatment *15: 411-418.*

and congenitally destructive behaviors evidenced by continuing drug use – both illegal street drugs, and prescribed psychotropic medications - during pregnancy?

From a neurocratic perspective, drug-using women may be more adverse to seeking care because of fear that it will be accompanied by state-level adjudication and the loss of child custody. A clinician who works with pregnant women explained:

> I see women who report PTSD and also a lot of bipolar disorder, and whether they have been diagnosed with it formally of not, the way their experience of it seems to play out, they way I see it showing itself is that all their decisions are based on fear. They have objectively experienced a tremendous amount of trauma, they have learned behaviors that have gotten them through [on the street] but aren't what they need to parent well, they are products of growing up in families where there was drug use and poor parenting. They will probably loss custody of their children.

Aspects of fear-based decision making may link to histories of family trauma, but it may also be connected to the real experience of lack of control women have over how a custody case will be decided should Child Protective Service (CPS) be alerted when a baby is born. There is a lack of medical sophistication, and personal bias, among CPS workers which can affect *their* decision-making. This reality effectively nullifys treatment system efforts at support and reassurance. CPS has the authority, even without the expertise. One physician shared her frustration,

> CPS involvement depends on the case worker, the range is huge. Some will look at the dose of methadone and make a decision to pursue the case. Even though good research shows that the degree of infant abstinence syndrome is not determined by the mother's dose of methadone. She could be taking 60 mgs and the baby could detox for 6 weeks, she could take 120 mg and the detox for the baby could be shorter. So the CPS worker could make this very important decision based on false assumptions. The fact that my client is working so hard, and has done everything right, but can't get housed – this might not be the deciding factor. [It might be her CPS case worker's assessment of her methadone]. And she is terrified. Terrified that she will lose the baby. And I can't tell her, unequivocally that she won't.

From a perspective of medical management of women who have mental health diagnoses, and are already engaged in a health care system, their pharmacological medication management is complicated by their pregnancy. They face the difficult decision of continuing on psychotropic medications that may have helped their mood state and daily function, but now place their fetuses at risk. Of they could change

medication, but their own mental health could be at risk. As one clinician pointed out, women who are bipolar have an evitable risk of 'psychotic episodes' after their babies are born.

> Atypical anti-psychotics are actually fairly safe in pregnancy. But the other component is that you have to be prepared for their symptoms to get worse if you change medications. So if somebody becomes pregnant and they were on [names a medication]. I might say "Well it's the first trimester, it is pretty risky that your child will have a neural tube defect, and not be born viable. So I can stop this medication. But now your pregnant and I am changing your medications around. The risks of you becoming unstable during your pregnancy increase, but the safety to your child may be more favorable. And then once you deliver we are going to go back to something that worked, but that is also another high risk period for post-partum psychosis.' And women who are bipolar are at by far the highest risk for having post partum psychosis. It is almost diagnostic for bipolar. It can happen outside of bipolar disorder, but it is kind of a tell tale sign that you have bipolar disorder if you have post partum psychosis.

Some women, like Lexi (who has a diagnosis of both bipolar disorder and PTSD) just quit taking their psychotropic medication on their own when they discover they are pregnant, and leave the system.

For the pregnant addicts in my ethnography mood states mixed regularly with drug use and the work (hustling) necessary to meet basic needs and stayed housed. Pregnancy was an unstable biological category which in turn destabilized mental health, relative to mood disorders, hormones, and anxiety. Pregnancy was additive. It was the add-on stressor to an already stretched emotional inner world, and an irrationally violent and exploitative social world. Notions of "pregnancy as disability" and the disabling aspects of pregnancy for homeless drug using women interrelate. Taken into the context of the everyday lives of the pregnant addict it is ironic that employment coverage for maternity leave is also referred as "disability." It underscores the bureaucratic logics that insist that conditions recognized under the rubric of "disability" are not politically or socially relevant. It is a matter of being able to work. The assumption is that women who are imminently giving birth or who have just given birth cannot "perform their regular work" to quote the SSI disability trainer. Officially, these claims are considered under short term disability, described below:

> Although motherhood is not a disability per se (though there will be plenty of days when it feels like it is), short-term disability (STD) insurance — which many employers and unions pay for and offer as an automatic benefit to their employees — will generally pay between 50 and 100 percent of your salary for a certain number of weeks after you give birth. Technically, STD is meant to cover your salary, or a portion of your salary, during the time you're unable to do your job as a result of illness, injury, or childbirth.

None of the pregnant addicts had jobs for which they were eligible for short-term disability benefits as a result of their pregnant status. Some were already granted SSI disability for mental and physical health conditions. All who did not enter residential treatment went back to (sex) work shortly after giving birth. Lexi needed to turn tricks to pay down her hotel debt once she left the hospital. She worked even though she had not healed properly from her hysterectomy. Ramona was pulling dates down the street when I came to accompany her to her methadone intake appointment, five days after her baby was born, also because of hotel debt. These experiences provide an extension to the concept of stratified reproduction.[224] Not only are some women discouraged from reproducing, some women get to claim disability through childbirth and some don't.

The reality of co-morbidity (dual, triple diagnoses) makes the compartmentalization of intervention responses to pregnant addicts inadequate right out of the gate. Yet the ability to diagnosis and respond to a substance use disorder (with a replacement therapy), a mental health condition (with a mood stabilizing drug), and a social environment bereft of support or future orientation (with stable housing) is a complex task. I discussed this challenge with a clinician who had a broad knowledge of both psychopharmacological agents and the everyday lives of addicts. I mentioned that many women I knew who were pregnant did not necessarily have an opioid addiction so they could not have access to one of the programs offering psychiatric evaluation. She reflected,

> There is no place for them [crack using women] to show up. Unless they get pregnant. And that is unfortunate, that the first time that we [the mental health system] catch them is when they are pregnant. If they get court ordered, late in pregnancy it is partially

224 See Ginsburg, F. and Rapp, R. (1995) *Conceiving The New World Order: the Global Politics of Reproduction* University of California Press.

> because there is not a lot that is advertised of available to them before that. We used to have a program that was defunded and may not even exist anymore. When I started, I worked with program, that was a place that women who were crack smokers could show up. But with cocaine, though, it doesn't matter if it is in methadone or through the mental health clinics. At no stop along the way do have anything [in terms of a pharmacological replacement therapy] to offer somebody that uses, abuses stimulants. Whether it is crack or meth. We don't have a drug [a psychotropic medication] that works for stimulants. If you have mental health symptoms, if you are depressed, I will treat your depression and I will do it aggressively with the hope that it will have an impact on your crack use. And that is our approach to take what ever else we can do something about – whether its their opioid addiction, their depression, their bipolar – and treat it really aggressively to put them in the best place to engage in therapy or counseling for their cocaine addiction. That is the best we can do. And that can be important because their life is often so chaotic because of the combined effects of, you know being bipolar, untreated and a crack user, that they are never gonna stick in a counseling program for their crack use, until we stabilize their mood, stabilize their housing, hook them up with medical services. And give them a lot of support so you can show up [to addiction counseling] on a daily basis for group.

The evidence that counts in making pregnant addicts socially legible is shaped by emergent practices of addiction and mental health, that assume both conditions are brain diseases which are heavily influenced by each other and by the environment in which the addiction, trauma, mania and depression is being experienced. Clinicians – physicians, clinical pharmacists, and psychiatrists seek medications that could manage both substance use and mental health symptoms. It is hoped that a psychopharmacological pathway can displace narratives of moral failure. A focus on disease offers that possibility. But current treatments for pregnant addicts are still organized around notions of personal responsibility. One provider told me,

> The problem of responsibility and accountability are huge. We are a drug treatment program. We expect accountability, we expect people to admit they have a problem, and that they need to take responsibility for it. Especially pregnant women, they need to take responsibility for the fact that she is going to have a child.

Medicalization and personal responsibility are linked in programs that can offer a "drug substitution" for addiction (methadone for heroin), and this may be cause for deserved critiques about the governmentality of addiction and the social control of addicts. From the perspective of pregnancy and addiction though, it is important to note that methadone is the only show in town. The discussion over what neurocratic futures might be possible for pregnant addicts never leaves the political economic domain,

because battles over scarce public health dollars are constant, and continually renegotiated. The costs of care and treatment for pregnant addicts emerged in most conversations I had with clinicians, regardless of how neurologically technical they may have begun. The argument was made that pregnancy and addiction would do well to plead its case in relation to health care costs. The lion's share of mental health resources for stimulant users in San Francisco are deposited into programs that serve the mental health and addiction needs of men who have sex with men (MSM). Speed using MSM are at high risk for HIV infection. HIV infection and AIDS are expensive diseases. But as one clinician pointed out, drug-using women who are unstably housed and working as sex workers and get pregnant, are also at risk for HIV infection. Focusing on the cost of caring for their infants post-partum was a strategy suggested to bring attention and resources toward this neglected group.

> Gay men + meth = HIV. That is just how the funding calculus works. Now, women + sex work + crack *does* equal HIV but it does not get the same level of resources. And I don't know why. Even if it isn't the same level of risk [for HIV] it still seems that the funding is too uneven. We can even break it down to costs, look at the dollars. What happens when those women get pregnant and show up at the hospital. These are kids that are in the NICU (neo-natal intensive care unit) for days afterwards. There a lot of resources that go in to the follow-up for babies that are born to mothers that use heroin. We need to look at the [health] outcomes and not just ask the question 'Is this a targeted population in San Francisco?' I think that [allocations of funding] become arbitrary without looking at the outcomes.

VII. Mental health transience

Neurocratic possibilities for social legibility have emerged since drug and alcohol dependence were both discontinued as medical conditions which afforded persons federally-funded disability benefits in January,1997. This change necessitated increased focus on the documentation of mental health disorders among drug users. Specific mental health diagnoses that counted for federal disability also served to institutionalize the desperation of traumatized homeless women. Bipolar disorder and PTSD have become the diagnoses that seem to cluster around the women I worked with in my

ethnographic study. When "street psychiatrics" came into play, women openly discussed their own mental health assessments and the ways in which they use drugs to "self-medicate" in opposition to using drugs to "get high."

"2 Do" List written on the wall Chandra Hotel March 2010
People have annotated to the original list which is focused on buying hygiene supplies: guaze (sic) and tape for treating abscesses, lotion, clothing. Additional things to acquire are: Drugs, pussy, and a new man. Next to the list someone has written: "Crazy? No Mother I'm awake."
Blood strains, shot from used syringes can be seen in the bottom right on the photo.

"Residential transience" – the movement between dwellings and changes in types of housing - is a risk for poor physical and mental health among drug users documented in the public health literature and an ever-present weekly reality for the women I studied renting daily rooms in private hotels. They also suffered from and leveraged "mental health transience." Mental illnesses moved. Diagnoses became an essential legitimizing force for making entitlement claims upon the State. Diagnoses attached themselves to practices of recognition for gendered physical (DV) and sexual (rape) violence in childhood and adulthood, through PTSD. A linguistic referent – bipolar disorder – captured the often despairing, yet also maniacal, social landscape of

predictable yet chaotic addiction in everyday life. And just as residential transience is conceptualized as an aggregate risk – not, by definition, effecting each individual in exactly the same way, mental health transience successfully sweep up some homeless women, pregnant addicts among, them into moral worlds that felt explanatory of their familial history (Kitt making the connection between running away, getting pregnant while using speed, and getting a bi-polar diagnosis), even comforting (Monica's 5051[225] after her rape). Other women played upon the social opportunities that mental health transience offered (Ramona at her methadone intake, May to get re-housed in a better hotel).

Addiction, mental illness, pregnancy and disability form a complex assemblage of biological and social markers which leverage state recognition and require governmental regulatory management. Neurocrats emerged out of a dual need on the part of city health policy makers. On the one hand, neurocratic recognition was designed to ensure economic stabilization for drug and alcohol dependent persons. Renewed SSI was meant to stave off street homelessness within the larger political context of welfare reforms that punished poor women, particular poor pregnant women and mothers and an increasingly virulent War on Drugs campaign. Aside from what neurocratic possibilities were created for individuals facing the lose of SSI benefits in the late 1990s, city health officials needed to support SSI advocacy for mental illness eligibility in order to bill for services delivered within the health and mental health safety net. Diagnoses of bipolar disorder and PTSD among drug-using, unstably housed women - currently widespread - occurs in a service context in which mental health diagnoses are needed and valued. These diagnoses follow a biomedical, pharmacological logic. Atypical anti-psychotic medications entered the market and appear to successfully treat the braod

225 „5150" is the police code for a mandatory arrest, followed by a 72-hour mandatory lock-down, psychiatric hospitalization for harm to self or harm to another.

spectrum of symptoms of mania, depression, rage, and despair characterizing women's lives, even if on-going crack use confounds the majority of diagnostic attempts. In the next chapter, I outline how pregnancy, addiction, mental illness, so configured, overlaid onto institutional interactions (with the public health system of epidemiological surveillance and intervention, drug treatment, and criminal justice system) designed to respond to and manage "risk" among pregnant addicts.

Chapter 7: Public health failures, viability, and metrics of success

I. Evidence, politics and risk

This chapter is about politics and risk. I explore the kinds of evidence that matter when pregnant addicts are multiply displaced within and between various public health interventions. Pregnant addicts unavoidably interface with institutional systems of care and control. Whether a pregnant addict self-identifies upon entering treatment, is court-ordered to treatment, deferring incarceration, or shows up at the hospital to deliver her baby, the state gets involved. The ethnographic reality of those involvements is far from a straightforward story of oppression and civil liberty violations. Rather, it is a continually renegotiated dance of assessment, cooperation, resistance and coercion. While the jailers shackle and corral, they also break protocol to allow women to spend time with their babies. While the drug treatment officials call for "personal accountability," they also manipulate dysfunctional systems of public health care to ensure women receive optimal prenatal care.

Pregnant addicts express both hate and admiration toward the institutional representatives that play such central roles in their family life. This ambivalence characterizes the revolving door that catches pregnant addicts, momentarily bringing them inside the system, only to fling them back out shortly afterward, then back in again, and then back out. This is an "institutional circuit" (Hopper, 1997), which does not rely so much on the liminal status of pregnant addicts as "excess labor." They are reconstituted through their pregnancy from throw-away addict sex workers into a new biologically-determined category: risk incarnate. They are politically volatile, impossible to ignore, victim/perpetrators. One clinician I interviewed described the risk pregnant addicts pose to systems and the necessity to manipulate those same systems to ensure some level of care. She paints a picture of a two competing constructs of the pregnant addict – a moral failure that just needs to stop using drugs and a diseased subject at risk

and in need of medical supervision. Politics ultimately dictates a systematic bait and switch.

> No one wants the liability for pregnant women. No one wants them. When they get picked up from jail, the jails want them out. They don't want a miscarriage or pre-term labor or birth on their hands. I can't even get a local treatment center to do a medical detox for pregnant women who need to be detoxified off alcohol. Now heroin, opiates, there are a lot of circulating rumors about detoxing too suddenly and its effects on pre-term labor and miscarriage. But the research seems to be that the uterine environment for women using those drugs is not that unstable. [In contrast] For alcohol or benzodiazepines, the research is clear. An unmedicated, rapid detox can kill you. These women need a medically supervised detox for alcohol. I have to use my background as a medical provider, because I know the language to get women admitted, to get them in to the hospital for an alcohol detox. I mention several health issues, I ask if the women can be 'tucked away for awhile' - that is the code. When I can establish that it is medically indicated then she can get a blood work-up, even get a pysch evaluation while she is hospitalized. But it is a 'social admit' in the sense that the community based treatment program should have taken her.

Those persons working in the "helping professions" (Weinberg, 2005) are tricky figures. They, like the pregnant addicts that they care for and coerce, are at turns hopeful and bitter, burnt out and optimistic: "Maybe she will be able to keep this baby, maybe this time." Pregnant addicts face the real and constant fear that the state – the child welfares services – will revoke custody of their children. While not all the women in this ethnography wanted to keep their children, the vast majority did (Dylan being the notable exception). Likewise, what I heard unequivocally and repeatedly from the professionals closest to pregnant addicts was not a rhetoric of pie-in-the-sky recovery. These professionals had no illusions about the challenges addiction posed. What they sought were incremental forms of stabilization – getting a woman to a clean birth, or birth with just a methadone detoxification, getting a woman to a birth without a CPS case, getting a woman to stay in aftercare long enough not to lose her baby before CPS closed the case. These professionals clung to "success stories," like they were tales of heroism and luck representing an almost mythic overcoming of incredible odds. And, indeed, several women, as of this writing, appear to have beaten the odds. They have

navigated ways out of the daily rent hotels, and are living tentatively, day to day, in drug treatment facilities with their babies. Others did not beat the odds.

What future possibilities can enfold for pregnant addicts – or foreclose upon them - are intertwined with institutions of care and coercion. Politics – the politics of interagency deferrals of responsibility, the politics of reimbursement for health and mental health care services rendered, and the politics of hatred for addicts – come into play as the risk of an impending birth, and its potentially poor outcome, looms large. The potential viability of women's unborn children becomes a complex calculus of social-institutional interaction, individual behavior, and time. Requirements of women to take individual, personal responsibility for themselves and their unborn children come into conflict with institutional regulatory mechanisms which produce unintended consequences. Are there ways out for pregnant addicts? Is it ever too late to be a "good mother"?

To understand the available interventions for pregnant addicts in this ethnography and how they were used, we need to first broaden the context to how pregnant addicts are construed in the field of public health. The women who lived in the daily rent hotels were sex workers, the majority of whom did not intend or plan for their pregnancies (Cupcake's "false" pregnancy being a notable exception). First, I discuss the "risky city" as a site of historic and current sexual depravity and vice - producing disease among sex-working drug users. Second, I explore a "tale of three abstracts," to determine how epidemiological data about childhood sexual abuse, drug use, early sexual debut, and unintended pregnancy paint a reproductive health picture with unplanned pregnancy as its inevitable outcome. Within this epidemiological picture of risk, sex workers operationalize their stories of risk, transforming them into numbers in pubic health studies, revealing their bruises at domestic violence shelters, lying about the health insurance to get STD medications.

Once women are pregnant, treatment professionals may configure them into two categories of women: those who are taking responsibility and those who are in denial. Of course, women's motivations and actions in the everyday tell a more complex story. Ethnographic evidence reveals those contradictions, as I trace how women are caught up into systems, avoid them, escape from them, but are ultimately forced to acquiesce to their rules and regulations until they can relinquish the label of "unfit". Those women who remain unfit return to the daily rent hotels, unshielded yet again from the "risky city."

II. The "risky city"

The city as a site of moral degradation, licentiousness, and risk is replete in multiple literatures that seek to describe and quantify urban landscapes and the problems of their populations. Sociology and American Urban Studies specifically, has produced tomes theorizing the ways in which cities embody larger US government policies of structural violence,[226] most specifically racism[227] and classism.[228] Although several ethnographic texts have offered more nuanced detail,[229] often these books seek to paint the city as a governmentally neglected site of urban squalor in which "social abandonment"[230] paradoxically occurs en masse. What haunts most of these portrayals is the same seminal literature which informs David Harvey's Marxist understanding of neoliberalism: Engels' writings on the industrialism and mass migrations to the city of the poor from rural enclaves in the mid 19th century. With this movement, Engels' writes,

226 There are divergent interpretations of the concept "structural violence." One definition - which many public health sociologists adopt - discusses increased morbidity and mortality as life spans are reduced when people are socially dominated, politically oppressed, or economically exploited. "[S]ickness is a result of structural violence: neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress. Farmer, *Infections and Inequalities*. UC Press. Page 14. Another perspective, consistent with a Foucault, does not locate structural violence only at the point of state withdrawal. Rather, structural violence originates with the "fruits of scientific and social progress," because these are the disciplinary tactics whose presence - not absence- reinforce racist and sexist social and scientific policies. See Wacquant, "Violence from above: deproleterianization, relegation, stigmatization" *Urban Outcasts*. Polity Press.Page 24-30.

227 See Massey, D. and Denton, N. (1993) *American Apartheid: Segregation and the Making of the Underclass.* Harvard University Press.

228 See Wilson, WJ. (1987) *The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy*. University of Chicago Press.

229 See Bourgois, (1995) *In Search of Respect: Selling Crack in El Barrio*. Cambridge University Press. Bourgois, Philippe and Schonberg, Jeff. (2009) *Righteous Dopefiend*. University of California Press. Wacquant, L. (2008) *Urban Outcasts: A Comparative Sociology of Advanced Marginality.* Polity Press.

230 Biehl, J. (2005). *Vita: Life in Zone of Social Abandonment*. University of California Press.

came intemperance (alcoholism) and sexual lasciviousness. Here vice and a lack of economic opportunity are linked and enacted in the "risky city." The city is made risky for bourgeois men who seek to satiate their carnal desires and quickly retreat, and risky for the women and the men in London who "succumb" to hardship, exploitation and disease. These groups incur different, and unequal, risks. Even Engels conjures the numerical imaginary of "40,000 prostitutes" to validate his point:

> Next to intemperance in the enjoyment of intoxicating liquors, one of the principal faults of English working-men is sexual license. But this, too, follows with relentless logic, with inevitable necessity out of the position of a class left to itself, with no means of making fitting use of its freedom. The bourgeoisie has left the working-class only these two pleasures, while imposing upon it a multitude of labours and hardships, and the consequence is that the working-men, in order to get something from life, concentrate their whole energy upon these two enjoyments, carry them to excess, surrender to them in the most unbridled manner. When people are placed under conditions which appeal to the brute only, what remains to them but to rebel or to succumb to utter brutality? And when, moreover, the bourgeoisie does its full share in maintaining prostitution - and how many of the 40,000 prostitutes who fill the streets of London (Alison 1840, volume 2) every evening live upon the virtuous bourgeoisie! How many of them owe it to the seduction of a bourgeois, that they must offer their bodies to the passers-by in order to live? - surely it has least of all a right to reproach the workers with their sexual brutality.[231]

Harvey utilizes the political and social policies that followed the bankruptcy of New York City in the mid and late 1970s as an "iconic" case example of what can happen to citizens when "[w]ealth is redistributed to the upper classes in the midst of a financial crisis."[232] The results were unequivocally disastrous for the health of the poor, specifically in relation to drug use and HIV/AIDS. Harvey echoes the sentiments of Engels over a century later:

> Working–class and ethnic-immigrant New York was thrust back into the shadows, to be ravaged by racism and a crack cocaine epidemic of epic proportions in the 1980s that left many young people either dead, incarcerated, or homeless, only to be bludgeoned again by the AIDS epidemic that carried over into the 1990s. Redistribution through criminal violence became one the few serious options for the poor, and the authorities responded by criminalizing whole communities of impoverished and marginalized populations.[233]

Harvey uses the case of NYC as *the* experiment that "established the principle that… the role of government was to create a good business climate rather than look to the needs

231 Engels, F. (2007) [1845] *Conditions of the Working Class in England in 1844.* BiblioBazaar. Page 158.

232 Harvey, D. (2005) *A Brief History of Neoliberalism.* Oxford University Press. Page 45.

233 Harvey, D. (2005) *A Brief History of Neoliberalism.* Page 56.

and well-being of the population at large."[234] This model was rapidly expanded under the Reagan and the Clinton administrations, contributing to a national dismantling of US domestic social welfare programs and structural adjustment programs abroad. To Harvey the "risky city" is the embodiment of the consequences of neoliberal policies in practice.

It is important to attend to *how* to city is rendered risky and for whom, in specific neoliberal discourses. The individuation of "risk" is fundamental to Foucault's rendering of government in the biopolitical sphere. Thomas Lemke, an Anglo-Fauldian scholar has argued the contractual terms of this biopolitical citizenship include a rendering of oneself responsible for all individual and social risks.[235] In Pat O'Malley's essay "*Risk and Responsibility*," he claims that it is important to construe "risk" in a neoliberal context not as "indicative of an imperfectly governed world." [236] Rather risk leads to opportunity, consistent with the rational-actor, entrepreneurial model of citizenship. It is the goal of social welfare liberals - a "no-risk society"[237]- that neo-liberals find suspect and dangerous. Thus the probability of risk and its subsequent quantification, play a significant role in the characterization of the interventions that governments forward to respond to urban poverty, and specifically to vice.

Many public health sociologists and epidemiologists are influenced by a conceptualization of the city made risky through federal – and sometimes state and local - withdrawal. Vlahov and colleagues argue that "urban" can be theorized on its own as a "social determinant" of health by measuring the "characteristics of cities such as size,

234 Harvey, D. (2005) *A Brief History of Neoliberalism* Page 48.

235 Lemke, T. (2001) 'The birth of biopolitics': Michel Foucault's lecture at the College de France on neoliberal governmentality. *Economy and Society* 30(2): 190-207. Page 201; (2008) *The Birth of Biopolitics: Lectures at the College de France*, 1978-79. translation: Graham Burchell. Palgrave: Macmillan. Page 144.

236 O'Malley, P. (1996). Risk and responsibility. In *Foucault and Political Reason: liberalism, neo-liberalism and rationalities of government*. Barry, A; Osbourne, T; Rose, N, Eds. University of Chicago Press, Page 204.

237 O'Malley, 1996 [citing Aharoni, (1981)] Page 203.

density, diversity, and complexity" in relation to health outcomes.[238] Freudenburg and colleagues employed public health statistics about tuberculosis infections, HIV infections, and homicides in New York City from 1975 to the early 1990s to demonstrate how the closure of public health clinics and services directly contributed to a "syndemic."[239] A syndemic is defined as "two or more epidemics, with biological determinants and social conditions interacting synergistically, that contribute to an excess burden of disease in a population."[240] Framing part of their analysis in economic terms, Freudenberg and colleagues claim that the combined health and social costs of excess (that is, preventable) cases of TB, homicides, and HIV/AIDS cases "ranged form 54.7 billion to more than 160 billion…[or] 5 to 15 times greater than the total dollar savings in city expenditures during the fiscal crisis."[241] In other words, the draconian social welfare and services cuts produced a more costly disease and fiscal burden than the original crisis. It is important to trace the sociological construction of the probability of risk in this domain in order to understand how the impact of environmental *conditions* (the concerns of social theorists such as Engels) came to find their representation in the quantified individual *behaviors* of city dwellers who were shown to be at risk.

III. The tale of three abstracts

How do pregnant addicts reveal themselves upon the epidemiological terrain of the risky city? An experiment in the analysis of abstracted evidence provides a unique lens into the construction of these risky women. The following three abstracts tell a tale, in aggregate. Taken together they form a narrative of risk - physical, sexual,

238 Vlahov, D; Freudenberg, N; Proietti, F; Ospad, D; Quinn, A; Nandi, V; Galeo, S. (2007). Urban as a Determinant of Health. *J of Urban Health*. 84(1): i16-i26. Page i16.

239 Medical anthropologist Merrill Singer originally developed the concept of a syndemic. See Singer and Clair (2003).

240 Freudenberg, N; Fahs, M; Galeo, S; Greenberg, A. (2006) The Impact of New York City's 1975 Fiscal Crisis on the Tuberculosis, HIV, and Homicide Syndemic. *Am J of Public Health*. 96(3): 424-434. Page 424.

241 Freudenburg et al. (2006), Page 430.

psychological, social risk. Each study describes through epidemiological snapshot a public health angle into the production of the pregnant addict. Ethnographic narratives of the women of the daily rent hotels offer specific, contextual confirmations of the statistics these epidemiological abstracts forward. Yet, they also introduce the nuance of subjectivity as they outline the lived experiences of abuse, drug use, and sexuality. The evidence of category–makers and infovultures taken together appears to render risk inevitable while making intervention pathways seem vague and muddled. Yet, it is precisely these two forms of evidence, statistics and stories that circulate in public policy discourse about pregnant addicts.

The first abstract is a study of Latinas, drug use and sexual debut. It reports that (1) length of time spent in the United States[242] and (2) a mother's drug use during a girl's childhood are associated with having sex at a younger age. Having sex at a younger age is associated with drug use and sexual risk.

> **US Latina age of sexual debut: long-term associations and implications for HIV and drug abuse prevention.**
> Frank R. Dillon; Mario De La Rosa; Seth J. Schwartz; Patria Rojas; Rui Duan; Robert M. Malow. (2010) *AIDS Care*. 3:1-10.
> This cross-sectional study explored associations among (a) age of sexual debut; (b) drug abuse; and (c) sexual risk behaviors among an urban community-based sample of 158 predominantly immigrant, Latina adults. Time in the USA and having a mother who used drugs during the participants' childhood or adolescence were significantly related to age of sexual debut. In turn, younger ages of sexual debut were associated with drug abuse and more sexual risk behaviors (greater number of sexual partners, more frequent alcohol and drug use before or during sex, greater levels of intoxication from alcohol or drugs during sex). Implications for HIV/AIDS and drug abuse clinical services and future research with US Latina populations are discussed.

Three excerpts from Crysanne offer a parallel immigrant narrative. One is which the American Dream collapsed and her mother turned to substance use (like her own mother before her). Crysanne is born became an inevitable anxious addict:

> So I think my father was gonna leave; get rid of everything and sell before he went to jail or had to pay and my mother got pregnant. So maybe being a good man he stayed. I don't know what

242 The phenomenon documented in public health of recent Latin and Central Americans' health being better than that of immigrants from the same countries of origin that have lived in the United States for longer is called the "immigrant paradox." The subtext of this paradox is that America – the food, the discrimination, the forms of poverty, etc – makes immigrants sick.

to think. But he lost everything. So it was back in the fifties so what happened? I think it was the taxes. Cause I remember his best friend jumped off the building…I remember yeah his partner killed himself. So I'm thinking that's what that was about, so of course they hate me. And then a little girl. My mother was from an [Southern European] immigrant family, traditional, she wanted boys. And my mother had a nervous breakdown. I was sick when I was born they say. I guess he planned on leaving her and my mother used to smoke 3 packs of cigarettes a day and drink coffee and she took valiums. So I don't know if I'm different because of that you know the sickly, the anemic sick.

My husband went to jail, so I went to college. I go "When he comes back I'm getting a divorce." He comes back; the first night I sleep with him I get pregnant. I was 19. And then my mother of course "You can't leave him now." I go "I don't love him." "Oh the baby." So that's what I did. I had the baby and just put everything into the baby. And then I wanted to leave him again and damn it if I didn't get pregnant again like a few months later. Then he started again – he hit me a couple of times and I said "Don't close your eyes tonight." I said, "Oh my God." I just got up and took the kids and grabbed one of the cars and came back to San Francisco. So then I lived in my van awhile until I got money and got a place. The kids were little, 2 and 3. And you know looking back [my husband] wasn't as violent as [names a later boyfriend, Jim]. Oh God. With Jim, I had guns in my mouth. Oh, every day for a year it was something. Every day.

My mother you know she had a rough life. She was the oldest of five; all her siblings are dead. She hated her mother; I'm like her mother way before her time. [My grandfather] would find [my grandmother] in bars drunk; drag her out of the bar. So they finally broke up and my mother was raised by a Jewish woman. She goes "Do you think I had it easy?"

Crysanne Mission Street March 2008

The second study seeks to examine the "combined influence" of substance use, childhood sexual abuse, and sexual risk among women who are receiving treatment for opioid addiction. Research on homeless women, drug using women, and female sex workers has documented the extremely high rates of sexual and physical abuse in childhood. Like all epidemiological studies, association is measured, not causality.

> **Substance Use, Childhood Sexual Abuse, and Sexual Risk Behavior among Women in Methadone Treatment.**
> Cohen LR, Tross S, Pavlicova M, Hu MC, Campbell AN, Nunes EV. (2009) *Am J Drug Alcohol Abuse*. 35(5):305-310.
> Background: Substance use and a history of childhood sexual abuse (CSA) are risk factors for unprotected sex among women, yet questions remain as to how their combined influence may differentially affect sexual risk. Objective: The current study investigated how complex relationships among drug use and CSA may contribute to unprotected sexual occasions (USO). Methods: A Generalized Linear Mixed Model was used to examine the interaction between current cocaine/stimulants and opioid use and CSA on number of USOs in a sample of 214 sexually active women in outpatient methadone maintenance treatment. Results: For women with CSA, an increase in days of cocaine/stimulant use was associated with a significant increase in USOs. In contrast, an increase in days of opiate use was associated with a significant decrease in USOs. For the group of women who did not report CSA, there was a significant increase in USOs with increased opiate use. Conclusions: Findings indicate that CSA is related to unprotected sexual occasions depending on drug type and severity of use. Scientific Significance: Women with CSA using cocaine are at particularly high risk for having unprotected sex and should be specifically targeted for HIV prevention interventions.

The authors conclude that "drug type and severity of use" are factors in USO (unprotected sexual occasions), and that women with a history of childhood sexual abuse and crack use are at particularly high risk. Monica describes her childhood sexual abuse and her crack use in relationship to her institutionalization in foster care – running away from her foster mother and her birth mother who Monica felt did not protect her from being molested:

> And I was molested as a kid [in foster care], yes…And then I left [foster mother's] house because I couldn't tell her, you know – I never could explain my feelings very well. I had a bad habit of hiding all my feelings, so I would try to kill myself…Every time that came up to my head, here I go, popping pills…You know, and I was, um, smoking a lot of marijuana. I was drinking; I was going out with boys and doing sexual stuff because I didn't know what to do. You know, I couldn't talk to her; I couldn't face her, you know? When I told my [biological] mom, she said 'Oh, you must have liked it [being molested].' How could a mom say that? That's why I hated her all these years. I didn't like her – I didn't wanna be around her. Every time I got around her, I just, you know, my blood would boil. I just disliked her so much.

Kitt also describes running away, after she became pregnant and was forced to have an abortion by her mother. Kitts second pregnancy was discovered after she got arrested

Kitt: And I had ran away when I was 15, me and my friends had ran away and when we ran away we went to live over a store, you know there was like Iranians [who owned the store]. And I had sex with one of the guys and we stole his car and I was like you know I was probably the only in my group that was having sex. And I had sex with him. And I didn't know I was pregnant with his baby until after I had my daughter…So before I came to the city I used to sell pussy. I'd run away. I started running away when I was like 13 because the first time I had sex I got pregnant and it was really you know traumatic for me because my mom, at that time I thought I wanted to keep it but my mom was like what are people going to say you know. And basically she kind of pressured me and I had an abortion and I didn't get any counseling and I was like daddy's girl. And we didn't discuss it after that. But I started acting out. My mom used to like threaten me 'Do you want me to tell your dad?' you know. She used to hold that over my head you know.

Kelly: That you had gotten pregnant and had an abortion?

Kitt: Yeah that she would – cause we kept it from my father and I'm the baby girl so me and my dad were like really close. And so finally I just told him. And my mom you know growing up my mother was real religious and she used religious abuse kind of in a way. The way I said it is because she would withhold her love if I wasn't like a part of her church; if I wasn't reading my Bible and stuff…So after I had the abortion my mother she was like "Well you're not going to church no more". And she kind of turned me over like she didn't want to have anything to do with me. And I started running away with my friends and I started you know being promiscuous you know having sex for self esteem. And when I got pregnant – I was 15 years old when I got used a mill [pimped out]. Me and my girlfriend had ran away and we went over to this guy's house – I mean we went to Sacramento with these guys and when we get to Sacramento the guy's talking about 'if we don't have sex you all gotta get out of the car'. And we met this guy like in front of A&P in Sacramento. Now I'm so naïve because when we went to his hotel room he had a lot of people coming in and out. I thought he had a lot of friends. He was dealing drugs. I was 15. You know I mean I had barely smoke weed. I think I hadn't at that time. I had drank before. [They gave me their dope to hold] and as soon as I put his jacket on there was a knock on the door and it was the police. There was a Bayer aspirin bottle full of crack in the arm of the jacket. And I found out I was two weeks pregnant in jail cause they did a blood test.

The third abstract reflects all forms of risk and poor reproductive health outcomes combined. Women who are heroin and crack using *and* pregnant are assessed for sexually transmitted diseases. The study finds that sex work and psychiatric comorbidity pose significant risks.

> **Sexually transmitted infections among pregnant heroin- or cocaine-addicted women in treatment: the significance of psychiatric co-morbidity and sex trade**
> C E Cavanaugh, S L Hedden, and W W Latimer. (2010)*International Journal of STD & AIDS* Vol. 21(2): 141-142
> Psychiatric co-morbidity and sex trade were tested as correlates of sexually transmitted infections (STIs) among 76 pregnant heroin- or cocaine-dependent women. Participants were recruited from a drug treatment programme and attended a clinician-administered assessment including the Structured Clinical Interview for DSM-IV (SCID-IV-TR) and self-report questionnaires about lifetime histories of sex trade and STIs (i.e. gonorrhoea, syphilis, chlamydia, herpes, genital warts or trichomonas). Lifetime and six month rates of STIs were 53.9% and 18.4%, respectively. The majority of women also had lifetime

histories of psychiatric co-morbidity (61.8%) and/or sex trade (60.5%). Participants with psychiatric co-morbidity (adjusted odds ratio [AOR] 3.9; 95% confidence interval [CI] 1.3–11.6) and/or sex trade (AOR 3.2; 95% CI 1.1–9.5) were more likely to report STIs during their lifetime compared with those without such histories while controlling for age, education and race/ethnicity. Results suggest that as many as one-in-five pregnant heroin- or cocaine-dependent women in treatment have one or more STIs that are concurrent with their pregnancy and may contribute to risk for contracting HIV and pregnancy complications; psychiatric co-morbidity and/or sex trade were associated with greater STI risk. Findings underscore the importance of identifying and addressing co-morbid psychiatric disorders and sex trade behaviour in this population.

This is perhaps the most proximate epidemiological rendering of the pregnant addicts in the daily rent hotels. It states that the statistical odds of STI risk among pregnant addicts to be 3-4 times higher if they "report" a psychiatric co-morbidity and/or trade sex. The abstract's evidence argues clearly that the women public health should worry about are the crazy-pregnant-sex-worker-addicts. It does not offer anything in the way of narrative reality. We do not know from reading the abstract – or the article – where these women are trading sex and getting pregnant. Kitt reported an STD shortly after her abortion, Lexi while she was pregnant. Unopened condoms and used needles literally litter the floor and the uncovered beds of many women's daily-rent hotel rooms.

Anita's bed Chandra Hotel March 2010

Ramona tells a narrative of rocky post-treatment experience in the daily rent hotels, trying to raise her daughter, prostitute and manage her crack addiction without stable housing.

Ramona's methadone intake **December 2009**

Ramona is describing what happened with her first daughter, DeLoni, who is now seven to an old counselor (Mary) of hers at the methadone clinic prior to her formal in-take with another counselor. This explanation of the outcome is way for Ramona to bring her old counselor up to date, to finish a story that started eight years ago when Ramona came to the clinic pregnant with DeLoni. Ramona says:

"I gave her up myself. I had to. I was trying so hard with her. You know I was. And I was clean for so long. You know that too."

The counselor shakes her head, yes. Her eye contact with Ramona is intense. Her eyes are full of concern, absolutely focused, and very sad around the edges. This counselor knows her well. They have clearly been on a journey together, a journey on which this counselor was absolutely present. Ramona's head is bowed, she is fidgety. She continues:

"After DeLoni was born, it was crazy. I was crazy. I was clean for awhile. But then I graduated from the program and I still had her with me. But I was living in the [daily rent] hotels. And I relapsed. I would take my daughter to preschool, come back to the room, have my tricks, smoke crack. I would hustle during the day while she was at school. The managers were always hassling me for rent. They didn't want my daughter there. I would clean everything up, pick her up and the evening was just me and her time. I won't even open the door. But I couldn't keep it up. I couldn't stay on top of it. I finally I had to call [names a relative] to come and take DeLoni. And it was lucky I got arrested that day. The day [the relative] came to get her. Because if I had been there [in the hotel] I would not have been able to let her go."

IV. Sex work, risk and debt in the daily rent hotels

Abstract behavioral constructs such as "sex work" lose their meaning unless they are placed in context. The economic exploitation of women in the daily rent hotels was dependent upon the structure – the hotel itself – functioning as a defacto brothel in which the proto-capitalists (the hotel managers) made a profit off of women's work. Hotel managers charged women fees for each "visitor," they regularly verbally harassed women and intimated them into engaging in sex work or facing eviction. Rental debts often spiraled out of control if women experienced a hospitalization or familial crisis. Kitt, who paid daily for her hotel room through sex work and other hustles, lost her housing when she had an abortion and then needed to attend to her elder child in the hospital. Lexi accumulated rental debt when she agreed to accompany Dylan to the hospital for the birth for Dylan's child. The hospital Dylan chose was not in the neighborhood and

Lexi was gone for two days during Dylan's long labor and delivery. The following field note excerpts taken during a 6 month period in 2008 give an impression of the structural constraints of sex work in the daily rent hotels.

Mission Street **January 2008**
Ramona has left the Nimish Hotel for now. She said she got kicked out because she was behind in her rent. She said, "I was paying 40 bucks a day." That's about $1200 a month for the Nimish, which is a really gross and worn-down hotel. She said, "They [the management] were robbing me, they were robbing my dates. They took all my stuff." And I said, "How are they robbing your dates?" She said, "They take 10 bucks per date."

Donut shop, Mission Street **January 2008**
Lexi's a mess. She was trying to figure out money for her hotel room tonight. She said she's bleeding out of her vagina. Her urine is straight blood, and she's really sick. She was trying to get some money out of some guys that were at the table next to us, to try and get her room paid. She's back at the Daya Hotel, back in her old room. They 21-dayed her last week but she is back in now.

Mission Street **February 2008**
I ran into Jackie who was right outside of the Grey Hotel so I asked her how the Grey was. She said she liked it because the guy [the manager] ran "a really tight ship" and he was really strict. I asked about visiting fees and this is what she described. She said, "If you lay down sixty bucks it's 45 for the room, plus '5 bucks for your late fee from last week, plus 5 bucks for your move out fee, plus 10 bucks for your stained pillow'. And so you have to be really careful to lay down just exactly the amount of money that you want to pay because he'll keep all the money and not give you any change based on whatever you give." The manager charged her ten bucks for taking a too long shower. He charges 5 bucks for visiting [to bring a trick up], but it's random when he's going to charge it and he gets to decide how long people stay. Then she says, "I like it cause it's got this controlled environment." But the hotel management was totally about policing her! She told me she thought it was safe, because the manager is such a cop about charging fees. But she was joking about it, she wasn't pissed and she said it was just part of the "business." The trick is to be savvy enough to pay him the right amount of money if you didn't want to get ripped off. She gets two free visits a night if her rent is on time. To Jackie it was all about knowing the rules but she described the rules as – her words were 'inconsistent', that "he's [the manager's] totally inconsistent."

Daly Hotel **March 2008**
The Daly Hotel is usually pretty mellow cause only Nicki's staying there. Now Cupcake and Steph are there too, which are two kind of new women to this hotel. Usually Nicki's on her own. I heard the hotel manager screaming at Nicki, "You better get out there and make some money because you need some money." She was really mellow. Nicki's usually really pretty intense, rushing around and yelling, totally manic. She was mellow. She was like, "Okay." Very submissive to the manager's yelling for her to get outside and start hustling (as a sex worker), which is unusual for her.

Mission Street **May 2008**
Lexi is outside. She got evicted from the Daya. She went to go dose [to her methadone program] and when she got back the sheriff was there. She was so upset. She was crying and she said she was "regressing" and that she knows she doesn't want to go back to a time where she had to wear 2 or 3 pairs of pants but last night she did it because she was so cold and it was just really hard to see her so down when she's such a strong person. She hasn't been homeless in a long time. She talked about having to do car dates [sex work in cars] even though she doesn't want to

and it's not safe and she can't make that much money. But there it is. That's what she's gotta do to get herself back inside. But first she needs an ID, which was stolen while she was sleeping. She was looking for Wisdom who she'd given her ID to hold. Lexi has spread her documentation out between like 4 or 5 people on the street so if something happens and her stuff gets lost somebody has a backup copy….I saw Cupcake. She's not getting much bigger for being pregnant but she was bringing a trick up. I heard her talking about whether or not he would use a condom when she was taking him upstairs into the Brigit Hotel. I didn't hear what he said about it.

Mission Street June 2008
There was a younger sex worker named Abril who I've seen before a couple of times. She said the cops were all over her last night and she couldn't – what did she say? She said [pretending to speak to the cops] "I gotta be out here to pay for my rent. If I don't work I don't get to sleep for the night so can you leave me alone."

These field notes paint a picture of economic exploitation within the daily rent hotels. Women frequently faced the fear of eviction from the hotels which can lead to homelessness and arrest by the police on solicitation charges. From hotel to hotel the application of costs for visitors, the extension of credit, and level of harassment by management varied – but not predictably enough to safeguard women in certain daily rent hotels from the brothel-worker experience. All the private hotels functioned as brothels, albeit with varying degrees of arbitrary cruelty. It is important to note that Jackie's assessment of the exploitation as part of "business" is absolutely correct. While I witnessed hotel managers harassing women and hostility between managers and women was frequent, it was hardly ever personal. It was about the rent. Money is evidence to the protocapitalist. Indebted women would be targeted would be targeted for more intense forms of harassment. When rent was paid, relations were friendlier in the hotels, or at least not fraught with conflict. However, because of addiction, debt, and exploitation rents were rarely paid easily or on time.

Here is another abstract, a complimentary rendering of risk written for an audience of category-makers that takes a political economic view of the ethnographic reality of sexual risk among women in the daily rent hotels:

Inner City Brothel USA: private, daily-rental hotels, women and HIV risk
Kelly Ray Knight, Philippe Bourgois, and Elise Riley
Background: Associations between sex work, HIV risk behavior, and HIV seroincidence have been well established. There has been very little research documenting the operational characteristics and political economies of brothels as specific sites of infectious disease transmission and poor reproductive health in United States inner cities. Methods: We conducted three years of ethnographic research that focused on housing contexts, HIV risk, income generation, mental health, and victimization among unstably housed women living in a US city. Results: Privately owned, daily-rental hotels in impoverished neighborhoods emerged as significant HIV risk environments in which hotel management preferentially reserved rooms for women conducting sex exchange and profited from these transactions, thus operating illegally as de facto brothels. Sex workers were charged illegal visitor fees and higher rents; they experienced increased residential transience compared to non-sex working tenants. Drug use during sexual transactions was commonplace in these settings. Women experienced regular harassment from managers to engage in sex work. Women reported accepting multiple sexual partners and agreeing to riskier sexual behaviors and partnerships due to the combined pressures of rental debt, drug withdrawal, and food insecurity. Protective factors offered by hotels, such as providing temporary sanctuary from street-level violence and assault, were overshadowed by numerous risk factors they introduced. Manifestations of on-going sexual risk included sexually transmitted infections and numerous unplanned pregnancies among sex workers in these private, daily-rental hotels. Conclusions: Micropractices of exploitation within private, daily-rental hotels contribute to HIV risk among women residents. Women in these housing environments face structural pressures to participate in sex work which can combine with individual drug use and mental health vulnerabilities to produce risk. Investigations of macro and micro level structural risk factors in inner city US brothels should inform interventions and policies that safeguard housing and decrease HIV vulnerability for unstably housed women.

V. (Ware)housing pregnant addicts

The abstract above presents unplanned pregnancies and STDs as reproductive health outcomes linked to the political-economic forms of exploitation that plagued women in the daily rent hotels. This discussion, like the larger ethnographic project, centers on private, daily rent hotels as specific sites of poor health production and reproduction. The pregnant addicts that I studied regularly stayed in these daily rent hotels, when they were not street homeless, in temporary shelters, or incarcerated. The two publicly managed hotels in which I had regular contact did not house any pregnant addicts. When I spoke to a housing official about this, he confirmed my ethnographic experience. He also echoed the sentiments of the provider quoted above, who said about pregnant addicts that “no one wants them.” The pregnant addict is again the

exception, the excess among the drug using urban poor, the "case" that is so traumatic it produces trauma among service providers.

> Kelly: I wonder why none of the pregnant women I know are accessing supportive housing?
> Official: They don't have a good case manager. Or they haven't sought out those services.
> Kelly: But they are getting 5150'd[243] to the hospital. They are going to the ER. They are having those interactions. They are *pregnant*.
> Official: There are no pregnant women in [supportive housing] buildings. You know what pregnant women become? [Pause.] Mothers. Then I have to worry about their kids. I have just watched so many situations like that [with pregnant women using drugs and alcohol] go *so bad*. I just can't tolerate it anymore. It is too traumatizing.

It would be a mistake to assume that there is no drug use, drug dealing, or sex work that goes on in publicly funded hotels, however. What seems in to be absent in publicly managed buildings is the extra level of economic exploitation (through visiting fee extraction) and the threat of eviction (because rent subsidies are in place, most often through SSI). While there were no pregnant women who were housed in the two public buildings I had regular contact with, it is also important to note that no women staying there *became* pregnant during the three years I was conducting field work. Most of the women, in fact, that stayed in these publicly funded hotels were much older and much sicker than the younger sex-working women. This is not necessarily the case across the board in all publicly funded buildings, as the housing official pointed out:

> Actually in our building that has the highest success rate [80% of tenants stay housed there at least two years]; there is a ton of sex work and drug use. And yet people stay housed. I am arguing the financial argument. The cost effective argument. 'If you spend the money here - on beautiful new supportive housing and you will reduce costs.' In an eleven site study, San Francisco is always highest on drug use. I think there are more conservative parts of the county who would see our most effective building as an abject failure. Because the drug-sex economy *is* still inside.

Even though abstinence is not a housing requirement and eviction sanctions are not invoked for sex work, women are not getting pregnant and they are staying housed. As the official points out, this makes the cost effective argument for publicly managed

243 „5150" is the police code for a mandatory arrest, followed by a 72-mandatory lock-down, psychiatric hospitalization for harm to self or harm to another.

supportive housing easy to make. So where can a pregnant addict get housed? One provider pointed out the paradox of housing, pregnancy and addiction. While she had assumed that pregnant women would be a top priority for housing placements, this was not her experience. If pregnant addict can successfully manage the requirements of the methadone maintenance program, they become poor candidates for residential treatment, because they are too stable Therefore they have to join waiting lists for low income housing, as opposed to "supportive housing" which is often allocated for single adults with no children and serious mental and physical health problems. These low income waiting lists often extend beyond the life of the pregnancy. A CPS case is then automatically initiated because of the woman's housing instability. The Program Director said:

> Pregnancy is not a 'golden ticket.' Not even for housing, which is incredible to me. Many women in the program call the housing agency and get excited by the thought of being housed only to find out that the waiting list is 6 months long. What are they supposed to do? They are going to deliver before that time, and they can't go back to the hotels with their babies, and they can't be homeless [because they will loose custody].

Prior to discussing the vital politics at play when pregnant addicts access institutions of care and coercion, I offer a brief interlude into the dynamics of "hustling systems". Hustling systems plays an essential role in destabilizing evidence produced about pregnant addicts and can reinstantiate the pregnant addict as a morally compromised liar.

VI. Hustling systems that hustle her

Hustling systems is an art form born of necessity. It requires women drug users to bring street survival skills into settings of public health research, health care, and service delivery in order to get physical, mental and social needs met. These survival skills are marked by bravado and the habitual misrepresentation of facts and circumstances. That is the "hustle." The multiple times I witnessed and documented

women hustling systems, it was quite obvious that their hustling generated from an accurate interpretation that they were being hustled by the system as well. The rules that dominate forms of intervention and service provision systematically excluded many drug using women from participation based on complex social categorizations. These categorizations flew in the face of epidemiological data, and everyday experience which (as demonstrated above) told a story of cumulative and overlapping forms of vulnerability.

Hustling systems reflected the intersection of audit cultures of categorization linked to funding streams that could easily dry up if all the women could access these services and the realities of the drug-sex economy. Women often experience the services and research studies which gate keep their eligibility as exercising the same arbitrary sets of controls that proto-capitalist hotel managers wield with their demands for visiting fees. And why shouldn't they? Both denials carry with them the risk of not having money for a hit, something to eat, or a place to sleep. Hustling the public system becomes a way for pregnant addicts to make visible the boundaries that are constantly being drawn between the worthy and the unworthy poor. These boundaries produce socially dead pregnant addicts and are produced for them.

Service providers are often caught in between the granting of the desired object (housing, food, research money) and the recognition of their implicit role in enforcing rules that are met with required deceptions. One clinician who works with pregnant addicts told me that she expects them to lie to her. The pregnant addicts she works with interpret this provider as culturally separated, as someone who could not understand their experiences. The provider does *not* attribute the misrepresentations to a recognition that services can operate *just like* the streets, however. To this provider, lying is a reflection of survival on the streets and an unavoidable consequence of the "disease" of addiction. I asked her how she can determine if the lying she sees among

pregnant addicts isn't the result of a "personality disorder." Personality disorders are considered to be rampant among homeless drug users. The clinicians I interviewed frequently expressed frustration at the lack of effective psychopharmacological intervention for personality disorders, thus many patients may end up with a bipolar disorder diagnosis in order to medicate them[244]. "Antisocial personality disorder" is particularly common diagnosis of which one of the main indications is "deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure."[245] Asked to distinguish between the lying as indication of antisocial personality disorder verses the interpersonal demands of negotiating an addiction, the provider stated:

> It shakes out in the end. I just try to be consistent. I anticipate that women will look at me and know that I haven't shot drugs and will believe I can't know anything about their lives. But I am a medial provider, I can offer a different perspective. And they sit and bullshit me the whole time and that's OK. I just wait it out. Eventually they see that I am here. That I am non-judgmental. I see the lying and the hustling as part of the active addiction. It is part of the streets and part of the disease.

Ramona echoed this interpretation when her intake counselor left the room. She turned to me - after misrepresenting a bunch of her psychiatric and health symptoms to the counselor, and generally being "difficult" about the process - and said "this girl; [the intake counselor] is all book." Ramona felt that since the intake counselor didn't call her on her obvious bullshitting that it showed that she was college educated: book-smart, but street-dumb. The forms Ramona is completing create evidence, clinical evidence about pregnant addicts and their physical and mental health. When they become reified in aggregate statistics they can leverage policies, serve as the catalysts for program development. What might it mean to recognize that they can be so skewed?

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244 See Chapter 6 for more detail of the complexity of mental health diagnoses among persons actively using substances.

245 *DSMIV-TR, Quick reference*. 2000. American Psychiatric Association. Cluster B Personality Disorders, 301.7 Antisocial Personality Disorder, Page 291.

Or is it worse to have social policies which ignore epidemiological data? The epidemiological literature is replete with data that shows that domestic violence and drug use are associated. Women drug users experience an inordinate amount of abuse. There is also a well documented literature that demonstrates that domestic abuse often escalates when a woman becomes pregnant. In June of 2008, we heard Benz yelling and throwing things in her room at the Nimish hotel. She said, "That is why I don't want to be on the street anymore!" She was having a terrible fight with another girl in the hotel room. Two weeks later, I received a call from an outreach worker Mara, seeking my advice on what could be done for Benz. As the field note describes, Mara, as a service person, expressed ambivalence about sending Benz into systems of care and also fear about Benz' safety. However, the bottom line was the fact that Benz would need to foreground her pregnancy and background her heroin use to get housed away from her abusive boyfriend. There are no DV shelters for actively drug using women.

Phone Call about Benz **June 2008**
Mara from outreach just called me for some advice. We just hung up.

Benz is pregnant. She found out two weeks ago. This means that she didn't know about it when we saw her after the fight that she had when she was in the Nimish [Hotel]. We thought that she was being beaten up by her boyfriend, looks like that was going on too.

When Mara was out tonight at the Raman [Hotel] Benz says, 'Hold on I can't get up' and she opens the door and her boyfriend was there. This is the guy who shot half his head off in some accident I guess, or maybe he was trying to kill himself but he didn't die. And after that he stopped using drugs and drinking and smoking but he still sells drugs. He doesn't like Benz using drugs even though she's got an enormous heroin habit.

So she's trying to get on methadone because of the pregnancy and apparently the methadone is really knocking her out. That is why she can't get up. Mara helps her up. It's like her head is under the bed and her leg's all twisted back so she's a total mess on the floor and she can't get herself up. Benz is really skinny and young and probably the best looking girl down there, very well put together. Benz walks down the hall with Mara to get out of earshot of her boyfriend. Benz she says that he is getting violent again. After he shot himself in the head I guess Benz had taken care of him and he had stopped being violent for awhile but she said recently is getting bad again. Mara was really calling me to get permission to do more of an intervention with Benz. Mara was worried that if she might be over stepping her bounds, directing Benz toward treatment. This was really an interesting harm reduction moment where Mara was feeling torn between trying to help Benz clean up and get away from the guy and also feeling like maybe that was too pushy.

I had to break it down for Mara. There are two main options for Benz, both of which probably involve lying about her drug use or her desire to stop using. She can go into residential treatment, or she can go to a DV shelter. Both are miserable options for someone with a big heroin habit. Benz can get into a DV shelter because she'll jump the list when she's pregnant. If she goes to drug treatment she doesn't have to succeed there. If she is afraid of her boyfriend, she can use drug treatment as a break. She just has to bullshit the system long enough to get a roof over her head because there are no other options. There's nothing else for her. As a pregnant drug using woman she can get methadone but in terms of the housing, to get housing, to get a situation where she's not with a violent boyfriend and in the middle of the crazy drug, sex work scene that is the Raman Hotel, she can't. She can't get out of it. She has to go into a shelter or into residential treatment where you're not supposed to use [drugs]. So I just said you know see if Benz wants to bullshit her way through [a local DV shelter] or some other program for a little while. Obviously she's smoking a lot of crack, so even on methadone she was still got a bid challenge. It just seems impossible. There are no good options unless she can stop using.

Benz did not go to the DV shelter or residential treatment in June. Towards the end of her pregnancy she entered residential when her boyfriend was facing jail time. She was able to regain custody of her baby after birth and remains in transitional drug treatment housing.

Sometimes misrepresentation can appear to be only about getting paid. But the reality of housing instability and homelessness formed the subtext of all the hustles I documented. One of the epidemiological abstracts quoted above remarks that sexually transmitted infections (STIs) among pregnant women drug users are common and place them at high risk for HIV infection. Alice's problem, when we find her at the Bridgit hotel is not being unaware that she has an STI, but rather being unable to afford the medications to resolve it. The collective wisdom indicates that her best solution is to lie to get the medications covered.

Alice's STI **Bridgit Hotel** **March 2008**

We went to the Bridgit, but didn't see anybody at first. I took a picture of a doorway that said 'Don't bother me, don't knock unless you're the police' next to the doorway of the guy who's dying of AIDS and the younger woman who is taking care of him. But they were not around. Anyway, the woman who was there was Alice who looks like she's about 20, really timid, very afraid of her boyfriend. She looks back over her shoulder several times during her interactions with us. Her boyfriend, you know I don't see him but it's like his presence is felt so strongly. She asks us again "Do we have anything for men." It just feels like she's gonna get the shit beat out of her the minute she walks back into her room. She's on methadone; she's a heroin addict trying to not use. She's got kind of like mousy brown –I mean she looks like somebody who could be a librarian. She's so timid and she and she's this little white girl with kind of short brown hair that she has kind of pulled back in a very kind of girlish way. Tonight she wants to know about healthcare stuff. She has Medicare. It's very complicated. When she goes to the hospital she

can't get prescriptions because they say that that she has Medicare. They'll see her but the Medicare that she has; she has Medicare and MediCal and they won't pay for her prescriptions.

So she's trying to figure out a place that she can go, because she's totally broke; she can't pay for her prescriptions. So she's got an STD and she needs antibiotics for it and she can't pay for the antibiotics even though she's already been diagnosed with it. So she's doing sex work and being out there with an STD and she's trying to figure out where to get treated. We try and suggest a few places to get treatment. I don't think she's going to make it to [the clinic across town]. Another woman told her to lie and not putting down her social security number so the computer wouldn't figure out that she had Medicare. Then she can get access to this program called Health Access California, which is only apparently for reproductive [health].

For Alice and her boyfriend, their housing depended on her being able to turn tricks. The STI was posing a serious problem. It seems unfathomable that she could receive an STI screening and positive test and still not receive a free prescription. One week later Alice and her boyfriend were gone, evicted like many others from the Bridgit Hotel that week. They haven't returned and I do not the outcome of her STI treatment.

In August, 2009, Lexi was temporarily homeless with her husband, Pano. Lexi was five months pregnant. Pano and Lexi had been offered a coveted weekly rate at the Grey Hotel. According to Lexi, Pano agreed to put his GA welfare money on that rent. When she checked with the manager, the weekly fee had not been paid. That meant the money had been spent on crack, and Lexi would have to (sex) work to pay for the room. She was furious and fighting with Pano when I came across the two of them. "Watch my stuff for me while I'm gone!" She demands of Pano as we leave so Lexi can dose at the methadone clinic. "He is not even gonna watch my stuff, you watch. What an ASSHOLE!" Lexi says in the car. The whole trip to the clinic was a blow by blow description of what a liar and "dog" Pano is. At the clinic, a friend approached Lexi and I with a flyer for a study offered by the Department of Pubic Health. Lexi used my phone to call while we road back to the Mission. She was given an appointment for the next day. She told me she had done the study like 3 or 4 times, she just puts on a different wig each time. She said, "They [the study personnel] so easy to fool, 'cause 'we (black participants) all look the same'". When we return to the Mission Pano is back guarding

her stuff. Things are tense at first, but immediately Lexi gets down to business. "You need to call this number, and get yourself an appointment. Just answer the questions 'Yes.'" She coaches Pano while he borrows my phone.

Lexi coaching Pano through the right answers to get access to a health study that pays $50 a visit. Both are homeless, staying behind a truck a couple blocks from 16th and Mission. August 2009.

I have no idea what the study was about or whether or not Lexi and Pano would indeed be eligible for it based on their behaviors. Regardless, the production of epidemiological evidence, just like the production of clinical evidence (in Ramona's case) is undermined, because its claims for scientific validity exist and exploit a social world driven by the political economy of hustling and desperation[246]. I am also not suggesting that these examples implicate all public health research or clinical data. The above epidemiologic study not withstanding, most public health researchers are savvy to the street economies in which participants live and their monetary incentive's effect in those

246 See also Bourgois (1998) for a description of how the moral economy of drug and needle sharing within social networks of homeless heroin addicts contradict their reported behaviors to anthropologist and on health surveys.

economies. They respond to hustling with the same resigned patience that the clinician quoted above does. They try to appear non-judgmental. Then they oppose more rules and security systems in order to "catch" participants trying to do the same research study twice. Further, anthropological evidence is no more immune to the hustle. As an infovulture, I was interpolated at times as someone with something to offer – food, money for a long interview, a ride to the clinic – and therefore someone to potentially manipulate. Other times I was not: offers of food or a ride were politely refused. I had no more than the advantage of time and the method of observation with which to discern the degree of facticity women's narratives may have contained. Perhaps fortunately, unlike statistical data, anthropological data is not slave to the metric of objectivity. Perhaps unfortunately, it runs the risk of reduction to anecdote.

When it comes to hustling the system, Child Protective Services is one institution that many women outwardly feared. Lexi may have made fun of the receptionist at the public health study, but CPS was no joke. In one description a provider gave to me, she described the complex explanatory webs in which pregnant addicts find themselves caught. To this provider the impetus for the need to lie to CPS originated from her "disorganized thinking," from not making "connections." To the mother, the explanation stems from her not wanting her son to see that she had been using crack. The provider struggles to convey to me that pregnant addicts seem to be unable to see the rational outcomes of "cause and effect" at work in their social worlds made irrational through drug use.

> I see women do not make connections, they do not see the connections between their behaviors, the choices that they are making, their mental health conditions, and the outcomes of their pregnancies. Here is an example. I have a woman in my program who just recently got granted visitation with her son. She was very, very excited about this. She was given one hour a week to visit. When I see her the next week, she says 'I didn't go to the visit.' When I ask why, she says "Because I'm too skinny and I didn't want my son to know that I was using." She doesn't make the connection that because she was up smoking crack all night, and she doesn't eat when she smokes crack that that is why is too skinny. And she can do something about that. So the reason is her drug use, but she says the reason is that she is too skinny. And she has to lie to the CPS worker about

why because it hurts her case when she doesn't show up. Her thinking is skewed; it is disorganized, because of her drug use, because of her trauma. It is very difficult to get to a cause-and-effect that makes sense.

Arriving at a cause and effect that "make sense" to both the pregnant addict and the service provider is a tall order. This is because this relationship is fraught.

VII. Victim/Perpetrator – Love/Hate

"Those motherfuckers were taking all my money, my whole check! But Gloria's [the counselor] got my back. She said she would have bed waiting for me, whenever I was ready to come back."

- Ramona after leaving residential treatment at 5 months pregnant, August 2009

There is a constant battle being waged within the discursive constructions of the pregnant addict. On the one hand she is construed as a victim – of her own brain chemistry, of her traumatic past, of her violent partner, even of her own body as she contends with a pregnancy she did not plan and may not feel capable of managing. On the other hand, she is also construed as a perpetrator -as someone capable of harming her baby through continued substance use, and through her refusal to enter treatment. Pregnant addicts often constructed family members, counselors, providers, clinicians, and case managers who coerced them and cared for them with the same ambivalent markers. They perceived and described others as others perceived and described them. With an equal dose of hostility and admiration. For example, Ramona went out of her way to explain to me that the pregnant addicts in her "crew" fiercely protected Mary, defending her like a mother, even while calling her a "bitch" on several occasions.

Ramona's methadone intake **December 2009**

Me, Ramona, and Mary are all sitting in Mary's cramped office at the drug treatment program. It is the day of Ramona's intake. Ramona is explaining to me how important her counselor, Mary, was to all the women in PPMT. Mary no longer runs the program after over a decade. Ramona says: "We were her girls though. You fucked with Mary, you fucked with us!"

"People thought I was a little tough." Mary says, turning to me. This is an understatement. I have heard several women call Mary lots of names. Ramona disagrees with Mary:

"Please, Mary. You weren't tough enough!"

When Lexi is telling me about giving birth to her son while in custody and then later entering residential drug treatment, I ask who had custody of her son during that transition. She remarks, “My sister had him. I have a beautiful family, man. Because of my family and my CPS worker I’ve been blessed.” Given that Lexi’s mother was responsible for physical abuse and forced Lexi to claim the child of her sister and brother as her own, one would think “beautiful” is a stretch. Yet, her mother is also the one raising her son because Lexi’s relapse led her to give up custody.

These constant contradictions in the attribution of blame and gratitude within interpersonal relationships also extended to women’s descriptions of institutional contacts, even those that were fleeting and highly regulated, such as hospitalizations, brief stints in treatment, and brief incarcerations. For example, Lexi was present at the birth of Dylan’s child. Lexi has made a point to me on multiple occasions that it was unbelievable how badly behaved Dylan was during this hospitalization. “For a full day she screamed at all the staff. She was yelling, throwing shit. I COULD NOT believe it.” Lexi said to me. When I ask Dylan about her experience, she self-righteously tells me: “I would never go to [the large public hospital]. No way. I went [to another hospital]. They treated me like a *queen*. It was fantastic.” When Kitt is released from jail she talks about voluntarily joining the drug treatment pod while briefly incarcerated, because there was more behavioral accountability and less drug use.

> In [the drug treatment program in jail] it’ll [an argument] be addressed; in the other pods it wouldn’t. Say if a person, I don’t know if they had a bad attitude or something like that they would just have a bad attitude. But in [the program] they would like – you could bring them in and have one on one or something like that you know and tell them what you don’t like that they’re doing. The [other pods] are like some lenient places with drugs and everything and in [drug treatment] there’s not too much of that type of stuff.

Kitt is someone who gets into physical fights regularly and is sometimes paid to beat up other girls on the street. Yet she expressed real appreciate for the possibility for conflict resolution offered in jail. Cupcake describes herself as someone who “has trouble with

authority. I don't like rules." When she is commenting about how she found out she was pregnant in jail at age 15 she states, "I can't believe that don't automatically test all the women that get arrested. Most don't know. They should test them!"

From a provider perspective the pregnant addict is often understood as someone who has a tormented history: a back story that makes her a sympathetic character of abuse and trauma, and got her into her current situation. As long as the woman construed as a victim but does not *act* like a victim, the relationships she can forge in various forms of treatment will not be entirely hostile, and might even be cooperative. One provider used the word "victim" reluctantly, seeking to describe to me a scenario in which professions intervened in the best interest of a woman and her baby and got rewarded with a lawsuit.

> The victim is the hardest to work. I don't want to use that word 'victim', because it sounds like I am being unfair, but they are women who are stuck in that victim role. And it is horrible because they *are* victims; they have experienced terrible things in their lifetimes. Terrible trauma. And yet if they can't take responsibility for what is happening right *now*, they won't be able to keep their babies. I will give an example. There is a woman who ended up at [the hospital] at 7.5 months pregnant and she told the providers that she was taking 30 Oxys [Oxycotins] and day and 20 Valiums, and so the doctors did what was medically indicated for the fetus. They stopped the other opiates and put her on methadone. Methadone has a long metabolic characteristics, it breaks down over 24 hours which keeps the uterine environment stable. Oxys create a high and then a withdrawal which is very unstable and potentially dangerous for the fetus. So the docs did what they were supposed to. She stayed in the hospital and delivered and was mandated to residential treatment. She had severe mental health and no housing. It turns out she is suing the hospital for getting her addicted to methadone. Everything that has happened, from her perspective is someone else fault. What do you do with that?

The call toward personal responsibility becomes extremely tricky when a child is involved. Now that the woman is pregnant, even if unplanned and unwanted, it is still up to her to act in the best interest of her unborn child. This is hard to argue against. I never heard from the mouths of any of the pregnant women, "I don't care. I don't care about this baby." Women, in turns, described themselves as victims and perpetrators, and expressed both love and hate toward those who were in place to intervene upon their lives and their babies.

VIII. Pregnant, in custody

The main avenue for pregnant addicts to access care and treatment was through some form of incarceration. The most frequent route was through picking up a case for sex work and ending up with a "deferral" into drug treatment. A deferral is essentially a court order. If the pregnant addict fails to show up at the treatment program she will be incarcerated at the jail. If she takes the deferral she is incarcerated at or through the drug treatment program. This does not necessarily mean residential treatment, but for many women it did. Ramona described her arrest several days before her baby was born as "bullshit", but it was indeed the intervention that got her into the hospital and on methadone. Lexi was actually in custody when her first son was born in 2000. She was transferred to a jail ward at the local public hospital. Lexi tells a story that highlights the absolute inhumanity of her treatment during this experience, reflecting the height of governmental controls over the bodies of the incarcerated poor. Yet within this narrative she also highlights a policy changing act of resistance by her jailor. The narrative reveals the complexity involved in the micropractices of governmentality at work upon pregnant addicts. Lexi retold the story to me in March 2009, shortly after she discovered she was pregnant again:

> [My son] was born in 850 Bryant [the city jail]. Not in 850 Bryant. He was born at [the hospital] but I was in jail. They took me [to the hospital] in custody and that's another thing that was so sad. Once you had a baby they immediately take you back up to the [jail] floor. You have to be shackled up and taken down and you have to get an officer, a duty officer, and I didn't see my baby for two days. Two fucking days. And I cried and cried. You have a baby down in delivery and as fast as they can get you back off to jail you're back up on the jail ward at [hospital]. And the baby is in the nursery. I didn't see him for two days, for two fucking days and I was crying. Cause I had to have an escort. And they wasn't doing nothing. They were just sitting around. And I'm in my room in the jail. It was fucked up. So finally the third day I was getting ready to be escorted [back to the city jail]. They'll never tell you when you're leaving but the doctor would come in and say okay, you can go back. I didn't see my baby once when I had him, that was it. It was fucked up.
>
> On my way to be transported back to 850 the Captain – I forgot her name but she was so nice. I told her. I says, "I can't believe it" and when I told her that [I hadn't seen my baby] she said, "No fuck it." It's all about the count you know they make sure about the count [that all the prisoners are back in jail]. [The Captain] fucked up the whole count at [the city jail] and everything because I wasn't there to be counted in and all that shit. But she took me to the nursery and we stayed

down there for about 8 hours. She got some pictures of him and got a camera of his face. That was the sweetest thing she ever did. I never forgot her for that. She was the sweetest thing. And I'm glad because she couldn't believe it. She sat there, she held the baby. She says, "Take your time." While I sat there she did a double shift and everything. She said, "Lexi will be staying here for dinner. I'm not taking her back. So if I gotta get written up let me get written up." She said to me, "It's going to be alright. You get yourself better and don't come back here." And for a month, about maybe three weeks later they opened up the [residential treatment] and I went in.

Anita shared a similar story with me about her 2007 pregnancy with her son. By evoking her own mother, Anita was able to convince the police officer to send her the hospital, but not to take her in to custody, so her mother could be present for the birth.

I was straight homeless. I was sleeping on this mattress on Folsom Street [in the Mission District] and I nodded out with the syringe still in me. Still sticking out of my fucking hip!"

Anita 'muscles' crushed up morphine pills into her hip/buttock area or her back just below her shoulder, because she doesn't have veins that she can easily inject into anymore.

"Anyway, I started to feel like I am going into labor. So I get up, and I stumble in to the alley to smoke crack. I still have the syringe hanging out of me, and I am bent over trying to take a hit, when two cops show up. Now I had a no-bail warrant out on me at this time. That means they *have* to arrest you. They *have* to take you into custody. And I say to cop, this lady cop, I say 'You can't arrest me, please don't arrest me!' And she says, 'You are eight months pregnant, in an alley smoking crack with a syringe handing out of your ass, and a no-bail warrant. Can you give one reason why I shouldn't arrest you?' And I said 'Yes. Because I am in labor, and if you take me into custody they won't let my mom be in the delivery room with me. My mom has been at the birth of all my children. Please don't make her pay for my mistakes. She shouldn't have to pay for my mistakes.' And it worked. The cop called an ambulance to take me to the hospital. It worked because the cop agreed with me. My mom shouldn't have to suffer for what I have done.

In December 2008, I run into Danell on the street, smoking a cigarette. She is about 7 and half months pregnant, maybe eight at this point. I haven't seen her in the hotels in a while so I ask where she been. "I got picked up." She replies. "Tonight is my last night out here. I am going to the detox on Albion Island and then into residential." Danell has been court ordered. Danell "chooses" treatment over jail. The next time I see Danell, I don't recognize her at first. She is coming to dose at the methadone program, smiling and laughing with the other girls getting of the van that transports them from residential treatment to the methadone program once a week to pick up their take-homes (doses of methadone that are dispensed outside of a methadone clinic under patient supervision). When I next see Danell again in August 2009 he baby is with her in

residential treatment. She looks happy and thrilled to show off her baby to me and Ramona, who has just checked in.

In November 2009, I am discussing the various options for pregnant addicts to gain access to housing with a health official. He raises the question of coerced residential treatment - incarcerating women so that they cannot use substances during their pregnancies. Our discussion begins as en exploration, a philosophical debate about the political palatability of pregnant women using drugs in publicly funded housing. Quickly it travels into more tricky political and ethical domains, directly at the heart of the matter: Is coercion in the form of incarceration ever justified to stop women from hurting their babies?

> Kelly: I wonder what kind of housing might work for [addicted] pregnant women.
> Housing official: That is a very difficult population to assess. Because women who are pregnant are not necessarily ready to stop using [drugs]. It would be awful hard to advocate for harm reduction based pregnancy housing. Gosh. That would be a tough sell. Even though I can get there because I recognize what the alternative is.
>
> The housing official recognizes that a pregnant women using drugs who is homeless is at much greater risk of a poor health outcome, than one who is housed. I ask:
>
> Kelly: Many people feel the ideal is a residential treatment program at least throughout the duration of the pregnancy.
> Housing official: But would you incarcerate women to achieve that goal?
>
> I pause. I am taken off guard by the practical nature of the question. In the world of intervention, two questions are always asked at once: what to do and how to do. If it can't be done, then it isn't practical, and should not be done. Thus residential treatment is irrelevant if women won't go. I decide to speak from my experience, initially avoiding the overall political and ethical dilemmas of the question.
>
> Kelly: I know a couple of women who have been court-ordered [to residential treatment] who are still with their kids, but…
> Housing Official: In South Carolina. There is a movement toward that, to incarcerate the woman for harming their fetus.
>
> He is taking the example to the extreme. South Carolina provided the landmark cases of incarcerating pregnant women for smoking crack in the late 1990s. I respond more strongly than I actually feel.
>
> Kelly: Yes, I know what you are speaking of. That is a waste of time.
> Housing Official: But that is the legal means, because you can't incarcerate someone for having cocaine in their system. But an incarceration that feels like a drug treatment facility, not like a jail. That is an opportunity.
> Kelly: It's an opportunity only because it's exploiting an opportunity.

> Housing official: [They say] the violation of civil liberties is justified because you are giving the kid the best opportunity.
> Kelly: I think that is a real slippery slope.
> Housing Official: All these things are slippery slopes. We are all going down the slide.

The conversation moves on, but I am left with a very bitter after taste. What are the social and moral parameters of vital politics here? How can I reconcile the fact that some of the women have expressed to me that – in their view - the only reason they have their babies now is because they were arrested. Danell – who was court-ordered to treatment at seven months pregnant or Ramona's "false" arrest and detention three days before the birth of her child. Lexi's first son, whom she had custody of for two years was born while she was incarcerated, a police officer looking on during the birth. Without the legal intervention none of these women feel they would have experienced any custody of their children. Even Cupcake felt that she would have surely had "a crack baby" if her arrest and subsequent mandatory pregnancy test had not come back positive, forcing her into treatment. Anita, who described convincing the police not to arrest her, explained that they were the ones who got her to the hospital by calling the ambulance. Kitt, when she described her drug use during several of her 6 pregnancies, indicated that "God helped" because she was arrested and stopped using drugs while she was pregnant as a result.

> I've like used in my pregnancy until I was like two or three months you know cause God has helped me by sending me to jail…With my middle son I went to jail when I was like three months. With Charlie [younger son] I went into jail and I went into a program so it was like three months too.

The adjudication of pregnant addicted women makes both me, and the health official who is trying to push my buttons, uncomfortable. It is anathema to progressive liberal politics of San Francisco, to notions of harm reduction that shape policy and started our conversation. What does this say about the vital politics that surround questions of viability for pregnant addicts and their babies, when incarceration becomes "opportunity"?

IX. The vital politics of viability

How might we best theorize a vital politics of the reproduction of social death? "Vital politics" have come to reference a variety of intellectual projects – from stem cell research or human genomics. The construct has been used in several scholarly conferences and books that discuss themes also emergent here in this ethnography – the remaking of psychiatric illness as organic facts, the reorganization of evidence about addiction around neurochemical vulnerabilities not failure of personal will.[247]

In the preceding sections of this chapter I have outlined the interface between pregnant addicts, institutions, and institutionary figures. I have discussed systems of care and their caregiver/coercers, such a drug treatment providers, clinicians, and program managers. I have presented an ethnographic picture of multiple adjudicators: those who profit directly off of women's risk status and behaviors (protocapitalists), those who lay in wait for women to access their services (providers), those entrusted to police pregnant addicts and force them to chose between incarceration or treatment (the criminal justice system). Those who want them (hotel managers and providers) can't always keep them; those who want to get rid of them are forced to be the main conduit for pregnant addicts into health and mental health systems. I have described the arbitrary and ambivalent social relationships that can develop in these sites of adjudication – crazed pregnant addicts attacking hospital staff, prison guards turning soft at the site of an injustice to motherhood. Taken together, these descriptions allow us to revisit a concept I introduced in an earlier chapter. Tweaking a famous observation by Georges Canguilhem that "society has a mortality that suits it,"[248] I argued that perhaps

247 See Nicolas Rose (2007) *The Politics of Life Itself*, Chapter Seven, "Neurochemical selves."

248 "Everything happens as if a society had "the mortality that suits it," the number of the dead and their distribution into different age groups expressing the importance which society does or does not give to the protraction of life [53, 94-97] Canguilhem, G. (1966) *The Normal and the Pathological*, Zone Books. Page 161.

here we see that society has a reproduction that suits it. The social death of a pregnant addict impacts the viability of her child.

Foucault discusses a politics of life, social policy and the assurance of a minimum of health in his recently translated *Birth of Biopolitics Lectures* given at the College de France. He argues that social policy "cannot have equality as its objective," but must instead only authorize the insurance of a "vital minimum" from those who have the most economic resources in society to those who are permanently or temporarily disabled.[249] These social policies serve to divorce the state from any responsibility for individual or collective risk management. What Foucault calls a "privatized social policy."[250] Drawing from Rustow's notion of the these social policies creating a "Vitalpolitik" or a "politics of life", Foucault describes vital politics as "not a matter of constructing a social fabric in which the individual would be in direct contact with nature, but of constructing a social fabric in which precisely the basic units would have the form of enterprise, for what is private property if not enterprise?"[251] Individuals in society are managed not in relation to nature but in relation to entrepreneurial and private ownership. Those who fail to cling to this social fabric must be disciplined to become more successful "entrepreneurs of self"[252], according to Foucault.

Arguably, the homeless pregnant addict might prove to be the most evocative example of a failed entrepreneur of the self. But there are two selves at stake here. One undisciplined (the pregnant addict) and one yet to be disciplined (the child). The biological realities of both pregnancy *and* addiction collide with the social policies of drug treatment allocation and legally prescribed parenthood. For example, of a woman is a heroin addict and poor, she often can not afford to pay for methadone maintenance

249 Foucault, *Birth of Biopolitcs Lectures*, page 143. Foucault acknowledges that assessing the "vital minimum" is, of course, subjective.

250 Foucault, *Birth of Biopolitcs Lectures*, Page 145.

251 Foucault, *Birth of Biopolitcs Lectures*, Page 148.

252 Foucault, *Birth of Biopolitcs Lectures*, Page 221.

treatment until she is pregnant. When she is pregnant, it is paid for. So her reproductive biological status has to change in order to stave off the withdrawal systems from her biological addiction to heroin, in a medically appropriate and state-sanctioned manner. The political economy driving neoliberal interventions that demand that the pregnant addict take personal responsibility, run head long into a moral economy which contains complex dualities: women and child, victim and perpetrator. One provider shared her experience with the many pregnant addicts who have entered her program. She carefully avoided separating women into "good" and "bad." This provider reifies the role of the pregnancy as an opportunity: either for a better future or for a worsened social death.

> It seems that for one group of women the pregnancy is an opportunity, a kind of 'wake-up call' to get into treatment, get their life together. For others - women who tend to come to the program later in pregnancy - they have been using throughout their whole pregnancy, the pregnancy was unplanned and unwanted. They are in abusive relationships. They are in denial about the pregnancy. They are sex workers and maybe have gotten pregnant from a trick. The pregnancy was further destabilized their already very unstable lives. They are spiraling downward.

Acceptance into intervention programs designed to help pregnant addicts required specific categorizations. The most frequent categorization I came documented was a strange hybrid, the "criminal-volunteer". Women entered into systems of care and coercion by way of criminal justice system involvement. The terrible irony is that those women who entered into those systems had the greatest likelihood of remaining in contact with their children, and even regaining custody. Those women who did not terminate their pregnancy, and also did not get court-ordered treatment had worse "outcomes" – one baby died, another three mothers lost custody immediately at birth. Once a woman is no longer associated with that program her status changes relative to the benefits she was allowed in the program. A potential future as a mother becomes foreclosed and she returns to the spiraling downward social reality of the daily rent hotels. The everyday lives of pregnant addicts become radically contingent upon their

relationships with institutions, and these institutions measure success on a metric of social death diverted among mothers and their babies, as much as the number of babies born substance free.

X. Metrics of success when evidence is compromised

The political economy of cost and the moral economy of necessity require that programs serving for pregnant addicts measure their success. Of course the metrics used to measure that success are contextual; they change according to the situational demands. Websites advertise statistics and offer stories, narratives that demonstrate the facilitated personal transformations women have made. These forms of evidence are not true or false, they are compromised. They reflect a compromise, when the truth of what you have in front of you must be packaged into a sense-making narrative. For example, one program that serves pregnant addicts in San Francisco posts the following statistics on its website:

> Yearly statistics on birth outcomes and numbers served (San Francisco only):
> - 90% normal birth weight
> - 95% born drug free
> - 2400 families a year
> - 300 families placed into permanent housing

These are astounding numbers. Yet, when I interview one of the Program Directors she is clear with me that they don't reflect the outcomes of women like those that I work with in daily rent hotels. Most of the women she is serving report smoking marijuana, and quitting it, during their pregnancy. That is an important health intervention. The services provided by this agency are absolutely beyond criticism. This program (unlike others) has an undisputed excellent reputation among all the pregnant addicts who live in the daily rent hotels. Ramona refers to the Program's founder as "one of my best friends." But their evidence – like anyone's evidence - requires careful examination. The

Program Director for the pregnancy and substance use program describes the missing data for some women

> There was a period of time when there was a cluster of women coming in who would come in really high, and just fall asleep on the floor. They just really needed a place to sleep and something to eat. Which we give them. A couple of them agreed to go into program. Went over to [the residential treatment], kind of spent the night, left the next day and then maybe we don't see them again. They don't keep their babies, but we don't have all of that data, kind of what happens when we loose them. [sighs]. So we try to follow up. We try to do outreach. There is definitely a cluster of people we want to try and 'keep in our clutches' [joking] as much as possible, and that is definitely that harder group of women to work with. So it's tough.

The Director also provides me with narrative of evidence which is more telling than the statistics – both of her depth of understanding about the challenges that pregnant addicts face, and the inability for systems of care and coercion to adequately support or discipline her.

In the first story, she describes a woman who the Director personally escorted her to her first prenatal appointment. The woman is an example of a "failure." Not because of she failed to show up for her follow-up prenatal appointments, but because the system that is meant to support her cannot adequately meet her needs. During our interview, she pauses and asks:

> Did you want a few little stories, or not? [I respond, "Sure."].
>
> OK. So one woman who would probably would fit your profile a lot. She lives in various SROs, goes hither and yon. And kind of got pregnant and showed up here. No prenatal care, actively using. Various drugs, mainly methamphetamine. Sometimes cocaine, crack cocaine. Actively using, but really wanting to not [use]. But not really wanting to do treatment either. So I was working with her. And she was great to talk to, knew all the right things to say. Very smart. She had come out here from [another State] to escape a very bad domestic violence situation. Was kind of in another one here. That wasn't so great either. Homeless for the last year. Just here and there, including outside.
>
> Anyway, so she wouldn't ever keep appointments but occasionally she would come in [to the Program] because she wanted some food. So one day, she said, you know she still hadn't had any prenatal appointments, wasn't quite sure when the baby was due. I said, 'Well let's go to [local hospital]. So she agreed to go. So we get in my car and we go to [the hospital], and it was really, it was an interesting experience. Because first we go to one place and then they send you to another place to sign up for MediCal – she didn't have any benefits or anything. Then we go back to first place, which if she was there by herself, she never would have made it from A to B, ever. If she even got to the hospital. But I kind of took her everywhere. And then while she was waiting at one place I went and got her some food. And then we wait for another hour and then finally they see her. And she gets a whole work-

up and everything. And she is *determined* to make it to that next appointment, like everything is going to be fine and she is going to make it to that next appointment. And she didn't.

And it's like 'OK, what happened?' Well she ended up in jail. Which is where she had her baby. So her baby was drug free, because the baby was born in jail. And her mother came from another state and actually took the baby. She still comes in form time to time. She wanted to go into a treatment program but she doesn't follow up. You know it is really hard, it's kind of like, if we were chained at the wrist – maybe I could keep her focused somehow. And you know I know that she will come back, but she might be pregnant again and the same thing might happen. But she wanted so much to try and do the right thing. It's unclear what would have happened if she hadn't gotten arrested, but it might not have made a difference. She might not have made that next doctors appointment anyway. But the thing was that there was a foundation laid where maybe she *could* have, maybe she would have. So, did we succeed with her? Well, not really. But we made that connection and she is still connected here. Like, *maybe*, down the road something might change.

You know we work with a lot of women who have lost baby, after baby, after baby to the foster care system, to CPS. And you know they will come in [pregnant] at one point and this will be the time. And they have a healthy baby, and they keep their baby. I got a call from one of those clients around the holidays, her son is now five going to kindergarten. She is doing great, has maintained her housing. No more drug use, after probably 20 years of being a prostitute, using drugs on the street. No one would have ever thought she would have made it.

In the second story the Program Director shares with me, a woman does have custody of her child. It is a "success" because CPS is not managing her family life. It is a "failure" because the Director is uncertain whether the woman can in fact care for her child. The responsibility to give the woman a chance at motherhood, undisciplined by the state, is at odds with the responsibility to ensure the child's safety.

It makes you not bond with your baby [when you have lost so many babies to the system in the past] because you are just afraid you are not going to be able to keep this one either. Or sometimes you give up, you sabotage yourself, because you just know what is going to happen.

There is a woman I work with who claims she's had 22 children. We knew her a long time ago, but I think it is probably more like 13. But it is still a lot. Only one that we know of that, when we were working with her, did she ever even have in her care for maybe a year or so. All the other ones, the minute she had them, they all tested positive [and she lost custody]. She'd come back here once in awhile and then we would never see her again. Then she would come back here a year later and she would be pregnant again, and then we would never see her again. And then she would come back. [pause]

So this last time, she came in, and I don't know what it was, maybe because I knew her for 15 years, I said, 'Well I will work with you. What do you really want to do?' She said 'I really want this baby.' So she wasn't using. She went [religious-affiliated shelter], which is not the easiest place to stay. I don't why they didn't put her out, but she managed to stay there. She stayed clean and she went into a regular family shelter. In between there were some issues with the baby's father and some violence. And times when she was going to get off track very quickly, and we kept trying to get her back on track. Anyway she had her baby a few months ago. And, I feel like there definitely are some bonding issues, like I don't feel she can…she

> still has the baby CPS in spite of *all* the other children that they have taken away from her, CPS felt like 'Well OK, she's made…she was clean and sober. She went to her doctors appointments. She has maintained her shelter.' She just got a little apartment. And it is like, 'OK, how safe is this situation, you know?' And CPS is willing to give her a chance with this baby. And there were a few referral calls about her [from the family shelter] maybe not holding the baby properly or arguing with a boyfriend. But they [CPS] are still giving her a chance, but I can see she is a little detached. Probably like not quite trusting. [She is asking herself] 'How long is this gonna last?'
>
> And I am always thinking, is the baby safe enough? Is she able to do it? Because there is a lot of mental health, and also some physical problems with this mom. She was in a very bad domestic violence situation and had a stroke. So there are even some physical issues of one side of her body being weaker, in terms of holding the baby or falling. So I'm trying to figure out, how safe is this baby. But she calls me several times a week, and she will usually come in once a week or every other week. CPS is hands off right now, they are just trying to check in with her maybe like once a month. They haven't demanded that she do anything. I don't know why I am surprised [that she is doing well]. We kind of advocated for have to have this chance. But she was in a shelter and there is more 24-hour coverage. You could feel a little more comfortable. Because someone is seeing what is going on [between the mom and the baby]. But she has created a support network around her of family. She got the baby in daycare. That is something we didn't even do for her. She got him in a good childcare. She set up what she needed to set up, so that she can do this. And this is so amazing to me, because so much loss, so much history of drug use, and just chaos and homelessness, and Oh my God. But if you saw her now, you kind of feel like maybe she can do this.

When pondering the micropractices of governmentality reflected, and perhaps deflected in the two narratives offered above, it is important to recognize that there are multiple, contested sides in the debate over "what is to be done" with the pregnant addict. Some American organizations and political figures argue that "success" in the realm of pregnancy and addiction is long-term birth control or sterilization, and failure is the inability to face the political backlash such policy interventions foment. For example, *The Prevention Project* is a national organization which drives a van into poor communities and pays drug using women $200-300 to agree to "obtain" long-term or permanent birth control[253]. The also post statistics on their websites, along with graphic images of drug exposed infants experiencing painful detoxifications. As their data indicates, as of October 2009, *The Prevention Project* counted the following among their "clients": "3,121 women and 29 men, who have made the decision to obtain long-term or

253 The Prevention Project's website reports that it has paid clients in 39 states including: California, Oregon, Washington, Nevada, Utah, Arizona, Colorado, New Mexico, Montana, Idaho, Texas, Oklahoma, Kansas, Alaska, Minnesota, Wisconsin, North Dakota, Illinois, Missouri, Arkansas, Mississippi, Alabama, Georgia, Florida, Tennessee, Ohio, Kentucky, Indiana, Michigan, South Carolina, North Carolina, Virginia, Washington D.C., Maryland, Virginia, Pennsylvania, New York, New Jersey, Massachusetts, & New Hampshire.

permanent birth control." Of those willing to be paid for medical and surgical interventions: "1,059 have chosen Depo-Provera, 1,193 Tubal Ligation, 758 IUD, 72 Implanon, 38 Norplant, and 29 Vasectomies." Finally, in order to avoid the charges of racial eugenics – criticizes which have been leveraged[254] - *The Prevention Project* publishes the racial and ethnic breakdowns: "1,544 clients have been Caucasian, 864 African-American, 408 Hispanic, and 334 of other ethnic backgrounds."[255]

Along with these statistics the prevention project website also offers narrative evidence. A woman named Denise Lewis agreed to have her story published on the website to counteract the "flak" *The Prevention Project* has received in the media. She

254 See Claire Murphy. (2003) Selling Sterilisation to Addicts. *BBC News*, September 2 2003.

255 Accessed from www.preventionproject.org, January 2010.

makes claims about heredity of addiction, the inability for people who are addicted to stop using drugs, and the damage to her children she feels is a result of her cocaine use during her pregnancy. She feels her “otherwise bright children may only be fit for the human scrap-heap, jails, prisons, and mental institutions, all because of an egg-donor who could not control her own womb's activities due to her intense craving for drugs, to the detriment of decent living itself”. She writes:

> I see from the newspapers and the television media that you are getting a lot of flak for what you are trying to accomplish with the "prevent in utero abuse of unborn children," by potential, drug/alcohol abusing parents. I have benefited from your advertising and program. How I wish it were so about thirteen years ago. I wish that I had some long-term birth control that I didn't have to think about at that time.
>
> I have no problem sharing my children's story with you. I have no problem with you sharing my story with your detractors. I don't think they get it, not even after 15 or 16 years of this crack/methamphetamine/heroine epidemic, how addict's and their irresponsible reproductive habits is causing a serious problem in the "community." I can speak on this, because I am one of those addicts that should have bee implanted with Norplant, or had permanent sterilization. Instead, I, due to my addiction and my complete and utter dedication of my life, my money, my time, my sexual nature (prostitution for the next hit), my every waking thought, all of my energy to the full-fledged pursuit of **CRACK COCAINE**.
>
> I'm an African-American woman, I have used drugs for a long time, on and off. I am thought to be highly intelligent, but cursed with a genetic code for self-destruction, alcoholism on both sides of the family tree. When I became strung out on crack, I lost my will to do the right thing. I lost the ability to pay rent, even while I was still working, I finally lost my place to stay, and as we in the 12-step program say, I "lived to use and used to live." I have done some horrendous things my quests for "The High-Life," all the way to living and turning tricks in alleys of Skid Row, and **I DIDN'T CARE!!!** I was pregnant, not only on one occasion, but two times. I continued to turn tricks and smoke dope, drink rot-gut wine, sleep on the sidewalk, go on dope-runs lashing for days at a time, couldn't eat, stayed awake at least 3 to 4 days at a time on a regular basis. What kind of life is that for a pregnant woman?
>
> Most folks will say, "Why didn't you stop? At least until the baby was born?" The people who would ask these questions don't understand the truth about addiction. The addicted party cannot help themselves. Every step the addict takes is in hot pursuit of their drug of choice, and the addict has no choice in the matter anymore, hence the horrific things we do while under the influence.
>
> The children are now 11 and 12 years old, respectively. A boy and a girl. I'm not sure who their biological father's are, due to the lifestyle I lived when I couldn't help myself, when I had no choice in the matter. They never came home with me, because they were born with cocaine in their systems. I had no home for them to come to, in any case. I never did get custody of the children, when I sobered up, it was too late. The children have been in the custody of their grandmother since birth, and their lives have been hard. Special Education, constant expulsions from schools, due to behavioral difficulties, impulse control issues. One child has even been CAT-Scanned. The neurologists said

that part of his brain does not exist. This child forgets everything. The other child, is now in a group home, because she cannot behave in an appropriate manner.

One of the children has begun to go to jail for violent behavior. They are allowed therapy, but that is a joke, because they clam up on psychiatrists and therapists and social workers. The DCFS worker involved in the case wants to take both children away from their grandmother to be raised in mental institutions, or group homes, without love, without care, the goal is to control the children, with high-powered medications, to the detriment of their fragile central nervous systems. Their minds and bodies are damaged from birth, just imagine what the psych meds are going to do to them, in the long run. These otherwise bright children may only be fit for the human scrap-heap, jails, prisons, and mental institutions, all because of an egg-donor who could not control her own womb's activities due to her intense craving for drugs, to the detriment of decent living itself.

And these wonderful protesters say, "Let the addicted woman/man keep reproducing at will!!!" I guess not too many of them have been around drug exposed children. What's funny is, that my children are first generation crack babies. Their behavior is unpredictable, violent and definitely anti-social. They are not at fault, they have been born that way. When they are not "going off" they are smart, loveable kids, but more often than not, they are off on a tangent. My children aren't the only ones, and to a certain extent they were lucky. I know of other addicts who babies were born horribly deformed, with AIDS or HIV positive, flat out and out hopelessly retarded, and physically disabled.

I'm not saying that these babies don't have a right to exist. I love my babies as best I can, from a distance. When you think of the long-term costs escalating behind pregnant addicts.....? Look at the infant intensive care costs, the special education costs, the court costs, the shuffling of the poor baby through the system, the loss of brain-power potential, the lack of emotional stability of the drug exposed child. Some say that I'm being too harsh, but I have a right to speak on this subject, because me and mine are **LIVING THE NIGHTMARE DAILY!!!**

I wish someone would have tied my tubes back then or installed an IUD in me, by hook or by crook. When you hear from your detractors again, talking about genocide, tell 'em to go and take care of some of these babies, and many of these children are quite beautiful, it's the peculiarities of the behavior and emotional instability will break the hardest heart. It's also important to know that the use of crack is known to kill all maternal instinct. I do not know much about methamphetamines, nor heroine, they were not my drugs of choice. I know about alcohol, Olde English, Cisco and the like. An addict woman will cradle her pipe before she cradles her own child. I know, I speak from experience. The stark truth is that most addicts/alcoholics will never get it together, they just continue on, only interrupted by stays in jails, prisons, mental institutions, and "rest stops" in recovery homes. Only to come out, looking good, got the loved ones all hopeful, just to step back off the planet. I've known women to have only drug babies, and plenty of them, back to back to back. I've known a woman who kept relapsing, getting pregnant, having a drug baby, sober up, can't stand reality, and go back out, end up pregnant again. Pitiful, huh?

I could go on and on. Mrs. Harris, I hope when you get the opportunity to share this story with your detractors that are protesting "genocide," so on and so forth, they are able to face reality, look around and help escort their neighborhood dope fiend to the nearest clinic, for some long-term birth control. The real truth of the matter is that the dope fiend started their own genocide with the first hit, snort of dope, the first shot. Why bring some babies into it, if that doesn't have to be?

THANKS FOR READING MY STORY, MY TRUTH, I'M ONLY ONE OF MANY LIKE ME, DENISE LEWIS

(Letter has not been edited for grammar or punctuation.)[256]

The Director of *The Prevention Project*, Barbara Harris, has four adopted children born of the same crack-addicted mother. She rejects the notion that her program is a draconian form of social engineering. Instead she proposes that financially incentivized birth control or sterilization for drug addicted women helps not only the children who would be born destined to reproduce a life of drug abuse and poverty. It also protects the women addicts who will not have children only to experience the pain and suffering of loosing custody of them. The following includes several quotes from Barbara Harris in BBC news interview conducted in February, 2010, wherein she responds to her critics.

> [Ms. Harris'] stand has drawn fierce opposition. Critics, such as US group National Advocates for Pregnant Women (NAPW), accuse Ms Harris of spreading "dangerous propaganda".
>
> They say what she does is social engineering, defining one category of people - addicts - as unsuitable to have children. The scheme has been compared to eugenic sterilization in the US during the 1930s and the Nazis' programme of eugenics, which led to the extermination of Jews and the murder of many gypsies, the mentally ill, and homosexuals.
>
> Organisations like NAPW don't deny the problems of mothers and fathers who are addicted, but argue that many do get clean and become loving parents of healthy children. Also, having a family is one of the most valued parts of many people's lives. By removing that, or the possibility of it, does she not remove a powerful incentive for an addicted person to get clean: the hope of that better life?
>
> "These women have a chance every time they give birth to a child," says Ms Harris. "They are told if they go into drug treatment they can get their child back. They are given chance after chance after chance.
>
> "And drugs are more important, but at the very least we can stop them from giving birth to children whose lives may end up the same as theirs."
> She takes an extremely hard line, but says she does feel sympathy for the mothers living in poverty. "If anybody believes that these women having multiple babies that are taken away is a good thing for these women, they are wrong," she says.
>
> She talks of one woman who had 13 children taken into care before she finally got off drugs. When she was clean she was unable to contact any of them.
> "She was heartbroken. She didn't know where they were, they were gone".[257]

256 Accessed from www.preventionproject.org, January 2010.

257 Jane Beresford. Should drug addicts be paid to be sterilized? *BBC News Magazine*. February 8, 2010.

The logic goes: better to deny the woman the child upfront rather than allow the child and the woman to suffer in the future. In public health lingo this type of intervention is often deemed "upstream." Stop the leak at the source, before the flooding ensues down river. While her opponents argue that resources should be spent on drug treatment instead, Harris retorts that drug treatment is a bad "gamble," with a poor return on investment. Her views are not based on opinion or experience, but research (survey) evidence:

> I do a survey on every one that comes into the programme," [Harris] says. "Most of them started using drugs when they were 11, 12, 13 years old. And all of them have been in and out of drug treatment programmes, in and out, in and out. So people tell me that I should be focusing on drug treatment not birth control but drug treatment is just a gamble you know. Women go in there, they get off drugs, they go back on drugs but that doesn't keep them from getting pregnant. If they feel so strongly about it then they need to start an organisation that does what they are telling me to do. I am concentrating on women who are addicted to drugs who are getting pregnant over and over again. That is really my focus.[258]

The blogged responses to the interview covered the gamut. The four examples below offer the range the references, from the burden on society for "raising" children of drug addicted mothers, to references of multiple forms of social engineering (tax and benefits systems) and punitive social control (incarceration), to personal revelations.

> We need a sensible debate about this sort of thing. It seems to me that the women who breed the most are often the least suitable people to bring up children. The cycle goes on and society doesn't want and can't afford the results.
> --
> People quite rightly call this social engineering, but the current tax and benefit system is a form of social engineering as well. This particular "experiment" states that all people who are biologically able to have children should be allowed to have children. I don't think this argument has any more validity than Project Prevention's one. Let's have a proper discussion about child rearing, rather than slinging the Eugenics accusation at anybody who dares to commit to a solution.
> --
> Reprehensible. This is coming from the right place in her head, but is skewed by her own experience and also the general attitude in the USA that people on drugs are BAD PEOPLE. It's the same with their jail policy which has a 0 percent rehabilitation rate mainly because they don't rehabilitate offenders. It's clearly exploitation and an attempt at social engineering which will clearly fail because it does not solve the underlying socio-economic problems that drug abuse is created by or creates.
> --

258 Jane Beresford. Should drug addicts be paid to be sterilized? *BBC News Magazine*. February 8, 2010.

> Seven years ago I got clean after finding out I was pregnant with my first daughter. I am the only woman I've ever met that got and stayed clean for a pregnancy. I know that I am an exception to the norm. In my years of using I witnessed much pain and suffering inflicted on children with addict parents, ranging from neglect to emotional, physical and even sexual abuse. Mrs. Harris is nothing short of a hero and the work that she's doing is truly a blessing. Addicts don't abuse substances because they innocently tried them once and became hopeless slaves. Addicts use in an attempt to compensate for a fundamental lacking and the truth is that most of them aren't going to change anytime soon, if at all. Anyone that would criticize Mrs. Harris' work obviously has little to no personal experience to speak from. [259]

In the realm of the reproduction of social death a vital politics of viability is always at play. There are medicalized metrics of success offered by clinicians (methadone instead of Oxycotin for the uterine environment) and by the pregnant addicts (days of infant detoxification after birth as a reflection of maternal achievement). And medicalized metrics of failure - a baby born with neonatal abstinence syndrome, low birth weight. When these metrics become aggregate they are statistics of the percentage of babies born substance free. When they are twinged by progressive liberal politics the metric of success is keeping women from getting a CPS case – in other words keeping what is perceived as the most ill-informed and draconian form of state intervention away form women and their babies. There are metrics that measure the success of social controls - pregnant addicts crediting incarceration for their child custody. There are social metrics of failure – pregnant addicts who smoke crack discussing how all the crack babies born in the 1990s are now dangerous, predatory crack dealers, with no conscience. Their brains and their morality thought to be irrevocably damaged in utero.

The stakes are both high and extreme in the vital politics of viability. As I listen to Mary and Ramona catch up during Ramona's intake appointment in December 2009, I am struck by an aspect of their conversation that goes unremarked by the two of them.

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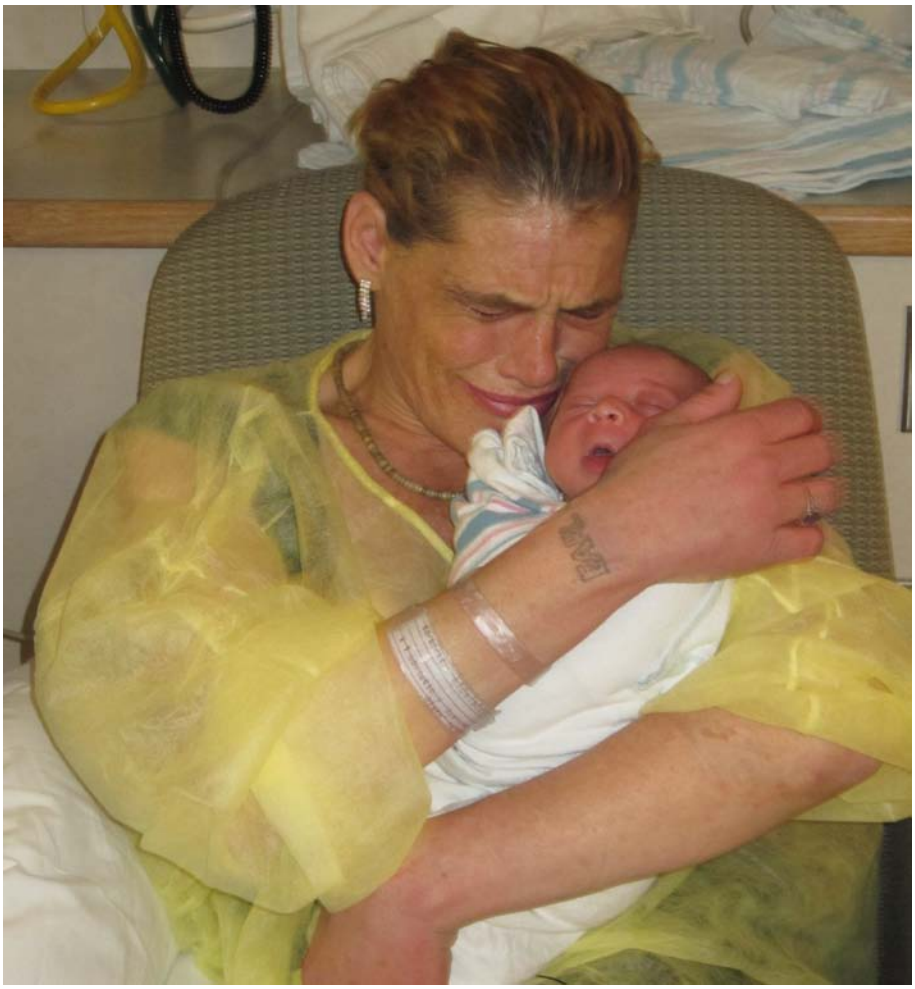
259 From Jane Beresford. (2010) "Should drug addicts be paid to be sterilized?" blog commentary. *BBC News Magazine*. Posted February 8, 2010. http://news.bbc.co.uk/2/hi/uk_news/magazine/8500285.stm Accessed February 19, 2010. Identifying names have been removed form the blog posts.

They are wheeling through a mental list of names, women who were in the program with Ramona when her daughter, DeLoni, was born. Mary and Ramona ask each other in turns, “What happened to Shani and her daughter?” or “Did you hear about Rally?” They discuss about ten women when I begin to realize that their “outcomes” are critically divergent. The women are either mothers, having regained custody of their children, or they are dead. Not just socially dead, but dead.

Chapter 8: Memento mori

I. Memento mori

A memento mori is a form of image that urged a European person of the late Middle Ages to "remember thy death." Its purpose is to remind the viewer that death is an unavoidable part of life, something to be prepared for at all times. Memento mori…express a concept of death that is characteristic of a specific time and place.[260]



When the socially dead reproduce, how is that death remembered? How is it portrayed, captured, analyzed, reconstituted? Minutes before we leave the hospital where Ramona's son is detoxing off methadone to drive her to residential drug treatment, she calls me over. "Kelly take out your camera. Take a picture of us now." She sobs, "I don't want to leave him. I don't know when I will see him again."

260 Dan Meinwald. *Momento Mori:Death and Photography in 19th century America*. http://vv.arts.ucla.edu/terminals/meinwald/meinwald1.html

II. Of vultures and vaginas

New York Times:	What does the V in V-Day stand for?
Eve Ensler:	For vagina and victory-over-violence and Valentine's Day. A lot of beautiful words begin with V – voluptuous, vulva, volcanic, vulnerability.
New York Times:	What about vulture?
Eve Ensler:	Vultures serve a positive function. They clean up the dead.[261]

The presence of the vulture concretizes death. It is a bad sign for the wounded and sick when they begin to circle. In this sense they embody both fear (of death) and finality (its inevitable arrival). But taken in their aggregate, when their role is examined in the larger hierarchy of the animal kingdom, they are doing important work. As Eve Ensler points out: "they clean up the dead." Even vultures' body chemistry is specifically engineered toward this task. Vultures have special enzymes in their stomachs that allow them to digest rotting flesh without succumbing to the parasites that invade it. Their feet release a protective sweat, with chemical properties that allow them to walk over and amongst the dead unscathed. This is why vultures can appear not only at the sight of a single dead animal in a solitary field, but swarming over masses of dead bodies – thousands of (human) remains on a battlefield.

When the vulture metaphor is brought to the interaction between the medical anthropologist and the socially dead, it can only be taken so far. As an info-vulture studying women in the daily rent hotels, watching for the appearance and outcomes of their pregnancies over three years, I was certainly a harbinger of social death. It is obvious to point out that few medical anthropologists study success stories – uneventful pregnancies among well nourished, middle class San Francisco women. Medical anthropologists tend to study things that are not working and the consequences of their failures. Like animal vultures, info-vultures could be accused of a morbid attraction to

261 Solomon, D. (2010) Questions for Eve Ensler: The V Generation Published: New York Times Magazines. January 21, 2010

the wounded, sick, and dead. In this sense my presence, and interest, in women's lives reflected the "public secret" (Taussig, 1999) of their social death.

Yet, this ethnography of pregnant addicts did appear by chance. It was not a topic I sought out to study when I entered the daily-rent hotels as an anthropologist, nor one I would have chosen. As an info-vulture, the reproduction of the socially dead was there before me. While collecting the narratives of women's experiences an intimacy developed between us that sustained me. My evidence is like that of the category makers and the neurocrats and all the other figures in this ethnography. It is produced as narrative, yet it is always in complex relation to my perceived ethical responsibility to be present for it, my professional demands to feed off it, and in a larger sense, my hope to play a role through the witnessing and the feeding, of its transformation into something else. Vultures don't just clean up the dead. By ingesting the dead, the dead become part of them.

Is this an example of the defining characteristic of the anthropological encounter as colonial? Achille Mbebe, in his writing about Africa and modernity, describes a necropolitical perspective. Colonialism is the politics of death: a close study of history, knowledge production, and violence in this ethnographic site could not produce another truth about it. To understand the phenomenology of [racialized] violence, one must recognize the phenomenology of body as population, internally. In the postcolony, the colonized must delegate death to and against an other, or defer it. Mbebe writes:

> [H]ow is it possible to live while going to death, while being somehow already dead? And how can one *live in death*, be already dead, while being-there – while having not necessarily left the world or being part of the spectre – and when the shadow that overhangs existence has not disappeared, but on the contrary weighs ever more heavily?...[F]irst, by being, literally, *several in a single body*. 'We are twelve in my body. We are packed like sardines.' In other words, the *being* that I am exists each time in *several modes* – or, let us say, several beings, which, although sometimes mutually exclusive, are nevertheless inside one another…This virtually constant passage from the single to the multiple must be performed in the very compartments of ordinary life, as circumstance and events occur…One still needs to know how to recognize oneself in these multiples, notably when they give out signals, lurch, liquefy, or do monstrous things…In the postcolony, it is power to delegate oneself that…enables one to delegate

> one's death to another, or at least to constantly defer it, until the final rendezvous. It follows that death, in its essence, can very well, each time, not be mine, my death; the other can die in my stead.[262]

Mbebe's words resonate deeply. They seem to capture the visceral nature, emotional discomfort, and sense of political and ethical betrayal I often experienced while info-vulturing in the daily-rent hotels with starving, drug addicted pregnant women. Women operated in several modes. I analyze them temporarily, not in reference to several beings. Yet, several beings were there, literally the woman and her unborn child. I came to see them as "living in death" because of the social circumstances of their survival in the daily-rent hotels and the childhood and adult histories they told. In her autobiography, *The Last Resort: Scenes from a Transient Hotel*, Aggie Max has a chapter called "Death." It begins:

> Because poverty is boring. The endless struggle to pay the rent is boring. Because you hate the dump where you live. Why struggle to pay rent for a place to live if you are not living? As though you're already dead, and you have to pay rent on your own grave. Worse, you have to pay it to the ones who killed you. And They didn't even kill you for personal reasons, or because you were some enemy of Theirs, they just wanted to profit from your misery.[263]

In addition to Mbebe's necropolitics, another Africanist's writing on the colonial encounter also struck a cord. Joan Comaroff's observations about the mutual transformative nature of the colonial encounter in the production of knowledge described the limits and possibilities of info-vulture and pregnant addict social relations. In line with a Foucauldian analysis of the productive nature of power[264], Comaroff argues that both (the colonized and colonizer) are changed in encounters of knowledge production that anthropologists seek to evidence. For Comaroff the "continuities and discontinuities of

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262Achille Mbebe (2001) *On the Postcolony*. University of California Press. page 201-2

263 Aggie Max (1997).*The Last Resort: Scenes from a Transient Hotel*. Chronicle Books. Page 116.

264 Foucault writes: "So the question is not: Why do some people want to dominant? What do they want? What is their overall strategy? The question is this: What happens at the moment of, at the level of the procedure of subjugation, or in the continuous and uninterrupted processes that subjugate bodies, direct gestures and regulate forms of behavior? In other words, rather than asking ourselves what the sovereign looks like from on high, we should be trying to discover how multiple bodies, forces, energies, matters, desires, thoughts and so on are gradually progressively, actually, and materially constituted as subjects, or as the subject." Foucault, *History of Sexuality, Volume I*; page 124-5.

the modern Tshindi world" are only accessible through a historical analysis which reveals that the "articulation" of the relationship between global systems and local formations "while inherently contradictory and unequal, is not universally determining."[265] Comaroff finds the Zionist movement among the Tshindi particularly illustrative of the ways in which the body is the ground of social suffering and of healing, that religion can arrive initially wearing the face of spiritual imperialism - to impart colonist ideologies of exploitation and dependence - and, in a future guise, come to criticize them. She writes: The "desired transformations focus upon 'healing' as a mode of repairing the tormented body and through it, the oppressive social order itself. Thus the signs of physical discord are simultaneously the signifiers of an aberrant world."[266] There is no passive witness, no information production that is neutral. The info-vulture is a narrative-stealing informant, an intimate, a feeder, and, even, a friend. But she goes home the end of the day.

III. Evidentiary intersections

> DESIGN: Prospective, multicenter study
> SETTING: 18 hospitals in the United States
> RESULTS: Interviews were completed by 667 women. Of these 26.8% reported no prenatal care before admission to labor and delivery. These women were more likely to have been born in the United States, have other children, used alcohol, and reported being unhappy.
> CONCLUSION: Further research is necessary to identify nontraditional models of care to enhance outreach to women at risk for no prenatal care.[267]

Christmas Day, 2009
I am reading some *Harry Potter* to my daughter when my cell phone rings. I think it is my aunt. She is dying from alcoholism and a related immune disorder and has been calling for a couple of days now. According to my other aunt she is drinking again. She can not remember that she has left several semi-hysterical and tragic voice messages. So she keeps calling. I sigh. I don't want to break up this moment with my daughter so I let the call go to voicemail.

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265 Comaroff, J. (1985) *Body of Power, Spirit of Resistance*. University of Chicago Press. Page 155

266 Comaroff, J. *Body of Power, Spirit of Resistance*, Page 9

267 Potter JE, Pereyra M, Lampe M, Rivero Y, Danner SP, Cohen MH, Bradley-Byers A, Webber MP, Nesheim SR, O'Sullivan MJ, Jamieson DJ. (2009) Factors associated with prenatal care use among peripartum women in the Mother-Infant Rapid Intervention at Delivery study. *Obstet Gynecol Neonatal* Nurs. 38(5):534-43.

Several hours later I check the messages. It was Ramona calling from *First Steps*. This is the message: "Kelly, Hey. It's Ramona. Just calling to say 'Merry Christmas!' I am still at *First Steps*. I started my visits with my son. He came Wednesday and Thursday. I get three hours a day, six hours total for a week. He is going to back Monday at 2:30. So, I just wanted to call and let you know that I am doing good and I think about you everyday. And I just wanted to say Merry Christmas. Okay. I love you. And give me a call here. Okay. I will be able to talk to you. Alright? Have a wonderful Christmas, honey. I miss you. Tell everyone I said 'Hi.' Bye."

I call her back and get through. She sounds good. She likes the foster mom that is keeping her son - so far. "She's black," she tells me, confirming her as a good choice. She mentions a Christmas party that Duke came to, and that if I see him I need to emphasize how important it is for him to show up at the court dates, so she can have her son placed in her custody once she "phases up" in her treatment program. I never see Duke because he doesn't live in San Francisco, and isn't in the Mission very often. But I tell her I will let him know if I do see him. "You should see little man, Kelly. He is getting darker (skinned) everyday. He looks just like Duke! He is still a little man, though. He isn't gaining much weight. He's okay though. He is totally detoxed now."

She mentions that Danell and her daughter are still there. We agree to talk in the New Year and hang up after about 20 minutes.

I revisit the question of reproduction and social death through the lens of evidence production, first by examining the two evidentiary forms offered above. An epidemiological abstract published in a peer-reviewed clinical journal, which includes a large sample of post partum women. A field note that describes a brief post partum conversation between an ex-pregnant addict struggling with her recovery and an anthropologist. How do they tell a similar story and how do they diverge in their narratives? More importantly, why might their similarities or differences matter? The abstract describes the importance of "outreach" to women who are at risk for not having prenatal care prior to delivery, the field note narrates affection and concern shared between the two women about a child, which offers a lens into what a "non-traditional" model of care might look like. The abstract presents faceless, nameless statistical renderings of a public health problem – women with no prenatal care – in an advanced Western capitalist society (18 US hospitals). The field note situates the two women, both as mothers who are facing wildly different parenting constraints characterized by their vastly divergent class positions and relationships to the state.

Each vignette provides evidence, a form of truth production, and they intersect. The anthropological field note may gain political traction through its narrative force. Any policy impact it might have often emerges when it is contextualized along side numbers that reveal the "problem" to be "big enough" to move beyond idiosyncratic, individuated tragedies to be defined as a full scale pubic health emergency. Vincanne Adams has commented about the hierarchies of attention attributed to public health problems according to their statistical power. When participating in a clinical trail of a technology to decrease maternal mortality, Adams was part of a research team who were told there would not be enough maternal death in their region of study to merit their research project.[268] Stark, but honest to the nature of the pubic health enterprise on the global field. Not all studies will be funded and the numbers have to justify research intervention. Is this statistical gleaning done to guarantee the production of "evidence-based" scientific results? Sure. Does it also mask the unequal distribution of health resources which then necessitate randomized, controlled trails to prove the efficacy of doing anything at all? Absolutely. One might ask of the epidemiological abstract: why did women report "being unhappy" as one of the statistically significant covariates in the lack of prenatal care? What does "being unhappy" stand in for here? If the anthropological narrative I offer in my field note above provides "texture" for epidemiological renderings, are such narratives always hand-maiden to the statistical apparatuses of public health? Do these ethnographic evidentiary representations continuously replicate what Nancy Campbell calls the "governing mentalities," of individuated risk and failure that moralistically frame health debates related to drug users?[269]

By setting the modes of evidence production side by side, I explore their points of intersection and their points of incommensurability. I hold each evidentiary form up to

268 Adams, Vincanne et al. (2005) The Challenge of Cross-Cultural Clinical Trials Research, *MAQ* 19:267-289.

269Campbell, N. (2000) *Using Women: Gender, Drug Policy, and Social Justice*. Routledge.

discovery and to criticism, in hopes of revealing the complex politics that lies thinly veiled behind each. I argue against the "ethnographers escape" – the tendency, especially in science studies, to smugly critique the producers of positivist evidence by depoliticizing the anthropologist presence and presenting an omniscient narrative. The infovulture is not an unbiased reporter of ethnographic "facts" in this ethnography, poised to pull back the curtain and reveal the foolishness of category-makers and the politicians they seek to influence. The info-vulture and the category maker are both serious and strategic, one carries the weight of the compromised ethics of witnessing, another claims objectivity.

The neurocrat and the proto-capitalist share evidentiary concerns as well; concerns about money. The evidence that matters to each is ultimately related to costs. The hotel manager seeks to defer the cost of empty rooms by economically exploiting as many women as possible on a daily basis. Women recognized and were sometimes angered by the exploitative practices of charging visitor's fees and forced monthly evictions. These practices were illegal and left women displaced, transience, and at risk for poor health. Women also often expressed resignation toward these practices because they were consistent with the logic of the drug sex economy is which hustling often meant making a buck on another's misfortune. Ironically the proto-capitalist hotel managers are "proto" because there concern about profits does not match their reward. The profits will line the pockets of those who manage the master leases for the hotel not the gate keepers and managers who met out punishments and privileges to the women renting rooms.

Public officials responsible for the management of neurocratic logics also need to attend to cost–effectiveness. Ensuring that drug users with mental illness can be diagnosed and documented for Social Security Income (SSI) benefits is not only a matter of creating legible forms of disability which might also support housing stability. It is a way for the city to be cost-effective in the mental health provision of services as part

of the San Francisco safety net. Neurocratic evidence is multi-referencial, but money is the bottom line. Two points of references: neurocrats provide a huge return on investment to the public health system (20 million dollars in Medical cost savings) and health policy recognition for certain mental illness to be equally disabling to physical illnesses. In an ironic shift of fate, should President Obama's proposed health care reforms pass, the Department of Public Health will no longer have its 'return on investment' argument to support SSI advocacy, because everyone will have access to Medicare and care providers will be able to bill for it automatically. This potential fallout from a progressive policy reform demonstrates the ultimate power of cost-effectiveness to drive city health policy for the urban poor.

How, then, do the urban, drug-using poor garner and circulate evidence about themselves? The focus of this project has been on pregnancy and addiction, so I have attended to the forms of evidence production most relevant to pregnant addicts. Other forms of social activism in relation of program closures and discontinued funding for homeless women's health service sin general were on-going during my ethnographic study. They included the threatened closure of both the *Women's Space* drop-in center (three times) and the threatened discontinuation of the outreach program that I volunteered for in 2009. I attended several rallies and demonstrations between 2007-2009 to protest cuts in services and increase public and mediated visibility about homeless women. Pregnancy was not a feature of these service demonstrations. I even participated in a newspaper article written about "women in the SROs"[270] that was part of a three-article series. Interestingly, the article about women in the SROs did not discuss pregnancy or children, but did address the drug-sex economy. The article about families living in the SROs,[271] did not discuss drug use. Instead it focused on

270 Vanessa Carr. Women Seek Stability in the SROs. Mission *Loc@L*. January 9, 2010.

271 Nina Goodby and Brooke Minters. A Family Home in an SRO. Mission *Loc@L*. January 5, 2010.

underemployment among recent immigrant women and their husbands who lived with them with their children in cramped SRO rooms. The pregnant addicts that I studied lived in the interstitial spaces between these two representations, and were therefore absent.

The exceptional nature of the pregnant addict allows her to rise to the top of the service food chain while not having a sympathetic, mediated representation around which to rally. Services for her, while not perfect, are rarely cut all together. For example, the PPMT (Prenatal and Postpartum Methadone Treatment) program was funded through the city's "general fund" and therefore not as susceptible to the pressures of city debt and fiscal crises, particularly those occurring in 2008-2009 when the national economy crashed. That said, the pregnant addict has no political constituency per se. There is no one marching in the street in defense of the pregnant addict. Her continued drug use while pregnant makes her political poison, however empathetic one might feel toward an individual woman embroiled in that situation. So evidence production for the pregnant addict was not a political, public construction during my ethnography. Indeed, the political invisibility of the pregnant women in the daily hotels led providers and health officials to raise their eyebrows in concern when I would mention that I had followed 20 pregnancies in a two block radius.

The truth that pregnant addicts told about their situation was historic, biological, and maternal: a narrative of her childhood - her mothering, and her own failure to mother her children; a tox screen at birth, and a child in her custody. Many women who had lost or given up custody of their children carried mementos, photographs which brought to life their longing and disappointment at the same time providing some awkward form of comfort – a connection to a past that made them recognizable to themselves. Kin of last resort sometimes had continuous contact with women. Ramona said she spoke with her daughter DeLoni everyday, and to prove it called her on her cell phone in front of me one

day while we were hanging out in her room and she was smoking crack. Other times kin of last resort appeared in women's lives suddenly and then disappeared again, when crises related to child custody and childcare arose. Each visit caused a women's complex relationship with her family, especially her mother, to rematerialize, requiring delicate negotiations that consisted of equal parts guilt, blame, gratitude, and anger.

Evidence with apparent biological markers was also discussed my pregnant addicts. Some fretted about hereditary inheritance of behavioral, and even moral, fallibility - to them from their mothers, and from them to their children. Of the women who gave birth to live children, all had their babies tested for drugs at birth. This testing provided a form of biological evidence – evidence of the presence or absence of drug use during pregnancy. The results of the tox screens were used by CPS workers, service providers and by pregnant addicts to justify or contest forms of social adjudication. Even a tox screen positive for only methadone could be combined with evidence of a women's "history" - past experiences losing child custody because of drug use – to justify child removal and open a CPS case.

Finally, for pregnant addicts evidence is maternal. The proof was sometimes the child, in the mother's arms despite the odds and however permanently or temporarily. The joy of this particular evidence trump all others, as Danell's photo below aptly demonstrates. But it was often fragile, requiring a Herculean self-discipline, in a Foucautian sense, to maintain, always under the watchful gaze of the state. Life is extremely uncertain for pregnant addicts who live in the daily rent hotels and the evidence about them, including that which they produce, is unstable.

Danell with her baby in drug treatment August 2009. Photo: Lynn Wenger.

Given the multiple and circulating truth claims about pregnancy and addiction, what added value does an ethnographic approach offer? Being a medical anthropologist in this setting allows for the creation of an additional narrative, one which can follow the evidence as it travels from the laboratory, to the clinic, to the street. This is not an omniscient story of passive witnessing, mere documentation and associated critique; the info-vulture is part of the story. A serious engagement with critical medical anthropological methods that observe and analyze the everyday and a science studies approach toward the production and circulation of evidence offers a unique lens into the complexity of pregnancy and addiction within this social world.

IV. Time seals all wounds

…until they reopen.

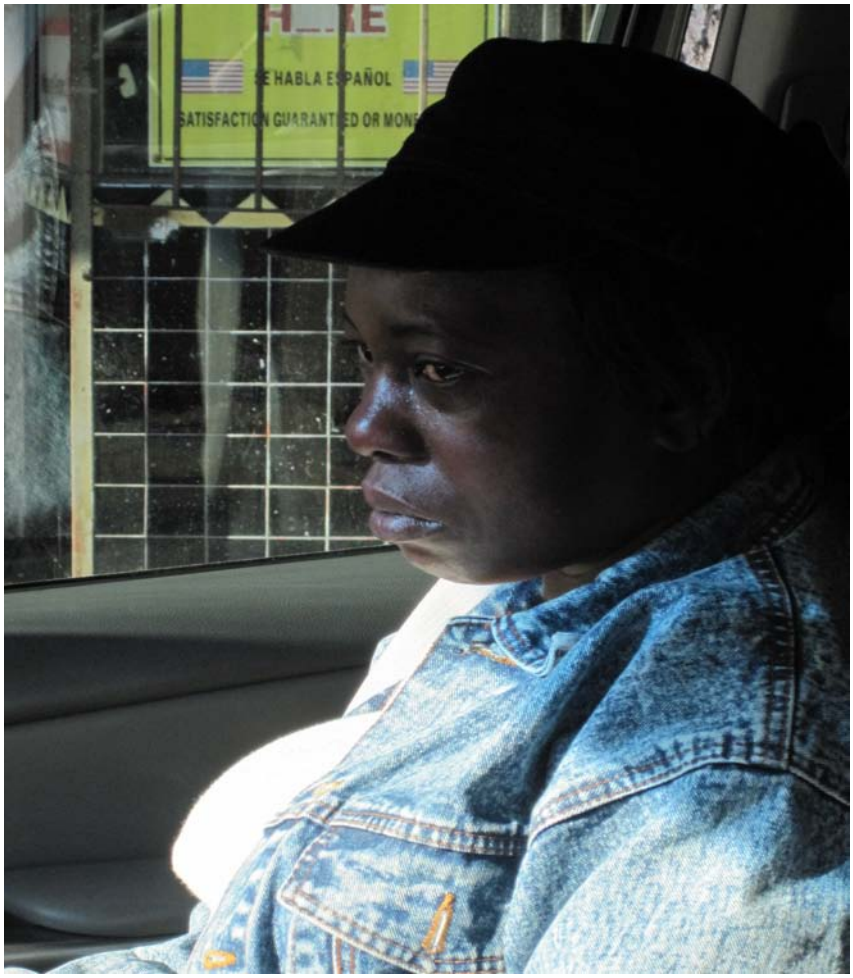
Lexi September 2009

"It is all bad Kelly, all bad," Lexi says to me as she is trying to get into my car. She can't do so without a lot of pain. She winches.

"I lost the baby, and…" Her voice trails off. She says softly. "I think it was something I did. I don't know. The same thing happened, [her cervix opened prematurely]. But see Pano and I were fighting and it was such a mess. Then the police came and when I got to the hospital. It was horrible. The baby wasn't right. He was deformed, and Oh my God." She stops. Lexi is numb staring out the window as we drive back to the Mission.

"I am so sorry Lexi." I say. I don't ask any questions so she continues.

"This was two days ago. I called my sister and then I found out that Lionel, that my mother is in the hospital and Lionel is coming down here on the bus tonight! So I gotta get my room paid for and get his papers and I have to take care of *him*, because this is a test. This is a test for me, because I ain't gonna have no more babies now. They took it all out [performed a hysterectomy]. So I gotta do right by Lionel and my family. I need to pay for the room and clean it up, and buy him some food, cause he is coming tonight. I didn't tell them [her family] what happened to the baby. This is a test for me, and I need to just take care of this today [Lionel and her rent] and then I will let them know.



Lexi two days after her son's death, driving back to her room at the Chandra Hotel, September 2009.

The present in this ethnography was linked most closely to the temporality of pregnancy. Pregnancy time marked the progression toward a resolution of uncertain futures or their foreclosure. Time repeated. Histories – of neglectful and abusive childhoods, of past children lost to the state or dead - were relived, while each pregnancy offered the often unfulfilled opportunity to change a life course. Understanding the multiple temporalities at stake in the everyday lives of pregnant addicts was essential to synthesize the wide ranging narratives and behaviors that I documented during my participant observation. Temporality was also central in the wide spread diagnosis of PTSD and bipolar disorder. The cumulative vulnerabilities born of neglect, abuse, loss and grief in the family and social histories of pregnancy addicts produced symptoms in the present. As the symptoms of these histories lingered over time, the rage, sadness, and irritability were packaged into psychiatric diagnoses and medicated accordingly.

Addict time, pregnancy time and hotel time exerted competing pressures on women, affecting the ways they are able to project futures for themselves as mothers. The institutional involvements enacted during jail and treatment time intervene upon and disrupt the lives of pregnant addicts, offering possibilities for access to services and imposing strategies of governmental management. Epidemiological time seeks to introduce scientifically valid temporal perimeters in order to quantify the complex social realities of women's behaviors and experiences. Women's pasts, their childhoods with their biological families, foster families, and institutional "families" constantly interject the present moments of pregnancy with weighty significance. How women try to square their histories, the traumas of past pregnancies and lost custody of children, with their present moment is a meaning-making exercise that adds to the production of evidence occurring in this ethnographic milieu.

V. Shifting the scene of the crime

> "What can you tell me about the defendants?"
>
> "In every sense, they are children ... in fact, lovely children, like any other. Under normal circumstances, they would have had a wonderful, normal life. But they are children of apartheid. Most come from broken homes and from deprived families where no one is working. Education is out of the question.... They have experienced everything, been exposed to everything."[272]

Nancy Scheper Hughes famously asked "Who's the Killer?" in her essay exploring the murder trial of a young, white female anti-apartheid activist by three boys in South African township riot. How do we sort the victims from the perpetrators in a landscape of political violence and generations of suffering? For pregnant addicts who embody the victim/perpetrator dichotomy, the scene of the crime is constantly shifting from brain to behavior, from deprived social histories to PTSD, from manic income generation to support drug addiction and stay housed to bipolar disorder, from daily hotel to the hospital to residential treatment facility, and back to the hotels. Blame and responsibility in relation to pregnancy and addiction are constituted and reconstituted as she moves through these various "locations". Observing what women did – their individual and social behaviors, revealed the political economic constraints of place. These locations could be progressive and not so progressive neoliberal public health intervention sites (hospitals, residential treatment facilities, advocacy programs, jails) or privatized daily-rent hotels. Each location helped explain women's vulnerability to residential transience, instability, and poor health outcomes while pregnant.

Some women told narratives of movement from a family home to an SSI home when they described the linkages between their childhood experiences and their current mental health diagnoses. Monica linked her suicidality, drug use and anxiety to her childhood molestation, sterilization and subsequent rapes. Kitt linked her bipolar disorder

272 Conversation between anthropologist Nancy Scheper-Hughes and Nona Goso, a defense lawyer, during the murder trail of Amy Biehl in South Africa. From Scheper-Hughes, N. (1995) "Who's the Killer?" Popular Justice and Human Rights in a South African Squatter Camp. *Social Justice.* 22(3):143-164.

to a forced abortion and confession to her father. Lexi (and her boyfriend Pano) linked her bipolar disorder to experiences of childhood molestation and being forced to raise her sister's child.

Some women told narratives of moving from the street to the hospital. Anita was taken directly from homelessness to labor and delivery. Ramona was arrested sitting on the ground at the 16th Street Plaza and taken to hospital where she was able to stay to give birth to a baby free of crack and stabilized on methadone. Danell and Benz both entered drug treatment in advance of the birth of their children, avoiding the hospital as crime scene location. Ramona did not completely escape this fate, her baby was tested and a CPS case opened. She was mandated into drug treatment and her son went to foster care. However, her entrance into residential treatment reconstituted her from a failed addict to a recovering mother.

Lexi, Dylan, and Anita all traveled, several times, directly from the hospital back to the daily-rent hotels. Lexi experienced the traumatic death of two of her children at almost 6 months pregnant and saw all of the social capital she had been given while a pregnant addict – access to methadone, case management, a chance for housing – evaporate when her biological status changed back into mere addict. Rocky was "called back" to the scene of the crime. Having gotten into treatment and gained custody of her son, she returned to drug use at the daily-rent hotels.

As pregnant addicts are displaced between these multiple locations they are reconstituted. They experience an ontological shift which shapes how they are visible as mother and as addicts, as victims and as perpetrators. It is difficult to assess whether this shift will only be a temporary deferral. Will history repeats itself, or she will land in a stable home?

VI. Mental health and addiction: categorical convergence?

Scientific renderings of addiction and mental illness appear to be experiencing a convergence. Discourse is recentering on the brain as the wellspring of relevant information about behavior and motivation. How does the pregnant addict both embody and disrupt this convergence? Construing mental illness and addiction as organic brain diseases shape moral discourses about pregnancy and addiction and provide necessary subtext in the diagnosis and treatment of homeless women addicts. Neurocratic practices biomedicalize the social realities of poverty and underemployment, specifically capturing the rage and despair many homeless women experience through the diagnostic "fit" of PTSD and bipolar disorder. The collective pharmaceuticalization of addiction and mental illness is manifest in the widespread diagnosis and treatment of these illnesses with atypical antipsychotic medications. This convergence is instrumental and it serves many masters. Neurocrats speak to the necessity of categorical convergence for social recognition and safety net reimbursement. Big Pharma offers atypical antipsychotic medications which psycho-pharmacologically cover over the problematic clinical reality of the diagnosis of PTSD and bi-polar disorder symptoms in women who are actively using stimulants and hustling in social environments which necessitate hyper-vigilance and mania in order to work, eat, and stay housed.

It is unclear what the future will hold in the convergence of mental illness and addiction. Many psychoanalysts could not, in their widest nightmares, have predicted in in1985 that by 2005, 27 million people in the United States – or 10 percent of the population- would be taking anti-depressant medications.[273] Better drugs changed the market and physicians became inundated with pressure to prescribe. Mediated images and public discourse about depression emerged combating stigma and contributing to

273 Liz Szabo. Number of Americans taking anti-depressants doubles. *USA Today*, Aug 9, 2009.

the doubling of mediation rates. We observe similar shifts occurring in the publicly mediated representations of addiction – there is more willingness to discuss addiction publicly. The disease of "addition", as compulsivity, has proliferated to absorb multiple problematic behaviors - not just alcohol and drugs, but food, exercise, sex, and gambling, to name a few. The National Institutes of Drug Abuse (NIDA) is optimistic that the scientific discourse will push the envelope of our understanding of addiction as a brain disease through improved MRI technologies and better rat studies. In this effort, NIDA, as a political entity, positions itself precariously in relation to the personal responsibility for and social fall out of addiction. The brain disease model for addiction could unburden many families – many mothers, who like the schizophrenogenic mothers of the past, incur blame and responsibility for their children's social failure. It could also liberate addicts themselves from guilt and shame. However, it appears that the right pill needs to be available – one which will do what the drugs do without the behavioral, health and social damage, in order to operationalize the addiction as a brain disease, on the ground.

We are, perhaps, a long way from that point. But it is interesting that even bench scientists, those whose laboratory experiments continue to add to the growing literature of neurological addiction science, waver at the loss of autonomy that might become the logical extension of the brain disease thesis. One neurologist of addiction I interviewed spent two hours explaining to me the intricacies of what is known about drugs, behaviors and the brain. Shortly before our tour of the rat lab, he paused to make this comment:

> "Abuse" is not a biological term. Addiction is. Addiction is in the brain. It is behavior you cannot stop doing. Once you start getting in to the actual neural mechanisms of it, all of that goes away. You stop making the value judgments. Science has nothing to do with value judgments. It really doesn't. What people try to do is that they try and use science to support their values. You see politicians do that all the time. I like being a scientist because I really want to get at explanations and I want to get around the confusing metaphors and narratives that people use. I don't really don't like that. But the biggest problem that I run in to is that I say "The brain is doing it." And they say "You mean the person is not responsible?" And I say "Yeah, that is what I mean, they are not responsible." Well if you do away with the concept of personal responsibility, the culture

> disintegrates. We need it. But it is just not scientifically-based. Not if you are a pure scientist. I would say that it has not been established that there are any scientifically validated value judgments. That is what I mean when I say that willpower is just another form of neural activity. Let's stop worrying about it.

In a recent issue of the *British Journal of Addiction* a debate ensued over the publication of an article, "The 10 most important things known about addiction." The article enlivened a rivalry between therapeutic and scientific camps in addiction health research that mirrored earlier debates between psychoanalytic and psychiatric orientations toward mental illness.[274] These contentions formed an interesting response because the article actually attempted to synthesize the brain science and treatment perspectives. It called for "unity" between "warring factions" to ease the suffering caused by addiction:

> This paper brings together a body of knowledge across multiple domains and arranged as a list of 10 things known about addiction…The 10 things are:
>
> (1) Addiction is fundamentally about compulsive behaviour;
> (2) Compulsive drug seeking is initiated outside of consciousness;
> (3) Addiction is about 50% heritable and complexity abounds;
> (4) Most people with addictions who present for help have other psychiatric problems as well;
> (5) Addiction is a chronic relapsing disorder in the majority of people who present for help;
> (6) Different psychotherapies appear to produce similar treatment outcomes;
> (7) 'Come back when you're motivated' is no longer an acceptable therapeutic response;
> (8) The more individualized and broad-based the treatment a person with addiction receives, the better the outcome;
> (9) Epiphanies are hard to manufacture; and
> (10) Change takes time.
>
> The paper concludes with a call for unity between warring factions in the field to use the knowledge already known more effectively for the betterment of tangata whaiora[275] (patients) suffering from addictive disorders.[276]

The abstract is far-reaching and concise. Numbers one and two place addiction squarely in the organic realm: addiction involves compulsive behavior that is "outside of consciousness" and therefore outside of reasoned behavior, outside of control. Number

274 See Lakoff (2005) and Luhrmann (2000; 2007) for discussion of these tensions in the field of psychology/psychiatry in Argentina and the United States respectively.

275 Tangata whaiora" is an aboriginal term used in psychiatric/mental health discourse in New Zealand. It's literal translation is "people seeking wellness," but it is also often translated as "consumers." In this abstract it is translated as "patients."

276 Sellman, D. (2010) The 10 most important things known about addiction. *Addiction* 105(1) 6-13.

four tags the fact that addiction and psychiatric disorders are overlapping and thus difficult to distinguish from one another. Numbers three, five, six, seven, and eight all underscore the variability of addiction at the individual level. They argue against a specific "recipe" for the treatment of addiction, and highlight that "motivation" is not an appropriate moral metric for addicts. Number nine is the perfect blending of the moral – the spiritual devastation that drug addiction brings to individuals and families - and the industry of treatment. "Epiphanies are hard to manufacture", indeed. Lastly, number ten references the complex relationship between addiction and temporality. "Change takes time." But whose has time? Not treatment professionals who are burnt out on pregnant addicts missing appointments and disappearing from services again and again. Not policy-makers who seek cost-effective (read timely, efficient) interventions with quick and lasting results. Least of all pregnant addicts whose biological clocks are ticking ever closer to delivery each moment.

VII. The labor and delivery of public policy

> What is problematic, then, is not the good verses bad intentions informing [policy] processes…but the contexts and forms in which such intentions are asserted, along with their unintended consequences.[277]

Public policy for pregnant addicts is labored. As Carol Kingfisher observed when studying a city counsel's decision making processes about building a homelessness shelter, both context and form bear weight upon outcome. During my period of ethnographic field work among pregnant addicts, a national economy crisis occurred which altered the stakes of housing and health policies in San Francisco. The belt-tightening that resulted from this crisis changed how health officials discussed evidence for supportive housing public policy making. In 2007, when I first interviewed a health and housing official he insisted that "Numbers don't build buildings, stories do." At that

277 Kingfisher, C. (2007) Discursive constructions of homelessness in a small city the Canadian prairies: Notes on destructuration, individualization, and the production of (raced and gendered) unmarked categories. *American Ethnologist* 34(1): 91-107, Page 103.

time he was arguing that public officials were swayed by testimony, by the kind of vignettes that a medical anthropologist might produce, as much, if not more so than by statistics about the health benefits of housing for the urban poor. The reasons for this were multiple. Epidemiological research studies take too long and lack the "human element" which conveys the importance of housing in people's lives. Policy makers also don't understand numbers. Narratives, people's stories, are easier to relate to, he argued. By late 2009, he was singing a different tune. He said:

> My budget is about cost. I like to think of it this way: I take one person – one drug user who is out on the street with a bunch of health problems and active substance use. My budget is whatever costs that person accrues yearly in the emergency room, and the psych ward, minus the cost to house that person for one year and defer those costly service visits. That is my budget. That is what I have to work with.

I am not inferring that housing and health policy was made regardless of cost prior to the economic meltdown, I am merely pointing to the changing context and forms of evidence that were leveraged in these different time points. The general political economic climate which exists in San Francisco is progressive, and liberal (outrageous to conservatives) with a solid safety net in place to care for the mental and physical health of the poor and uninsured written into city law. Harm reduction efforts to house the homeless mentally ill, and prioritize pregnant addicts for treatment and services are broadly supported. Given that these progressive, structural interventions were in place, I found it disconcerting that most pregnant addicts were not accessing them. Rather, they were entering drug treatment through interactions with the criminal justice system. While programs for pregnant addicts were supported and even protected from budget cuts, and services existed specifically to engage women who were addicted and pregnant into care in order to *avoid* CPS involvement and retain child custody, most women didn't go. Until they were forced to be court order. Furthermore, many women credited their interaction with the criminal justice system as that which secured their later child custody.

These claims on the part of pregnant addicts flew in the face of my own judgments about the criminalization of women drug users. They have forced me to self reflect upon my own political views, views that were tested when the events I observed fell outside of my academic comfort zone. The on-going criminalization of women in the daily-rent hotels disrupted their ability to conduct sex work, criminalized their addictions, and was never directed toward the hotel managers who illegally exploited women in a daily basis. Yet, at crisis points during many women's pregnancies, an arrest and court order was what got them out the hotels and closer to gaining custody of their babies. Were the allied relationships that many women described during these interactions with police some form of Stockholm syndrome, where the captive bonds with, and ultimately defends, her capture? Where they simply a reflection of the extent of the women's lumpen status[278]? I am unsure.

Services exist for pregnant addicts in San Francisco, yet they are underutilized or inconsistently utilized without court mandate. Supportive housing initiatives exist for homeless women in San Francisco, yet none of the pregnant women I studied in the daily rent hotels were accessing those supportive housing programs. Facing this quandary that I feel unable to solve, I instead make demands on an anthropology which would bear witness to pregnancy and addiction to also remain located in the socially compromised everyday realities of women's lives. Anthropology which seeks to comment on publicly adjudicated social problems needs to turn a critical eye upon itself. What role can anthropological evidence play here? A conversation I had with a supportive housing policy maker highlighted the tensions between an interventionist's orientation toward the social problem of homeless pregnant addicts, and witness' stance.

278 See Bourgois, P. and Schonberg, J. (2009) Righteous Dopefiend. University of California Press.

What's worse? **November 2009**

I am having lunch with a friend, colleague, and long-time interlocutor. I have let it slip that it is very hard for me to bear witness to pregnant women smoking crack, during a conversation with this service provider who is also a health official. She asked me what I do and I had said "I don't know. Sometimes I just want to kill her."

Later in the conversation she says, "Kelly I have to tell you, you seem really burnt out. I don't think I have every heard you say you wanted to kill one of your woman before. What are you doing to take care of yourself?" I laugh uneasily, "I am trying to finish this up."

She says, "To me, what's hard is lack of gratitude. Me and my staff work so hard, and try and make it work, try and keep people housed, keep them from dying. There is no gratitude. It may be ego but sometimes I feel I need that, that acknowledgement of my work."

"That is so messed up, because I get thanked all the time. Women are always so grateful to me. I get so much love. And sometimes it makes me feel so cheap. Here is you, offering medical care, offering housing. You have something, some skill that *could* be useful. I have nothing to offer." I complain.

"I think having someone to hear your story can be very beneficial…"

My skeptical face stops her short from finishing.

"Blah. blah. blah." She says in reaction to my raised eyebrows. "Well at least you aren't in the position of offering an intervention, of defending an intervention, that might not be working, one that might be the wrong thing. That is a horrible feeling."

"Peddling snake oil?" I question.

"Exactly. That's the fear. That's worse [than being an anthropologist]."

We exchange glances. We have both been doing our versions of "this work" for over 15 years in San Francisco. This is an honest conversation.

As we grab our coats, she says "What I don't understand is that there don't seem to be any less of them. No less misery. I have housed thousands of homeless people in this city – a huge number. Yet when I look at the streets, it seems the same. I don't believe they are coming from the East Bay to use up San Francisco's resources, but I just don't get it. How can there be more?"

VIII. The reproduction of social death

> [T]he boundary between collective trauma and individual trauma is as difficult to discern as is the passing of historical trauma from one generation to the next.[279]

The journey of the pregnant addict, full of plight and possibility, unfolds as a collective and individual traumatic drama. The pregnant addict embodies social failure – somewhere in her history things went horribly wrong. In her brain? In her childhood? With her family? A result of all the drugs? Too much abuse? Not enough social

279 Fassin, D. & Rechtman, R. (2009) The Empire of Trauma: An Inquiry into the Condition of Victimhood. Princeton University Press. Page 284.

intervention – or the right one at the right time? She is now struggling with addiction – really struggling and loosing everyday – and with impending motherhood. Staying and (sex) working the daily rent hotels amid social conflict, violence, and the daily economic exploitation. She becomes pregnant, keeps using drugs, has a child, and loses custody. Or, she becomes pregnant, uses drugs, enters treatment, then regains custody. It is difficult to rely on any temporal cross section in the life of an individual woman in this story. One inescapably feels that the life cycle of housing instability, violence and neglect is merely being temporarily disrupted by pregnancy. Pregnancy among most women I studied did not reconfigure their life course, at least not for long. As the statistics point out, the majority of women who use drugs before and during pregnancy return to drug use post-partum.[280]

This is the reproduction of social death among pregnant addicts. Because the women are socially dead when they become pregnant it is an act of sheer resurrection to escape the pull back into her pre-pregnant social world. Several women – Danell, Benz, Ramona - have accomplished that feat. But Lexi and Anita's narratives also describe moments of mothering victory – two years clean and sober with Lionel for Lexi, two children born drug free for Anita. What followed for Lexi and Anita is the opposite social reality – children dying and children lost to custody because of drug use. The story of Anita's child custody hearing bears witness to raging addiction to drugs, constant temporal deferral, and fraught familial and institutional relationships. My appearance as "driver" raises the question of whether the event would have occurred at all, outside of its anthropological generation.

280 The NSDUH (National Survey on Drug Use and Health) Report. Pregnancy and Substance Use. January 2, 2004. Retrieved December 2009. http:///www.oas.samhsa.gov.

Anita packs her things for court: a comb, a cross and a crack pimp, March 2010

Anita's trip to court **March 2010**

I arrive at the Chandra Hotel to pick up Anita for her daughter's custody hearing at about 8:20 am. We are supposed to be at court at 9:00, and we need to swing by and pick up her mother, who lives a couple of blocks away. Anita's aunt has been refused custody of Anita 6-month old daughter. Anita says this is because, "I keep having babies, and they [CPS] are afraid that my family will keep taking them for me. Because I don't get it together [go into treatment]." I also suspect that the fact Anita's aunt has 8 children under her care already, including Anita 3 year old, that CPS is reluctant to add one more. The custody hearing today is to decide whether her daughter will go for permanent adoption, which will permanently terminate any custody claims Anita or other members of her family, could make on her.

When I knock on the door, Anita says "Shit. She is here *already*." She seems surprised that it is already time to go. She opens the door and come in. There is a guy in her room named Darren. He is sitting very close to the TV watching an episode of *ER*. It is the one where one of the show's doctor stars falls, goes into labor and has a difficult and dangerous birth followed by an emergency hysterectomy. We are all watching the show and it lends a sense of urgency to the eerie, dark scene in the hotel room. The curtains are drawn, the bed has no sheets on it. I am not sure that Anita has slept at all. Darren doesn't say a word, and doesn't move much. Anita also seems absorbed and stunned to silence.

Then, as if waking up suddenly, Anita starts cleaning up the room a bit. There are needles spilt all over the bed and all the contents of the Anita's purse has been dumped out on the floor. I sit in a chair, whose cover is ripped up and stuffing is leaking out of it. There are clothes every where, piled under the desk, to the right of the door and by the TV. Anita stops to sit down and smoke some crack. She then tries to find some pants that don't have stains on them and a jacket. As she reaches over the bed I notice that the abscess on her back left shoulder has opened and is bleeding down her back. I point this out and she tries to mop up the blood with some toilet paper. A few minutes later I say, "Anita, honey, your really bleeding. We should bandage that up." I look

around and see some gauze still in the wrapper and some tape on the desk. I do a quick and haphazard job of covering the wound.

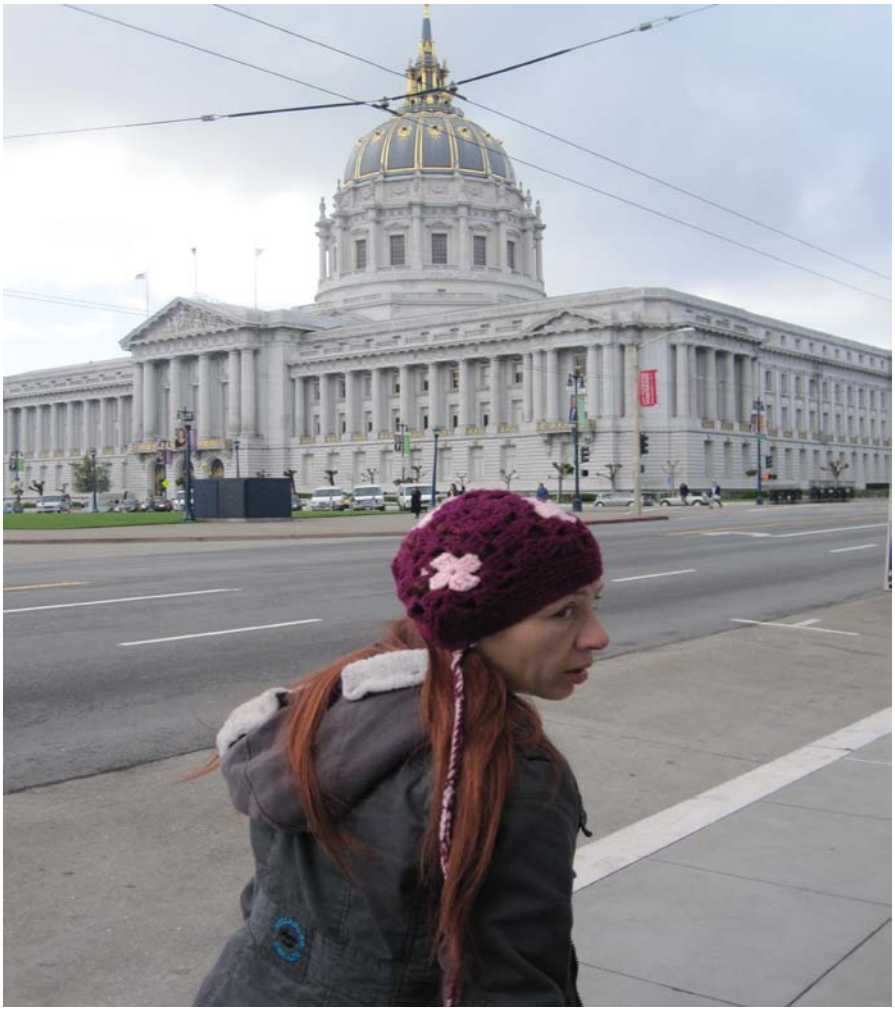
We watch more *ER*. The father of the baby in sent to ICU, but it looks like the baby will be OK.

After a short while I mention the time. She says, “Don’t worry they [the court hearings] never start on time. Do you have your phone?” She asks “Call my mom and see if she is there.” Anita gives me the number and I dial. No answer. “Jut let it ring.” Anita instructs me.” After a while I hang up. “She already left. “says Anita. “They don’t think I am going to make it, because I didn’t go to the methadone program.” Anita had plans to go to methadone, so she could show the judge that she is making an effort in drug treatment. She didn’t go.

She keeps looking for her coat, and cleaning up all the needles into a plastic bucket. She asks me if I would take some pictures of the huge hole in the floor underneath her bed that cold air is coming for. “Watch out for the needles, don’t go on the bed. They are everywhere.” She tells me. I move the bed a bit and see the hole and take several pictures of it. I open the curtain to look at the air shaft. “So this where Nancy fell?” I ask. “Yeah,” Anita says, sighing. “The paramedics had to breakdown my window to get to her.” A week earlier one of the woman who stayed upstairs, Nancy, fell, or was pushed, out of the window trying to escape from someone in a drug deal gone wrong. She fell, broke her back, and became paralyzed.

Anita goes down the hall to settle up some business and get more crack. She whispers specific instructions to Darren. “Do not leave my door open.“ She commands. She has left her next hit of morphine loaded in a syringe on the desk and is afraid someone will steal it while she is at the hearing. Finally we are ready to go. We start to drive toward the court house, and she suddenly motions me to turn around. We go to a local drop-in where she picks up a methadone voucher. She feels this might help, if she shows it to the judge. After having moved slower in her hotel room, Anita is now agitated about the time and worried about getting there.

On the rest of the ride down, Anita explains that her mother has always been there for her, through all her pregnancies. She reiterates that it was not until her father passed way that any of her children were “born dirty” [with a tox screen positive for illegal drugs]. Her father did blame her drug use for the stillborn death of one of her children with Down’s Syndrome. But Anita explains that she went into premature labor and the doctors wanted the baby to be bigger so they could perform an operation on him to correct for birth defect. According to Anita, it was her father’s mother who refused to leave a shopping mall to go back for Anita’s forgotten medication which caused her son’s death. “I begged my grandmother to go back [and get her medication], but she didn’t want to use up the gas. So of course I went into labor again. Both me and my mother agree that it was that mean birch who killed my son. If she had gone back, he would have lived.” As we rush to the hearing Anita stops to put on a hat her grandmother – the same women whom she blames for her son’s death – made for Anita when she was five. “Maybe the hat will bring me good luck [in my custody case]” she tells me. “There was a time that the woman was nice to me.”



Anita rushing to her daughter's custody hearing in the hat her grandmother made for her. March 2010

We arrive 45 minutes after the hearing was supposed to have taken place. Anita is now panicked, looking in all the court rooms for her aunt and her mother, while I wait in line at information. When we reach the desk, Anita starts to cry. "She says her name, and that she hopes the hearing isn't over." We find out that it is over. We go to court room #4 anyway. Her mother and her sister are not there, but the CPS lawyer is there. She explains to Anita that she cannot discuss the case because Anita has a lawyer, but that the decision has been postponed until June. The CPS lawyer tells Anita to find her who is out in the hall. The CPS staff are helpful and attentive. Anita asks the CPS lawyer, "Will it make a difference if I am in treatment, now?" As we leave the small court room, Anita says she does not want to find her lawyer, she wants to leave.

Anita searching for her methadone voucher outside her daughter's custody hearing, March 2010

Walking to car Anita says mostly to herself, "OK, so I just need to get into a program by June. OK." In the parking elevator I ask Anita what she is going to do now. "Smoke crack." She says with a sheepish grin. But then immediately retorts in a tougher voice, "You asked."

It is a bit strange that in the midst of all the shifting signifiers of category and causation characterizing the production of knowledge in this domain, somehow "pregnant addict" still remain immediately recognizable; there is a mental picture to conger up. Yet behind the media portrayals and the numbers, before the diagnoses, and in the everyday a much more complex and contradictory set of explanations begins to emerge. The fracturing of the narratives – the inconsistencies, corrections, and thoughtful pauses – ushered forth from the army of professionals struggling, often

sincerely, with how to understand and *respond* to the social problems of homeless drug-using women is one of the most interesting part of the larger story. These fractured narratives oddly mirror those of many pregnant addicts, themselves, who perform their own self-reflexive categorization and causation exercises as they seek to understand their everyday lives and the institutions and relationships which they use, abuse, and those which use and abuse them.

The difference in the stakes and consequences of these necessary exercises in evidence production and circulation make political and ethical demands on all involved. The examination of evidence production is crucial to broaden our understanding of seemingly intractable problems that the anthropologists often witnesses and the public often reads about – repeated rape and assault; smoking endless amounts of crack cocaine; hostile, overworked doctors casting a blind eye toward women's suffering; activist's producing pictures of those the government has left out of its urban planning. There may be many ways to tell the stories of "pregnant addicts." Yet, we cannot lose sight of who falls faster and harder when the evidence gets too muddled, and the stories begins to loss whatever ability to generate empathy they may have had.

Even so, it would be a mistake to interpolate pregnant addicts as victims, only. Because in doing so, one can ignorantly endorse the paradigms of the worthy and the unworthy poor, and silence the possibility for alternative narratives. Pregnant addicts are producers of evidence who can narrate their own stories. She has a theory, an explanation, or an opinion at least, about why it turning out this way. It is when she – or her baby - end up in the morgue – a behavioral health statistic transformed into a death statistic – that it is blatantly obvious: one story can be silenced in a manner others cannot be. Evidence production and circulation matter because how we know what we know about a social problem matters. We need to be critically inclusive and self-

reflexive in our understanding and then bring that full weight to bear upon “useless suffering,”[281] in the multiplicity of forms that its truth comes to light.

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