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Intersectionality in the Opioid Crisis: Anti-Black Racism and White, Pregnant, Opioid Users

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Khiara M. Bridges, Race, Privilege, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy, 133 **Harv. L. Rev.** 770 (2020).

Political and social discourse is often characterized by an oppression Olympics. Which group, which characteristic, can assert that they are "more authentic, more oppressed, and thus more correct"? This dynamic appeared in full force during the Democratic primary. Was Pete Buttigieg more oppressed because of his homosexuality? Elizabeth Warren for being a woman? Kamala Harris for being a black woman? As a recent article by Khiara Bridges shows us, thinking about oppression in this way misses the nuance of how different forms of oppression intersect with one another. In Race, Pregnancy, and the Opioid Epidemic, Khiara Bridges weaves together some of today's most perplexing issues.

Bridges begins with a puzzle. White privilege, as commonly understood, is supposed to promote the life outcomes of white individuals (and, conversely, undermine those of people of color). If that is the case, how can we explain the opioid crisis that has disproportionately undermined the life expectancy of white individuals? The problem can be stated more universally, beyond the opioid context: "[W]hen bad things happen to white people—when the jobs and the industries on which they once relied disappear, when their preferred university denies them admission, when they lose a promotion to a nonwhite candidate, when they die from suicide and drug overdoses at unprecedented rates—we are left to believe that white people experiencing these negative consequences did not have white privilege[.]" (P. 774.) Some might even argue that white privilege never existed to begin with. Perhaps other axes of oppression—sex or poverty—have more oppressive force than race.

Bridges uses the regulation, arrests, and prosecutions of pregnant people for the use of opioids to show how "white privilege is a double-edged sword." (P. 775.) (She notes that because data collection in this context uses the category of "women," she does too, although not just women become pregnant. I follow suit.) Bridges first sets up the paradox at the heart of the Article: she shows how white women—who putatively experience white privilege—are nevertheless the face of opioid punishment. Bridges begins by providing an overview of the opioid epidemic that has resulted in 400,000 overdose related deaths between 1999 and 2017. The face of the epidemic, she notes, is white, although the distribution of opioid deaths across race tracks the racial population of the American population as a whole. To my mind, such a framing is appropriate: while deaths are not racially disproportionate in purely numerical terms, they are disproportionate in terms of how economic, class—and race—privilege is distributed. Given the disproportionate capture of such privilege by white America, the fact that white individuals perish in proportion to their representation in the population as a whole is remarkable.

Bridges contrasts the treatment of the opioid epidemic with that of the crack-cocaine epidemic. If the opioid epidemic codes as white, crack cocaine was associated with black America. Scholars suggest that this differential coding resulted in unequal treatment: the opioid crisis is generally understood as a medical problem; white opioid addicts are victims who cannot help their fate. Black crack addicts, on the other hand, were demonized; the crack epidemic was the subject of criminal, not medical, intervention.

Pregnancy, however, is an exception to this general rule—unlike other opioid users, white pregnant women who use opioids *are* treated as criminals. Bridges documents how pregnancy has historically been the site of state intervention. Historically, although the evidence suggests that women of color and poor women do not disproportionately use substances during pregnancy, "prosecutions for substance use during pregnancy have tended to fall on the shoulders

of black women." (P. 820.) Between 1973 and 2005, before the opioid epidemic hit its stride, 52% of women arrested for substance abuse during pregnancy were black. Part of the racial disparity of these "first generation prosecutions" (P. 823) came from the higher rates of testing poor black women experienced, as Bridges's body of work documents. It also developed as a result of state decisions about which substances would be criminalized. Bridges writes, "A number of … substances can harm fetuses…. the state's choice to single out users of crack cocaine for criminal punishment, while ignoring users of the abundance of other substances that are unhealthy to fetuses, is a consequence of crack cocaine having been racialized as black." (P. 819.)

The opioid epidemic, however, has resulted in a rash of "second generation prosecutions." (P. 824.) Now, white women are being targeted at unprecedented rates, with white pregnant defendants prosecuted for substance use in South Carolina outnumbering black defendants 16:1 in 2014. Further, although state laws mostly criminalize only opioid *possession*, rather than opioid *use*, prosecutors have turned to other statutes to criminalize opioid-use-while-pregnant. Pregnancy thus expands white women's criminal liability beyond that which non-pregnant opioid users would experience (to the extent they experience any criminal liability at all).

Herein lies the paradox: how could individuals with "white privilege" become the face of opioid prosecutions? How can one reconcile scholarship that treats crack prosecutions as a manifestation of racism and white privilege with the white face of opioid prosecutions?

As Bridges explains, the concept of white privilege has been problematized in the face of suffering among white individuals. Some scholars argue that only certain kinds of white individuals experience that privilege, or that white privilege may sometimes yield only intangible benefits. However, Bridges argues that white privilege is very much responsible for the coercion that poor pregnant white opioid users experience.

First, "white people are at times made vulnerable to disadvantage *because* they occupy a privileged social location." (P. 828.) For example, some accounts suggest that "white people's drug use is a result of their disappointment with their current social and financial condition—a disappointment produced by the belief that they were going to be better off," (P. 827) in part, perhaps, because of their race. Minorities, who lack similar expectations, are therefore arguably less susceptible.

Next, Bridges points to the history of the eugenics movement. There, while *white* women who were "imagined to bear substandard genes" (P. 830) were subject to sterilization to protect the integrity of the white race, people of color—whose race was already inferior—were not. Similarly, in the opioid epidemic, she suggests, an overriding preoccupation of the well-being of white babies, undergirded by a preoccupation with preserving the "vitality of the white race," (P. 832) drives prosecutions. Unlike the "crack babies" of the crack-cocaine epidemic, which commentators denounced as future burdens on the state, white babies in the opioid crisis are treated as sympathetic victims. Put simply, "[i]nasmuch as society prizes white procreation over its nonwhite complement, the higher esteem in which it is held has made white reproduction a site of particular interest to the state. This interest, in turn, has opened white people up to state violence—this time in the form of prosecutions for opioid use during pregnancy." (P. 833.)

Third, Bridges points out, race is constructed. While the concept of "whiteness" at the founding of the nation was quite limited, over the centuries various ethnic groups (such as those of Irish and Polish descent) were incorporated as fully white members of society, to better draw the divisions against people of color. She suggests that "[t]he most radical interpretation of [opioid] prosecutions would be that they are about the desire to exclude from the white race a segment of people with a nominal claim to inclusion." (P. 841.) I think this interpretation is perhaps too radical and sits uncomfortably with Bridges's earlier suggestion—white pregnant women are disciplined precisely *because* of their membership in the white community. But Bridges's overall point is well taken. Although she does not explicitly draw on expressive theories of law, I read Bridges as pointing to the expressive function of opioid prosecutions: chastising women who have "degraded" their "whiteness… functions to establish what whiteness really is. Whiteness is not poverty, criminality, substance dependence, or corrupted pregnancy." (P. 843.) These prosecutions do the work of

reinforcing race boundaries by policing those who transgress the boundaries of race. By being made "examples" of, pregnant white women prosecuted for using opioids are once more victims of the class privilege they putatively enjoy.

If on one hand white women are rendered vulnerable by white privilege, they are also made vulnerable because of black disadvantage. White pregnant women are not just white—they are also pregnant women. In that way, they share a social space with black women who experienced profound racial disadvantage in the crack cocaine context. Path dependence in that space damns white pregnant women as well: while opioid dependency is treated as a health problem, very differently from the crack cocaine epidemic, for *pregnant women*, "the racist prosecutions that took place during the crack cocaine scare might have normalized" punitive approaches. (P. 850.) "The result is the reduction of white privilege's power to protect its holders from disadvantage." (P. 850.) In this way, "sex and gender," specifically in the context of reproduction and fetal welfare, "constrain the promises of white privilege." (P. 847.)

Bridges's seamless synthesis has broader implications, beyond the specific context she excavates. First, to my mind, it shows how discourses of power can provide cross-cutting support to each other. It is no accident that white supremacy uses as its sacrificial cautionary tales those who experience disadvantage because of gender and economic status. In shoring itself up, it also reinforces these other categories of oppression. This reinforces key insights of intersectionality theory and of activists on the ground who would discard an oppression Olympics metaphor for one of interlocking oppression.

Further, it offers insights for other ways in which discourses of power can often harm those who putatively benefit from them in other contexts. Scholars have noted how masculinity discourse can actually work to harm men; in various contexts, men who feel they have not lived up to the ideal that gender hierarchies expect of them exhibit behaviors that are problematic from a public health standpoint. They do not obtain required mental health support, and engage in substance abuse at higher rates. Indeed, gay men, who may feel less constrained by traditional gender roles, are more likely to seek out mental health care than straight men. Similarly, bisexual individuals, who some may assume occupy a higher status on the hierarchy of sexual orientation than lesbian and gay individuals, suffer far worse health outcomes than both gay or straight people. As scholars and practitioners incorporate understandings of social structure and injustice into healthcare, they must nuance their understanding of the roles we play with respect to the various discourses we occupy.

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